Wynward Insurance Group
Est. 1920

Insurance Broker: McCaslin Horne Insurance Brokers Inc.
211 Guelph Street, Suite #4, Georgetown, ON L7G 5B5
Toll Free – 1-800-668-4830 Fax 905-702-1892
Email – info@mccaslinhorne.com

CAPT CANADIAN ASSOCIATION OF PHARMACY TECHNICIANS

TECHNICIAN MALPRACTICE APPLICATION – *CAPT* MEMBERS ONLY

Name of Applicant: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ _____
(First Name) (Last Name)

Residence Address: _____ CAPT Membership # _____

(Please state full Postal Address including Postal Code)

Residence Phone: _____ Email Address: _____

Current Employer & City: _____ Business Phone: _____

Policy Period: from _____ 12:01 a.m. to _____ 12:01 a.m.
MM/DD/YY MM/DD/YY
All times are local times at the applicant's postal address stated herein

1. You are a licensed Pharmacy Technician: ☐ Yes ☐ No License # _____

2. Is there a claim or suit pending, or has a claim been paid or judgment entered against you for damages on account of malpractice, error or mistake, alleged or otherwise, which occurred in the practice of pharmacy?

   ☐ Yes ☐ No If yes, please provide full details: _____

3. Are you aware of any current or pending investigation by the College of Pharmacists against you?

   ☐ Yes ☐ No If yes, provide full details: _____

4. Do you have knowledge of any act which may give rise to a claim or do you anticipate any claims being brought against you?

   ☐ Yes ☐ No If yes, provide full details: _____

5. Have you ever been declined for malpractice liability insurance, or has any such insurance been cancelled or renewal thereof refused?

   ☐ Yes ☐ No If yes, provide full details: _____

6. Is this policy replacing any prior policy? ☐ Yes ☐ No Prior Policy No. _____

   Limits _____ Insurer _____

Limit of Liability
Claims Brought in Canada
$2,000,000 / Aggregate Limit $4,000,000 **$75 +8% RST**
Defense Costs are not limited by the Policy Aggregate.
$50,000 LEGAL EXPENSE COSTS COVERAGE FOR DISCIPLINARY HEARINGS INCLUDED

CONSENT AND DISCLOSURE

I have reviewed all parts and attachments of this application and acknowledge that all information is true and correct and understand that this application for insurance is based on the truth and completeness of this information.

I have provided personal information in this document and otherwise and I may in the future provide further personal information. Some of this personal information may include, but is not limited to, my credit information and claims history. I authorize McCaslin Horne Insurance Brokers Inc. (my broker) or Wynward Insurance Group (my insurance company) to collect, use and disclose any of this personal information, subject to the law and to my broker's or insurance company's policy regarding personal information, for the purposes of communicating with me, assessing my application for insurance and underwriting my policies, evaluating claims, detecting and preventing fraud, and analyzing business results.

_____ _____
SIGNATURE OF APPLICANT DATE

CREDIT CARD PAYMENT OPTION

Your total insurance premium can be charged annually to your Visa or MasterCard account. No processing fee applies to this method of payment.

AUTHORIZATION FORM

Named Insured (First Name) (Last Name)

Address

☐ **Visa** ☐ **MasterCard**

Cardholder Name (as it appears on the card)

Card # Please fill in all 16 numbers on the line above.

__ __ / __ __
Expiry Date (MM/YY)

AUTHORIZATION FOR CREDIT CARD

I/We authorize Wynward Insurance Group to debit my/our account in payment of my/our insurance premium. I/We understand that the premium may change in order to keep my/our insurance up to date and that Wynward Insurance Group reserves the right to adjust the payment to reflect any change. I/We understand that Wynward Insurance Group is not liable for any service charges levied by my/our financial institution. **This authorization is to remain in effect until cancelled in writing by me/us**. Wynward Insurance Group will make every effort to inform me/us in advance of any change.

Date

Signature #1

Signature #2

Note: if more than one signature on a joint account please provide all signatures.
A sample cancellation form and further information on your right to cancel are available at www.cdnpay.ca.