PHARMACIST'S /TECHNICIAN'S

INDIVIDUAL PROFESSIONAL LIABILITY APPLICATION 2025
FOR ONTARIO RESIDENTS ONLY

PERSONAL INFORMATION: Please Print Clearly
Please note we can only insure Ontario Residents.

First Name: _____ Last Name: _____

List any/all name changes (if applicable) _____

Home Address: Street _____ Apartment/ unit #: _____

City _____ Province _____ Postal Code _____

Main Telephone _____ Fax _____ Cell Number _____

Email _____

Would you like to receive our emails: ☐ Yes ☐ No

Policy Effective date: _____ (Please note we cannot back date a policy)

PROFESSIONAL INFORMATION

Pharmacist - ☐ Student/ Intern ☐ or Technician ☐

Employed by Pharmacy Name (if applicable): _____

Applicant College of Pharmacy Registration Number _____

Registered in the province of: _____ Coverage needed for the province of _____
(list all provinces applicable, please note we can NOT insure you for Quebec) We can only insure Ontario Residents.
If needed for outside Ontario give reason why: (please use separate sheet to explain)

_____

Risk Details:

1-Are you trained to administer injections?	☐ Yes ☐ No
2-Do you want **coverage** for immunization?	☐ Yes ☐ No
3-Are you a narcotics signer?	☐ Yes ☐ No
4-Do you dispense pharmaceuticals to patients outside Canada?	☐ Yes ☐ No
5-Are you providing sterile compounding at your workplace?	☐ Yes ☐ No
6-Do you provide temporary or relief services?	☐ Yes ☐ No
7-Do you mix or compound health food, natural or herbal remedies	☐ Yes ☐ No
8-Do you Dispense Methadone?	☐ Yes ☐ No
9-If yes, are you currently holding your CAMH, ODT certificate	☐ Yes ☐ No

Please note that if you answer **YES to the question **below**, Aviva **CANNOT** insure you as they do not offer coverage for professionals working in a **hospital**, **Long Term Care facilities or other healthcare facilities**.
Are you or will you be working in a **hospital**, Long Term Care facilities or other healthcare facilities? ☐ Yes ☐ No

PRIOR CLAIMS INFORMATION

Have you ever been the subject of a disciplinary action by your governing body?	☐ Yes ☐ No
Have you ever been the subject of a claim or legal action alleging professional malpractice?	☐ Yes ☐ No
Are you aware of any allegation, compliant or incident that may result in any action against you?	☐ Yes ☐ No

(If you answered Yes, to any claim questions, please provide details including dates and results on a separate sheet)

Insurance History of Applicant

Has any insurer ever cancelled, decline or refused to renew your professional liability insurance? ☐ Yes ☐ No
(If you answered Yes, please provide details including date & result)

PRIOR COVERAGE INFORMATION: (Mandatory) Please state your last insurer for Professional Liability.

Insurer: _____ Expiry Date: _____ ☐ First Insurance Policy
Limits: _____ Basis: ☐ Claims-Made Or ☐ Occurrence

Rates: Please check off the coverage you wish to purchase

Must check off the immunization coverage option if you want this coverage. Highly recommended if you carry the immunization injection course certificate. **Certificate of Training must be provided to add immunization coverage**

Limits of Insurance Required: Individual Liability Coverage Limits

- ☐ $2,000,000 per occurrence / $4,000,000 aggregate $175
- ☐ Injection Coverage $50

- ☐ $3,000,000 per occurrence / $5,000,000 aggregate $245
- ☐ Injection Coverage $50

- ☐ $5,000,000 per occurrence / $5,000,000 aggregate $330
- ☐ Injection Coverage $50

Legal Expense Reimbursement Endorsement with deductible amount of $2,500

(THIS IS MANDATORY - MUST CHOOSE ONE, COVERAGE COMES WITH THE POLICY)

- ☐ $25,000 per occurrence / $50,000 aggregate $70

- ☐ $50,000 per occurrence / $100,000 aggregate $100

- ☐ $100,000 per occurrence / $200,000 aggregate $250

Note : Pharmacist E&O policies are subject to a minimum retained premium of $100

Consent to verify and share information

The undersigned authorizes the Insurer and its service providers to:

a. Verify, using outside sources, any information provided by this application or by documents attached to this application or by any subsequent documentation submitted by or on behalf of the applicant.
b. Transmit, in the event of a claim, such information to lawyers, loss adjusters and similar organizations for the purposes of investigating, defending, negotiating, or settling such claim.

Declaration : The undersigned declares that the answers provided in this application are true and complete.

Agreements

The undersigned agrees that:

a. if the information provided by this application changes between the date this application is signed and the effective date of the insurance for which application is being made, he/she will immediately give the Insurer written notice of such changes
b. the Insurer, after receiving notice of such changes, may withdraw or modify the premium and exclusions previously quoted and any authorization or agreement to bind coverage; and
c. if a policy is issued for the insurance for which application is being made, this application shall form part of the policy,

Name: (Please print) _____

Signed: _____

Dated: _____

Signing this Application does not bind the undersigned to purchase this insurance, nor does it bind the insurer to issue this insurance. However, should the insurer issue a policy, this Application shall service as the basis of such policy and will be attached to and form part thereof.