



## PHARMACY TECHNICIANS E&O APPLICATION – NEW ONTARIO

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

Employer: \_\_\_\_\_

Personal Address \_\_\_\_\_, City \_\_\_\_\_, Province \_\_\_\_\_, PC \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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	Provincial Tax – 8%	Please indicate your choice
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\$2,000,000	\$4,000,000	\$125	\$10.00	<input type="checkbox"/>
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\$5,000,000	\$5,000,000	\$175	\$14.00	<input type="checkbox"/>
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**Note: Coverage is not bound until payment is received. Annual premium is minimum and retained**

4. Provide details of all Errors and Omissions or Professional Liability Insurance carried in the past three years:

Insurer	Period	Limit	Deductible
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

### DECLARATION

The undersigned declares that all statements made in the Application and the information contained in documents attached is true. It is agreed that the Application shall be the basis of the contract.

My signature below authorizes my broker and/or insurance company to collect, use and disclose any of this personal information, subject to the law and to my broker or insurance company's policy regarding personal information, for the purposes of communication with me, assessing my application for insurance and underwriting my policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I specifically consent and agree with the College of Pharmacists in my province of practice providing information to confirm the statements which I have made under this application regarding my practice as a Pharmacy Technician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**SHEPPARD INSURANCE SERVICE AND RISK MANAGEMENT INC.**  
...an Assurex Global Partner

Unit 118, 14315 – 118 Avenue  
Edmonton, Alberta T5L 4S6  
Telephone No. (780) 421-1515 Fax No. (780) 425-0689  
Toll Free (800) 663-2242 www.sheppardinsurance.com

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Name: \_\_\_\_\_

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

- Visa Credit Card Only
- MasterCard Credit Card Only

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

Circle Payment to be applied: \$135.00 OR \$189.00

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

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

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

**Please fax this form with the application to 780-425-0689. If you have any questions, please call us at 780-421-1515 or 1-800-663-2242.**

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