



Please forward application to:
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Application

Errors and Omissions Insurance and Commercial General Liability Insurance for Members of The Ontario Association of Speech-Language Pathologists and Audiologists

THE APPLICANT

1. Name of Applicant:
2. Address:
3. Email Address:
4. OSLA Membership Number:
5. Is the Applicant a licensed: Speech Language Pathologist Audiologist
6. During the past five years, has the Applicant had:
 - (a) any ethical or code violations as they pertain to the Applicant's practice? YES NO
 - (b) his or her license, registration or certification revoked or suspended? YES NO
7. Does the Applicant have any exposures outside Canada? YES NO
8. Please list all locations at which business is conducted, providing details indicated below.

Location/Address	Occupancy	Square Metres	Owned or Leased?

INSURANCE COVERAGE

9. (a) Has the Applicant ever previously purchased professional or errors and omissions liability insurance? YES NO
- (b) If yes, please give the following details for the last three years:

Insurer	Period	Expiring Premium	Limit	Deductible
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
- (c) With respect to (b) above, please indicate if such coverage was offered on an occurrence basis or claims-made basis:

If claims-made, what was the retroactive date of the policy (dd/mm/yy)?
10. Has insurance coverage ever been declined or cancelled or the renewal thereof been refused? YES NO

If yes, please attach details.

LOSS EXPERIENCE

10. (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.

LIMITS REQUESTED

11. Please select one of the following:

Errors and Omissions

Limit	Deductible	Premium	✓
\$2,000,000 per claim/\$4,000,000 annual aggregate	\$0	\$65	<input type="checkbox"/>
\$2,000,000 per claim/\$4,000,000 annual aggregate	\$500	\$62	<input type="checkbox"/>

Commercial General Liability

Limit	Deductible	Premium	✓
\$2,000,000 per claim/\$4,000,000 annual aggregate	\$1,000	\$175	<input type="checkbox"/>
\$5,000,000 per claim/\$5,000,000 annual aggregate	\$1,000	\$225	<input type="checkbox"/>

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.

Signature of Applicant

Date