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MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Please forward application to:
CSDMS
PO Box 1220
Kemptville, Ontario K0G 1J0
Toll Free: 1-888-273-6746
Facsimile: 1-888-743-2952
Email: bethbcdms@bellnet.ca

Application

Errors and Omissions Insurance for the Members of the Canadian Society of Diagnostic Medical Sonographers

THE APPLICANT

1. Name of Applicant:
2. Address:
3. 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.

4. 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

5. (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	Limits
		\$
		\$
		\$

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

If yes, please provide details:

LOSS EXPERIENCE

7. (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 provide 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.

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.

Name of Applicant (please print)

Signature of Applicant

Date