Excel

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

DIETITIANS E&O APPLICATION - RENEWAL (ALBERTA)

Term April 1st to April 1st

1. Your Name: _____

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

_____

_____

2. Are you a current licensed member in good standing with a provincial college of registered dietitians?

❑ Yes ❑ No **NOTE: You must be in good standing to participate in this program**

3. Claims Information:

i. Has a claim ever been made against you in the past 5 years or are you aware of any facts, circumstances or allegations which may give rise to a claim against you? ❑ Yes ❑ No

ii. Have you ever been investigated, summoned to a disciplinary panel, or been suspended from practice by any regulatory body governing the practice of your profession? ❑ Yes ❑ No

If you answered YES to any of the above claims questions, Please contact Sheppard Insurance before proceeding further

4. This policy is a Claims Made Form. The following limits are available. Please indicate your choice.

Per occurrence	Aggregate	Premium	Please indicate your choice
$2,000,000	$2,000,000	$175.00 +$25.00 Fee	☐
$5,000,000	$5,000,000	$220.00 +$25.00 Fee	☐

Optional: (only available if E&O coverage is purchased)

Commercial General Liability	**$2,000,000**	**$105.00**	☐
***NEW* Cyber Liability Coverage**	**$50,000**	**$80.00**	☐

5. Do you work in a clinic? ❑ Yes ❑ No

Do you work in a hospital? ❑ Yes ❑ No

Are you self Employed? ❑ Yes ❑ No

Other? _____

IMPORTANT NOTE:

COVERAGE CANNOT BE BOUND UNTIL PAYMENT IS RECEIVED. PREMIUM IS MINIMUM AND RETAINED.

Sheppard Insurance Service and Risk Inc.
Unit 118 14315-118 Avenue Edmonton, AB T5L 4S6
T. 780-421-1515 F. 780-425-0689

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6. Are you authorized to perform restricted activities?

❑ Yes ❑ No

If yes, please list the activity (ies)

_____

_____

7. Do you travel to patient's or client's homes?

❑ Yes ❑ No

Please provide details

_____

8. Payment Options: **Visa or Mastercard Only**

Total to be applied to Credit Card* $_____

Credit Card Number: _____

Expiry Date: _____ mm/yy

Name on Card (Please Print): _____

Signature

_____

***** If submitting electronically, you are agreeing to debit your credit card for the amount indicated on this application.**

Please email signed application to laura@sheppardinsurance.com or fax to 780-425-0689

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DECLARATION

The undersigned declares that all statements made in the Application and the information contained in documents submitted with it is true. It is agreed that the Application shall be the basis of the insurance 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's or insurance company's policy regarding personal information, for the purposes of communicating 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 provincial college, in which I am registered, providing information to confirm the statements which I have made under this application regarding my practice as a Registered Dietitian. I also understand that the premium is fully earned, and therefore, cancellation will not entitle me to a refund.

_____ _____

Signature Dated

Please email signed application to laura@sheppardinsurance.com or fax to 780-425-0689

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☐ I would like to receive additional insurance information that may benefit me and/or my business.

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