APPLICATION

Malpractice Insurance

CDSPI ADVICE. INSURANCE. INVESTMENTS.

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For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1.800.561.9401 or 416.296.9401, E-mail: insurance@cdspi.com

Please complete all pertinent questions to avoid processing delays and return to:
CDSPI, 155 Lesmill Road, Toronto, ON M3B 2T8 Fax: 1.866.337.3389 or 416.296.8920

INDIVIDUAL INFORMATION

Section 1 Applicant Information

1. Name (*please print*):
Check one: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
☐ Partnership ☐ Corporation

Last (*or name of partnership or corporation*) First Middle or Middle Initial

2. Individuals only: ☐ Male ☐ Female

3. Mailing Address:
Check one: ☐ Home ☐ Business

Street and Number Suite No.

City/Town Province Postal Code

4.
Business Telephone Home Telephone

Mobile Telephone Fax

5.
E-mail address (*please include to expedite the application process*)

6. Non-Dentists Only:
Home Address (if different than Question #3):

Street and Number Suite No.

City/Town Province Postal Code

7. A. Account Number, if known: ☐☐☐☐☐

B. Billing Preference (*check one*):

- ☐ Same as current
- ☐ Annually
- ☐ Quarterly
- ☐ Monthly*
- ☐ Pre-authorized Chequing*
- ☐ Automatic VISA/MasterCard*

** To pay monthly, quarterly or annually under this option, you must complete and send in a pre-authorized payment plans form. To obtain this form, visit www.cdspi.com.*

Note: A 2.23 per cent processing charge applies to monthly and quarterly payments.

8. Language Preference: ☐ English ☐ French

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Section 2 Party To Be Insured

Note: Please complete even if the applicant is the party to be insured.

1. Name:
Check one: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. Birthdate: Day Month Year

4. Your professional dental corporation(s) can be insured under this policy. Please list.

5. A. Person to be insured is licensed or will be licensed to practise in the following province(s):

B. If not licensed, expected date to be licensed:

Day Month Year

6. STATUS (*check one*):

☐ Dentist
☐ Member of Provincial/Territorial Dental Association*
☐ Member of CDA
* Excluding the ACDQ in Quebec.

Year of Graduation: Day Month Year

Name of University or Dental Faculty:

Dental Specialty:

☐ Hygienist†
Under Contract to/Employed by (Name of Licensed Dentist):

☐ Certified Dental Assistant†
Under Contract to/Employed by (Name of Licensed Dentist):

☐ Dental Nurse†
Under Contract to/Employed by (Name of Licensed Dentist):

† *Coverage for auxiliaries applies only to professional services performed while working under the direction or supervision of a licensed dentist.*

COVERAGE APPLIED FOR

Section 3 Coverage Details

1. Dentists only:
A. Amount of insurance applied for (check one):

☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000
☐ $10,000,000 ☐ $25,000,000

B. Deductible:

☐ $1,000 ☐ $2,500 ☐ $5,000
(If no deductible is chosen it will automatically be $1,000.)

For dentists, coverage is effective on the later of the license date or the date a valid application is received by CDSPI. For information phone CDSPI Advisory Services Inc.

2. Auxiliaries only:
Effective date of coverage: Day Month Year

Hygienists, Certified Dental Assistants, and Dental Nurses are offered coverage in the amount of $2-million and with a deductible of $500.

NOTICE ON PRIVACY AND CONFIDENTIALITY – **Must be detached, read and retained by the person to be insured**

Aviva Insurance Company of Canada is committed to protecting your personal information and using or disclosing it only for the purposes for which it is collected. When you apply for insurance, consumer and previous insurance reports containing personal, credit, factual, investigative or previous claim and loss information about you may be sought in connection with these matters. By submitting your application, you consent to Aviva collecting, using or disclosing personal information collected in connection with this application. If you wish to withdraw your consent you must notify Aviva immediately in writing. For more information about how Aviva uses and protects your personal information, please refer to Aviva's privacy statement at www.avivacanada.com.
You may request to review and make corrections to the personal information in the insurer's file by writing to Aviva Canada Inc., Attention: Privacy Officer, 10 Aviva Way, Suite 100, Markham, ON L6G 0G1, or sending an e-mail to CAPrivacyOfficer@aviva.com.

Access to information which you provide to CDSPI or CDSPI Advisory Services Inc. will be restricted to those employees, mandataries, administrators, agents or brokers who are responsible for underwriting, marketing and administration of services and the processing, facilitating and investigation of claims and to any other person you authorize or as authorized by law. You may request to review and make corrections to the personal information contained in your file at CDSPI or CDSPI Advisory Services Inc. by writing to: The Chief Privacy Officer, 155 Lesmill Road, Toronto, ON M3B 2T8.

Section 4 Temporary Coverage*

1. If you are applying for coverage for a short period of time (e.g. a few days or weeks), please indicate how long coverage is required.

   Start date: ____ Day Month Year

   End date: ____ Day Month Year

Note: There is a minimum premium charge of $250 plus any applicable tax. Payment is required at time of approval. Please contact CDSPI.

2. I have or will have a temporary licence for the following province(s):

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   Name of province(s)

DECLARATION AND AUTHORIZATION

Section 5 To Be Read, Signed and Dated By the Person To Be Insured

Malpractice Information: I agree that information on claims made against my Malpractice coverage may be disseminated by Aviva Insurance Company of Canada to CDSPI or CDSPI Advisory Services Inc. (CDSPI's licensed affiliate), and that such information and confirmation of my insurance coverage status MAY be transmitted to the licensing body of the appropriate province if this information is so requested.

I apply to Aviva Insurance Company of Canada for the insurance indicated above. The information provided by me is true and complete and Aviva Insurance Company of Canada may rely on it in issuing insurance coverage to me. I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality. A photocopy or facsimile of this authorization shall be as valid as the original.

I declare that, except as described below, I do not now have knowledge of or information concerning any claim, notice of claim, demand, or suit for professional negligence and there is not any claim or suit pending against me arising out of the performance or non-performance of professional services. I further declare that no claim has been or has to be paid by me or on my behalf and no judgment has been entered against me for damages on account of any malpractice, error, or any alleged malpractice, error, or mistake occurring in the practice of my profession except as follows:

Disclosure of claims information

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______________________ Date: ____ Day Month Year

Signature

Note: Eligibility for coverage or increased coverage is limited to dentists resident in Canada, and hygienists†, certified dental assistants† and dental nurses† resident in any Canadian province or territory and employed by or under contract to and who perform dental services only when in the office of or acting under the direction or supervision of a licensed dentist.

† *Staff members who have purchased malpractice coverage may maintain it if they change employment, as long as the new employer is a licensed dentist.*