ALBERTA PHARMACISTS' ASSOCIATION

Professional Liability Insurance Application

Membership Period: July 1, 2019 – June 30, 2020

Please complete the following that is applicable:

You must have a 2019 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**
☐ PROFESSIONAL MALPRACTICE LIMIT	
☐ $2,000,000/claim; $4,000,000 annual aggregate* » **YOUR PRICE $130.00** ☐ $5,000,000/claim and annual aggregate* » **YOUR PRICE $225.00** *Annual aggregate = maximum amount payable within the policy period regardless of the number of claims ☐ Yes** ☐ No Has a Pharmacist Malpractice claim ever been made against you and/or the Pharmacy you were affiliated with? ☐ Yes** ☐ No Are you aware of any incidents or circumstances which could lead to a Pharmacist Malpractice claim? **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	
☐ SUPPLEMENTARY 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

☐ *Yes* ☐ *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.*

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.

Signature: _____ Date: _____

Payment Options: Due by June 30, 2019

☐ Visa ☐ Mastercard

Card Number: _____

Expiry Date: _____

Card Holder Name: _____

Signature: _____

☐ Cheque

Alberta Pharmacists' Association (RxA)
1725, 10303 Jasper Avenue · Edmonton, AB · T5J 3N6
Tel: 780. 990.0326 | Fax: 780. 990.1236

ONLINE: www.rxa.ca

GST Registration # 82905 51144