encon

Please forward application to:
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Application

Errors and Omissions Insurance for Member Provincial Organizations of Canada's Professional Chemists/ Chimistes professionnels du Canada

THE APPLICANT

1. Name of Member Organization: Association of the Chemical Profession of Ontario / Association des chimistes professionnels de l'Ontario
2. Name of Individual and Individual Entity, if any: _____
3. Are you a member in good standing? YES ☐ NO ☐
4. Membership Number: _____
5. Address: _____
6. Telephone: _____ Facsimile: _____
   Email: _____ Website: _____
7. Years of experience: _____
8. Please provide a complete description of the Applicant's activities and attach any brochures and/or promotional literature:

   _____

   _____

9. (a) Please indicate the Applicant's gross annual revenue: $_____

   (b) Does the Applicant provide services or perform activities outside Canada or for clients who are outside Canada? YES ☐ NO ☐

   If yes, please provide full details for our review and acceptance and indicate the services provided as well as the location and the gross annual fees or income from the past year and anticipated for the next year.

10. Has the Applicant ever been investigated by or suspended from practice by any governing body of his/her profession? YES ☐ NO ☐

    If yes, please provide details.

INSURANCE COVERAGE - **If you are renewing your policy with ENCON, do not complete this section.**

11. Has the Applicant ever previously purchased professional liability or errors and omissions insurance? YES ☐ NO ☐

    If yes, please provide the retroactive date of the current policy: _____

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12. Has insurance coverage ever been declined or cancelled or the renewal thereof been refused? YES ☐ NO ☐

If yes, please provide details.

LOSS EXPERIENCE - **If you are renewing your policy with ENCON, do not complete this section.**

13. (a) In the past, has the Applicant or any of his/her employees ever been the recipient of any allegations of professional negligence in writing or verbally? YES ☐ NO ☐

(b) Is the Applicant or any of his/her employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? YES ☐ NO ☐

If yes, please attach details.

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURER, IT IS AGREED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY EMANATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

COVERAGE OPTIONS

14. Define your status as:

(a) ☐ Employee of government agency

(b) ☐ Employed by others (state name of employer): _____)

(c) ☐ Self-employed with gross revenues of less than $200,000

(d) Other – please describe: _____
(to be referred for acceptance and rating)

15. For gross annual revenues of less than $200,000, complete the following:

(a) **Employee of government agency**:

Limit Per Claim	Aggregate	Deductible	Premium	Limit Selected
$250,000	$500,000	$500	$200	☐
$500,000	$500,000	$500	$227	☐
$500,000	$1,000,000	$500	$251	☐
$1,000,000	$1,000,000	$500	$267	☐

(b) **Employed by others**:

Limit Per Claim	Aggregate	Deductible	Premium	Limit Selected
$250,000	$500,000	$500	$250	☐
$500,000	$500,000	$500	$277	☐
$500,000	$1,000,000	$500	$301	☐
$1,000,000	$1,000,000	$500	$317	☐

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(c) **Self-employed with gross revenues of less than $200,000**:

Limit Per Claim	Aggregate	Deductible	Premium	Limit Selected
$250,000	$500,000	$500	$560	☐
$500,000	$500,000	$500	$636	☐
$500,000	$1,000,000	$500	$702	☐
$1,000,000	$1,000,000	$500	$748	☐
$2,000,000	$2,000,000	$500	$850	☐

APPLICANT'S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM

I hereby acknowledge that the information collected in the Application form is acquired by my insurance broker to be transmitted to ENCON Group Inc. for the sole purpose of obtaining an insurance policy, and will be kept confidential.

Moreover, I authorize ENCON Group Inc., its insurers or service providers to:

- conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation;
- in the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purposes of investigating, defending, negotiating or settling any claims, as required.

For more information on ENCON's privacy policy, please contact privacy-officer@encon.ca.

DECLARATIONS AND SIGNATURE

The undersigned Applicant for this insurance declares that, to the best of his/her knowledge and belief, the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application form. The undersigned further agrees that if any significant change in the condition of the Applicant is discovered between the date of this Application form and the effective date of the policy, which would render this Application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurance Manager.

Although the signing of this Application form does not bind the Applicant to purchase the insurance, the undersigned Applicant agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this form will become part of the policy.

It is also agreed that, should a policy be issued, it is understood that eligibility for this program is contingent upon membership in good standing with a member provincial organization of Canada's Professional Chemists/Chimistes professionnels du Canada.

_____

Name of Applicant (please print)

_____ _____

Signature of Applicant Date

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