

**PHARMACIST E&O APPLICATION – RENEWAL  
 ALBERTA**

1. Your Name: \_\_\_\_\_

If your employer, personal address or contact information has changed, please indicate below:

\_\_\_\_\_

\_\_\_\_\_

2. Is there a claim or suit pending, or has a claim been paid or judgement entered against the Applicant for damages on account of Malpractice, error or mistake, alleged or otherwise, occurring in the practice of his Profession?  Yes  No If yes, please attach details.

3. This policy is an Occurrence Base. The following limits are available. Please indicate your choice.

Per occurrence	Aggregate	Premium	Please indicate your choice
\$2,000,000	\$2,000,000	\$195	<input type="checkbox"/>
\$5,000,000	\$5,000,000	\$355	<input type="checkbox"/>

**Note: Coverage is not bound until payment is received. Annual premium is minimum and retained**

**Payment Options:** Cheque for amount indicated above attached to the application, Visa, MasterCard or on-line.

To pay premiums *on-line*, select *Sheppard Insurance* as a payee, and use the *Customer Number* provided within the email sent to you with the Renewal Instructions.

- On-Line (Please complete amount of payment and signature below)
- Visa Credit Card Only
- MasterCard Credit Card Only

Card Number: \_\_\_\_\_

Amount of Payment: Circle One: \$195.00 \$355.00

Expiry Date: \_\_\_\_\_ / \_\_\_\_\_ mm/yy

Signature: \_\_\_\_\_

Name on Card: \_\_\_\_\_

**Please fax this form with the application to 780-425-0689.**

**Your policy documents will follow within 15 business days. Thanks for your business!**