

## Certificate of Being Insured Under a Professional Liability Insurance Policy Form (COBI)

Please PRINT all information clearly. The College understands the importance of protecting personal information. The information contained on this form will be used by the College in carrying out its regulatory activities only; for the purpose of regulating the profession in the public interest. All required information is marked with an asterisk (\*). Please complete all sections below.

### A. Personal Information

		<b>* Registration Number</b>
<b>* Last Name</b>	<b>* First Name</b>	Middle Name

### B. Policy Details

<b>*Name of Insurance Company</b>	<b>* Policy number</b>
<b>* Policy amount</b>	<b>* Does the policy state "Professional Liability Insurance" <input type="checkbox"/> Yes <input type="checkbox"/> No</b>

### C. Optician Acknowledgement

**\* I understand and acknowledge that making a false statement may be considered an act of professional misconduct for the purposes of clause 51(1)(C) of the Health Professions Procedural Code  Yes  No**

### D. Optician Declaration and Signature

**\* I \_\_\_\_\_ (please print name) hereby certify to the College of Opticians of Ontario that I am insured under a professional liability insurance policy with policy limits of not less than \$1,000,000, this policy is in full force and effective as of the date hereof;**

**AND**

hereby undertake to the College of Opticians of Ontario that, in the event the said policy is due to expire prior to January 1, 2010, I will either renew or replace the policy, prior to the expiry date, with one that contains policy limits of not less than \$1,000,000 and that will not expire prior to January 1, 2010.

<b>* Optician Signature:</b>	<b>* Date:</b>
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**\* Signed at (Location/ including province or country):**

### E. Witness Information

**\*Witness information/ signature is requested to confirm the authenticity of the signature of the member.**

<b>* Registration Number (If a Member of the College of Opticians)</b>	<b>* Last Name</b>	
<b>* First Name</b>	Middle Name	<b>* Occupation of witness</b>

### F. Witness Address

<b>* Street Number</b>	<b>* Street Name</b>	Unit/ Apartment No.	
P.O. Box	<b>* City</b>	Province	<b>* Postal Code</b>
<b>* Home Phone</b>	Home Fax	Email	

### G. Witness Signature

<b>* Witness Signature:</b>	<b>* Date:</b>
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#### PLEASE NOTE:

**This COBI expires December 31, 2009.  
A new COBI must be provided at each renewal, unless a Member signs an Undertaking that he / she will not engage in the practice of opticianry.**

**Please mail or fax this form to:**  
The College of Opticians of Ontario  
85 Richmond Street West, Suite 902  
Toronto, ON. M5H 2C9  
Fax: 416-368-2713 OR 1-800-990-9698