

# The Canadian Association of Optometrists L'Association Canadienne des Optometrists

## PROFESSIONAL LIABILITY APPLICATION

### FOR MEMBERS OF THE CANADIAN ASSOCIATION OF OPTOMETRISTS

1. Name of Applicant \_\_\_\_\_
2. Preferred Mailing Address \_\_\_\_\_
3. Business Phone ( ) \_\_\_\_\_ Business Fax ( ) \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ E-mail \_\_\_\_\_
4. New Registrants: I understand this insurance is only available to members of a provincial optometric association / Canadian Association of Optometrists. I am not currently a member of my Provincial association / Canadian Association of Optometrists, but I will do so within 21 days of this application date.
- 5 (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 advised above? YES \_\_\_ NO \_\_\_

**If yes to 5 (a) or 5 (b), 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.

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 in the Canadian Association of Optometrists.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
**Effective Date of Coverage**  
(must be date signed or later)

\_\_\_\_\_  
Date Signed

**Return Completed Application to:**

**Western Canada**

Harvard Western Insurance  
Attn: Connie Middleton  
2151 Albert St  
Regina, SK. S4P 2V1  
Fax # 1-306-757-1534  
Email: cmiddleton@harvardwestern.com

**Maritimes**

Caldwell Roach Agencies Ltd  
Attn: Petra MacDonald  
P.O. Box 543, 643 Princes St  
Truro, NS. B2N 5C7  
Fax # 1-902-893-0208  
Email: pmacdonald@cral.com