APPLICATION FOR MEMBERS OF THE DENTURIST GROUP OF ONTARIO FOR PROFESSIONAL AND COMMERCIAL LIABILITY

1. Name of Applicant: Given Name:_____ Surname:_____

a) If applicable, Personal Corporation (i.e., Holding Company):_____

2. College Registration Number: _____

3. Is the Applicant a member in good standing with the Denturist Group of Ontario? ☐**YES** ☐**NO**

4. Primary Clinic Address *(This should be the same information as registered with the College, please update with the College if necessary):*

Number and Street: _____

City: _____ *Province*: _____ *Postal Code*: _____

Phone: _____ *Fax*: _____

E-mail: _____ *Website*: _____

5. Do you provide denturist services outside of Canada or for clients who live outside of Canada but are receiving your services in Canada? ☐**YES** ☐**NO**

If 'YES', you need further separate coverage. Please provide full details for our review and acceptance by indicating the services provided, the location where provided, and the gross annual fees or income from this year and anticipated for next year.

_____

_____

6. Has the Applicant ever been suspended, had their license revoked, or been denied a license to practice by any governing body of his/her profession? ☐**YES** ☐**NO**

If 'YES', please provide details: _____

7. Has insurance coverage ever been declined or cancelled or the renewal thereof been refused by an insurer? ☐**YES** ☐**NO**

If 'YES', please attach details on a separate sheet and attach to this application.

8. In the past, has the Applicant or any of his/her employees ever filed any Errors & Omissions Liability and/or Commercial General Liability claim with an insurance company? ☐**YES** ☐**NO**

If 'YES', please attach details on a separate sheet and attach to this application.

9. 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 on a separate sheet and attach to this application.

IT IS UNDERSTOOD AND AGREED THAT IF KNOWLEDGE OF ANY SUCH FACTS, CIRCUMSTANCES OR SITUATIONS EXISTS, WHETHER OR NOT DISCLOSED, ANY CLAIM OR ACTION SUBSEQUENTLY ARISING OR DEVELOPING THEREFROM SHALL BE EXCLUDED FROM COVERAGE UNDER ANY POLICY ISSUED BY TRISURA GUARANTEE INSURANCE COMPANY.

10. Do you operate your own clinic or are you working in a clinic owned by someone else?

a) *I operate my own clinic* ☐ **OR** *I work in another denturist's / dentist's clinic* ☐

If you own and operate your own clinic, answer the following:

b) Provide the full legal name: _____
(E.g. **incorporated name of clinic***)*

c) Provide the number of owners of your clinic: _____

d) Confirm the number of other denturists working from your clinic (employed or independent contractors): _____

e) Confirm the number of clinic locations where services are provided:

Home based:_____ Leased commercial location:_____ Owned commercial location:_____

It is important that you purchase liability coverage for your clinic entity when you lease or own a commercial location. See Part B below.

11. Professional and Commercial General Liability Rating:

Professional and Commercial General Liability				
PART A: Individual Professional Coverage **The following is for your own personal Professional and Commercial General Liability:**				
Individual Denturist Coverage	**Limit of Liability, Per Claim/Per Policy Period**	**Deductible**	**Select**	**Annual Premium**
Covers licensed Denturist and your Individual Professional Corporation	**$2,000,000/$5,000,000 – Professional Liability** **$2,000,000/$2,000,000 – Commercial General Liability**	**$0** **$1,000**	☐	**$275**
PART B: Clinic Coverage **If you lease or own a commercial location for your clinic then you should purchase Liability Insurance for your clinic entity:**				
Clinic Coverage	**Limit of Liability, Per Claim/Per Policy Period**	**Deductible**	**Select**	**Annual Premium**
Covers clinic corporation in addition to individual denturist	**$2,000,000/$5,000,000 – Professional Liability** **$2,000,000/$2,000,000 – Commercial General Liability**	**$0** **$1,000**	☐	**$25**

IF YOU OWN A CLINIC AND DO NOT PURCHASE COVERAGE B, THERE IS NO COVERAGE FOR A CLAIM AGAINST YOUR CLINIC

PART C: Optional Property Coverage Section

Please complete the following section if Property coverage is required.

12. Do you rent or own or lease the clinic's premises? ☐ OWN ☐ RENT/LEASE

If you have more than one location, *you need further separate coverage – please contact PROLINK for additional information.*

Property Insurance			
Type of Coverage	**Standard DGO Program Package**	**Increased Limits – Option 1**	**Increased Limits – Option 2**
Office Furniture, Equipment, EDP Equipment, Supplies	$75,000	$100,000	$150,000
Select Option to be Purchased	☐	☐	☐
Annual Premium	**$375**	**$475**	**$550**

PROPERTY COVERAGE IS FOR ONE LOCATION ONLY

If you own the Building, are you interested in purchasing coverage through the DGO program? ☐**YES** ☐**NO**

If 'YES', you need further separate coverage – please contact PROLINK for additional information.

TOTAL PREMIUM DUE *(CALCULATE from part A/B/C in charts above and send payment with application)*:

PART A: Professional & CGL Premium	$275
Part B: Clinic Coverage	$
Part C: Optional property coverage	$
8% PST:	$
TOTAL DUE WITH APPLICATION:	$

Payment Options: Cheque payable to PROLINK Insurance Inc. *(mail with application)*, or Credit Card *(fax, email, or mail the attached authorization form).*

Total is 100% minimum retained

PRIVACY DISCLOSURE AND CONSENT:

The undersigned authorized representative of the Applicant acknowledges that any personal information provided in connection with the insurance applied for, including but not limited to the information contained in this Application, has been collected in accordance with all applicable privacy legislation. The undersigned confirms that all necessary consents have been obtained for the collection, use, and disclosure of such information for the purposes of any investigation and inquiry in connection with this Application for insurance and, if applicable, investigating and settling claims, detecting and preventing fraud, and acting as required or authorized by law.

DECLARATIONS AND SIGNATURE:

The undersigned authorized representative of the Applicant:

(i) declares, after inquiry, that the statements and representations set forth in this Application, and all materials submitted to or requested by the Insurer in conjunction with this Application, are true;

(ii) acknowledges that these statements, representations, and materials are relied on by the Insurer and that they shall be deemed material to the acceptance of the risk assumed by the Insurer under the insurance applied for, should the insurance be effected; and

(iii) agrees that if the information supplied in connection with this Application changes between the date of this Application and the effective date of any insurance effected pursuant to this Application, the undersigned will immediately notify the Insurer of such changes, and the Insurer may withdraw or modify any outstanding indications, quotations and/or authorization or agreement to effect the insurance.

Signing of this Application does not obligate the Applicant or the Insurer to effect the insurance, but it is agreed that all materials submitted to or requested by the Insurer in conjunction with this Application are hereby incorporated by reference into this Application and made a part hereof. Terms and conditions, including limits of coverage, offered by the Insurer may differ from those applied for by the Applicant. It is further agreed that this Application and all materials submitted to or requested by the Insurer in conjunction with this Application are the basis of and are deemed attached to and incorporated into any policy effected pursuant to this Application. It is understood that the eligibility for this program is contingent upon membership in good standing with the College of Denturists of Ontario.

Name *(Please Print)*: _____ **Signature:** _____ **Date:** _____

Please submit completed and signed applications to DGO@prolink.insure or fax it to 877.595.1649, *Attn: DGO Account Manager*
For more information please visit www.prolink.insure or call 1 800 663 6828.

PAYMENT OPTIONS:

☐ **OPTION # 1** Full Payment by **CHEQUE** — *Please make your cheque payable to 'PROLINK Insurance Inc.*

☐ **OPTION # 2** Full Payment by **ONLINE BANKING** — Please make your online payment to PROLINK Insurance Inc. noting your Account No. which can be found in the top right corner of your invoice.

☐ **OPTION # 3** Full Payment by **CREDIT CARD** — *Please complete the credit card payment information (SEE BELOW).*

ADDITIONAL FEES: **Please note that a $35 fee will be assessed for all cheques returned due to in-sufficient funds. Please note that a $35 fee will be assessed for all declined credit card due to funds not authorized or invalid card numbers.**

CREDIT CARD PAYMENT AUTHORIZATION FORM (ONLY COMPLETE I F YOU SELECTED OPTION 3 ABOVE):

PLEASE NOTE: FULL PAYMENT WILL BE APPLIED TO THE CREDIT CARD INFORMATION SUBMITTED.

ADDITIONAL FEES: **Please note that a $35 fee will be assessed for all declined credit card due to funds not authorized/available or invalid card numbers.**

Client Name or Entity Name: _____

Name on Card: _____

I hereby authorize PROLINK Insurance Inc. to charge the following credit card. ☐ **Yes** ☐ **No**

Name of Person Authorizing Payment: _____

Type of Card: ☐ **VISA** ☐ **MASTERCARD**

Credit Card Number: _____

Credit Card Expiry Date: _____

Total Amount to be Charged: _____

Date credit card is to be charged: _____
(*if no date provided charges will be processed immediately*)

Email address if receipt is required: _____
(if no email address is provided receipts will not be provided)

THE FOLLOWING WILL BE COMPLETED BY PROLINK STAFF:

Customer Code: _____

Name of PROLINK Staff: _____