INSURANCE PROPOSAL FOR THE MEMBERS OF THE COLLEGE OF REGISTERED PSYCHOTHERAPISTS OF ONTARIO

PLEASE COMPLETE THIS FORM ELECTRONICALLY TO ENSURE THAT WE CAN RESPOND TO YOUR REQUEST QUICKLY.

Company name:			
Address:			
City:			
Province:		Postal code:	
Telephone:		Email address:	
Website address:		Employees:	
Total revenue:	$		
Coverage effective date:	MM / DD / YYYY		

PLEASE RESPOND TO THE FOLLOWING STATEMENTS:

1. Does your current annual revenue income exceed $100,000 ? ☐ Yes ☐ No
2. If you derive revenue from the USA, is this LESS than 10% of your total revenue? ☐ Yes ☐ No
3. Are you a registered member and hold a certification with The College of Registered Psychotherapists of Ontario? ☐ Yes ☐ No
4. Do you undertake any services with animals? ☐ Yes ☐ No
5. Have you had continuous errors and omissions cover? ☐ Yes ☐ No

   If so, please advise the retroactive date if known: MM / DD / YYYY

PLEASE SELECT COVER OPTION:

Errors & Omissions: ☐ $1m/5m Agg ☐ $3m/6m Agg

General Liability: ☐ $1m ☐ $2m ☐ $5m

ADDITIONAL COVER & LIMITS - please refer to the cost & rating table on the next page for further details

6. If you require Cyber or Legal Expense cover, please tick the relevant box(es): ☐ Cyber ☐ Legal Expense
7. If you require property cover, please select your package from the options listed on the next page and indicate your choice:

   ☐ Bronze ☐ Silver ☐ Gold ☐ Other

CLAIMS INFORMATION

After full enquiry, are you aware of any circumstances, complaints, claims, loss, or penalties/fines levied against you in the last five years, in relation to the risks that this application relates to? ☐ Yes ☐ No

DECLARATION

I declare that after proper enquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact. I agree that this application form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon.

I undertake to inform underwriters of any material alteration to these facts occurring before completion of the contract.

Full name:		Date:	MM / DD / YYYY
Position:		Signature:	

PLEASE NOTE: DO NOT PRINT AND SCAN THIS FORM. PLEASE COMPLETE THIS FORM ELECTRONICALLY, SIGN USING A DIGITAL SIGNATURE, SAVE A COPY FOR YOUR RECORDS, AND SUBMIT VIA EMAIL. THIS WILL ENSURE WE PROCESS YOUR APPLICATION QUICKLY.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF INSURANCE, PLEASE IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES. THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORISATIONS OR AGREEMENTS TO BIND THE INSURANCE.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED INTO THIS APPLICATION.