Application

for Members of the Canadian Association for Integrative Nutrition and Canadian Health Coach Alliance

THE APPLICANT

1. Name of Applicant:

2. Address (including postal code):

   Telephone: Website and Email:

3. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other

   Note: Coverage under the program is intended for individuals (sole practitioners), partnerships and personal corporations only. If the Applicant is a corporation or partnership of more than two owners, the Applicant can be considered for coverage on a stand-alone basis.

   ☐ Please check this box if you are a sole practitioner, not employing any other professionals, who has an incorporated practice and you want to include your corporation as an Additional Named Insured on the policy. Please provide the name of your incorporated company below:

4. Are the Applicant's total gross revenues for the past year and projected revenues for the upcoming year less than $150,000 annually? YES ☐ NO ☐

5. Please confirm that no more than 15% of the Applicant's gross annual revenues are generated outside of Canada and in the United States of America. YES ☐ NO ☐

6. Please check the corresponding designation(s) or status of the Applicant:
   ☐ Registered Holistic Nutritionist (RHN)
   ☐ Registered Holistic Nutrition Practitioner (RNP) (applicable in Alberta, New Brunswick, Nova Scotia, Quebec)
   ☐ Registered Health Coach (RHC)
   ☐ Registered Nutrition & Health Coach (RHNC – II)
   ☐ Qualifying Student Member (contact a representative at Waypoint Insurance Services Inc. for details)

7. (a) In the past, has the Applicant or any of their employees ever been the recipient of any allegations of professional negligence in writing or verbally? YES ☐ NO ☐

   (b) Is the Applicant or any of their 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 INSURERS, 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.

8. Please list all locations at which business is conducted, providing details indicated below:

   Location/Address Owned or Leased? Occupancy Square Metres

LIMITS REQUESTED

9. Please indicate coverages and limits required:

Option A Errors and Omissions	$1,000,000	$2,000,000	Please Specify ✓ the Limit Option Desired
($0 deductible) Unlimited Telephone Legal Advice provided by DAS Canada at a $15 premium (included).	$215 ☐	$285 ☐	This is a mandatory coverage that must be acquired by all members. This coverage must be acquired to be eligible for Option B.

Option B Commercial General Liability	$1,000,000	$2,000,000	$3,000,000	$5,000,000
($1,000 deductible)	$125 ☐	$175 ☐	$230 ☐	$280 ☐

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 their 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 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 further 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.

Signature of Applicant Date (dd/mm/yyyy)

Please forward application to:
Cary Augustini
Waypoint Insurance Services Inc.
1262 Quadra Street
Victoria, British Columbia V8W 2K7
Toll Free: 1-844-210-2953
Email: CAIN@waypointinsurance.ca