Wynward Insurance Group
Est. 1920

MALPRACTICE LIABILITY APPLICATION

	first	middle	surname	Email:
Name of Applicant:				

Residence Address: ______ Phone: ______ Fax: ______
(Included postal code in addresses)

Employer: ______

Employer Address: ______ Phone: ______ Fax: ______
(include postal codes in addresses)

This coverage expires each year on July 1st (12:01 AM) and must be renewed annually

1. The Applicant is a qualified Pharmacist ☐ Yes ☐ No Registration No. ______
   Circumstance if not: ______
2. Limits of Liability Claims Brought In Canada $2,000,000 per occurrence/$2,000,000 aggregate
   Increased limits up to $5,000,000 are available. Please contact Lothman Insurance at 306-956-0820 for details
3. Is there a claim or suit pending, or has a claim been paid or judgment 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 provide full details: ______
4. Has the Applicant been declined for malpractice liability insurance, or has any such insurance been cancelled or renewal thereof refused?
   ☐ Yes ☐ No If yes, provide full details: ______
5. Has this Applicant carried other malpractice liability insurance? ☐ Yes ☐ No If yes, please provide details: ______
6. Consent in accordance with the Protection of Personal Information and Electronic Documents Act:

If it should be necessary for the purpose of my file, I, undersigned, the applicant, specifically consent that my broker and my insurers, for the time required to fulfill their functions:

a) gather all the pertinent necessary information from the holders of my prior insurance files, intermediaries in the insurance industry, insurance companies, financial institutions, credit agencies, prevention, detection or repression of crime agencies and institutions that gather and compile data on insurance risks and loses:

- for the purpose of establishing the premium and the assessment of risk; and, if you would like to consent now,
- for the purpose of verification, assessment and the settlement of losses.

b) disclose, in the case of my broker, the information obtained to insurers with whom he is doing business, when it is my insurers, to institutions that gather and compile data on insurance risks and losses and prevention, detection or repression crime agencies solely the employees, mandatories or representatives of my broker, insurers or of institutions referred to in this paragraph will have access to this information when required within the execution of their functions.

Furthermore, I consent that holders of information concerning me and covered by the present consent be released from their confidentiality undertaking and that they convey the required information to my broker, my insurers, their employees, trainees or representatives.

I acknowledge having been informed of my right to access to information obtained by virtue of the present consent and to have it corrected, if need by.

Furthermore, I acknowledge having been informed that I may address all questions regarding the present consent to my broker and/or my insurers, their employees, trainees or representatives.

DATE ______ SIGNATURE ______