Prince Edward Island Pharmacists Association

E-transfers Accepted
Send your Registration Form & Payment electronically.

Pharmacist Membership Registration Form April 1, 2025-March 31, 2026

COMPLETE AND RETURN THIS FORM ALONG WITH PAYMENT.
Please make cheques payable to the PEI Pharmacists Association.
Email: executivedirector@peipha.com Mail: PEI Pharmacists Association Inc., PO Box 24042, Stratford, PE C1B 2V5.

Name_____

Address _____

Workplace _____

Email (required) _____ Telephone _____

A. Membership Dues: PEI Pharmacists Association

$270 + $40.50 HST = $310.50 **(A)**

A	$310.50

B. Choose your Professional Liability Insurance Limit

CPBA Personal Malpractice Limit	Premium **(B)**
☐ $2 000 000 per claim/$4 000 000 aggregate	$ 165.00
☐ $5 000 000 per claim/$5 000 000 aggregate	$ 270.00
☐ Insurance Not Required (Other coverage)	n/a
☐ Supplementary (secondary insurance option-see below) **	$ 50.00

B	

(HST# 80513 0390 RT0001)

TOTAL A + B

**SUPPLEMENTARY INSURANCE OPTION:

** Members who are already insured with an employer's professional liability insurance policy have the option to purchase a "Supplementary" policy that will cover you for potential gaps in your employer's policy. You must hold a minimum 2M VALID primary coverage in order for the Supplementary Professional Liability insurance to respond. Please ensure that the primary coverage has not lapsed, was cancelled, nor is invalid. Contact the Association for more details.

Required: Name of your employer or affiliate: _____**Insurer:** _____

Current primary policy number: _____ **& Limit of primary coverage:** _____

Please Answer the Following:

1. Has any application for Professional Liability insurance ever been denied or cancelled? ____ Yes ____No
2. Have you ever sustained a Professional Liability loss or has such a claim been made against you in the last five years? (Only answer "Yes" if you have not already reported this to BMS/the insurer) ____ Yes ____No
3. Have you any knowledge of any negligent act, error or omission or breach of duty which might give rise to a claim against you? (Only answer "Yes" if you have not already reported this to BMS/the insurer) ____ Yes ____No

The PEI Pharmacists Association (PEIPhA) is seeking your express consent to stay in touch with you electronically. I agree to receive PEIPhA email communications which include newsletters, notifications and updates containing information about PEIPhA and its partners. You can withdraw or provide your consent at any time by contacting the Association. ____ Yes ____No

The PEI Pharmacists Association can share the information provided with CPhA for membership purposes. ____ Yes ____No

DECLARATION:
I declare that during the last five years no insurer has cancelled, declined or refused to issue me any form of liability insurance and that this application discloses the hazards known to exist at the date of this application. I declare that the statements made herein are in every respect true and correct and hereby apply for a contract of insurance to be based upon the truth of the said statements. Submitting this form does not bind the Applicant or company to complete the insurance but is agreed that this form shall be the basis of the contract should a policy be issued. The insurance premium is fully retained and not refundable.

Signature_____Date_____

All personal information collected on this form will be handled in accordance with our Privacy Policy, found at www.peipha.com.

PEI Pharmacists Association Inc. PO Box 24042 Stratford, PE C1B 2V5 Tel: 902-367-7080 e-mail: executivedirector@peipha.com Website: www.peipha.com