

Please complete the following that is applicable:

You must have a 2018 Alberta Pharmacists' Association (RxA) membership to register for Professional Liability Insurance.

First Name: _____ Last Name: _____

ACP Pharmacist License #: _____

CPBA PROFESSIONAL LIABILITY INSURANCE » Choose an Option	TOTAL
<input type="checkbox"/> PROFESSIONAL MALPRACTICE LIMIT	
<input type="checkbox"/> \$2,000,000/claim; \$4,000,000 annual aggregate* » YOUR PRICE \$130.00 <input type="checkbox"/> \$5,000,000/claim and annual aggregate* » YOUR PRICE \$225.00 <small>*Annual aggregate = maximum amount payable within the policy period regardless of the number of claims</small>	
<input type="checkbox"/> Yes** <input type="checkbox"/> No Has a Pharmacist Malpractice claim ever been made against you and/or the Pharmacy you were affiliated with? <input type="checkbox"/> Yes** <input type="checkbox"/> No Are you aware of any incidents or circumstances which could lead to a Pharmacist Malpractice claim?	
<small>**If you answer yes to either of the claims above please provide all supporting documentation to the insurer including: Statement of Claim, Description of any Circumstances and Insurance Documentation, i.e. Loss Runs, Insurance Policies and Claims Resolution Documentation. Send information to Marsh Canada Limited: #680, 10180-101 Street, Edmonton, AB · T5J 3S4 · Fax 1.780.429.1422 · www.mmc.com</small>	
<input type="checkbox"/> COMPLEMENTARY POLICY	
Supplement to employer paid policy; to cover members who wish to purchase a policy that will cover any possible gaps to their employer policy and/or increase limits. \$3,000,000 /claim; \$5,000,000 annual aggregate » YOUR PRICE \$35.00	
Please provide the following information: Name of your employer: _____ Current primary policy number: _____ Name of insurer: _____ Limit of primary coverage: _____	
GRAND TOTAL	
CONSENT	
<input type="checkbox"/> Yes <input type="checkbox"/> No I, _____ consent to be contacted directly by email by Marsh Canada Limited and/or ENCON Group Inc., concerning the professional liability insurance coverage (primary and complementary), they make available to me through the Canadian Pharmacists Benefit Association and the Alberta Pharmacists' Association, and my eligibility and application for, and renewal of, such insurance coverage. I understand that I may withdraw this consent at any time.	
<small>The undersigned applicant declares that to the best of his/her knowledge the statements set forth in this application are true. The applicant further declares that if the information supplied on this application changes materially between the date of this application and the time when the policy is issued, the applicant will immediately notify the company of such change.</small>	
Signature: _____	Date: _____

Payment Options: Due by June 30, 2018

Visa Mastercard
 Card Number: _____
 Expiry Date: _____
 Card Holder Name: _____
 Signature: _____

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