

PHYSIOTHERAPISTS INSURANCE PROGRAM

Professional Liability Insurance Program – Registered Physiotherapists
New / Renewal Application

General Information				
Name of Applicant:				
Mailing Address:				
City:		Province:		Postal Code:
Phone Number:	Cell Number:	Fax Number:	Email Address:	
Are you registered with the College of Physical Therapists of Alberta? Yes <input type="checkbox"/> No <input type="checkbox"/>				Registration #
Has your license ever been revoked? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes explain:				
Do you currently carry Errors & Omissions insurance Yes <input type="checkbox"/> No <input type="checkbox"/>				
If yes please provide: Insurance Company Name: _____ Policy Number: _____ Date Coverage First Purchased: mm/dd/yy				
Have you ever been de-registered by the College of Physical Therapists of Alberta? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If Yes explain:				
Do you provide any services outside of Canada? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Are you ceasing practice and would like to purchase coverage for an extended reporting period? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Has an insurance carrier ever cancelled, declined or refused to provide you with Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Have any claims or suits been made against you, or are you aware of any circumstances which may result in any claim or suit being made against you? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes explain:				
How would you like to receive confirmation of coverage: <input type="checkbox"/> Post <input type="checkbox"/> Email <input type="checkbox"/> Fax				
Coverage				
Province	Coverage Form	Limit of Liability	Period of Coverage	Annual Premium
Alberta	Errors & Omissions	\$5,000,000	October 1, 2011 – October 1, 2012	\$225.00
Would you like to add Commercial General Liability Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> if yes please select a limit			<input type="checkbox"/> Limit: \$1,000,000.00 – Annual Premium: \$100.00 <input type="checkbox"/> Limit: \$2,000,000.00 – Annual Premium: \$175.00 <input type="checkbox"/> Limit: \$5,000,000.00 – Annual Premium: \$275.00	
Signature				
<p>I/We declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as practicable. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I/We hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into.</p> <p>The information provided will be utilized for the administration of your insurance requirements, and will not be provided to third parties for any other purpose. By signing this form you are consenting to the above statements.</p>				
Name (please Print):			Title:	
Signature			Date:	
Payment – Please Check One				
<input type="checkbox"/> Cheque	Please make cheques payable to Renfrew Insurance Ltd.			
<input type="checkbox"/> Online Banking	Account Number is the first three characters of your last name followed by PH1			
<input type="checkbox"/> Credit Card	Master Card <input type="checkbox"/> Visa <input type="checkbox"/>		Credit Card Number:	
	Exp Date: mm / yy			
	Name on Card:		Signature of Card Holder:	
	Cardholder will pay the issuer the above amount pursuant to the cardholder agreement.			



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