



1 Valleywood Drive, Suite #100,
Markham, Ontario L3R 5L9 Canada
Email: programs@holmanins.com
Tel: (905) 886-5630

**Ontario Traditional Chinese Medicine and Acupuncture
Professional and General Liability Insurance
Application**

www.holmanins.com
www.tcm-insurance.ca

NOTE: THIS APPLICATION IS AN IMPORTANT DOCUMENT AND IS BEING RELIED ON BY THE INSURER TO DETERMINE WHETHER IT WILL PROVIDE YOU WITH COVERAGE. PLEASE ENSURE THAT ALL RESPONSES ARE ACCURATE. THIS DOCUMENT WILL FORM PART OF YOUR POLICY.

“Applicant” means the individual practitioner detailed in question 1 below. This application form must be completed in ink, signed and dated by the **Applicant**. Please attach an updated and relevant resume/CV together with certificates proving all relevant qualifications in respect of this application. All questions must be answered and where appropriate “Not Applicable” or “N/A” specified. The completed application form along with additional information provided will form part of the contract of insurance with the Insurers. All facts material to the proposed insurance must be disclosed fully and truthfully and to the best of the **Applicant’s** knowledge and belief whether or not they are the subject of a specific question herein. In addition to the information contained in the application form including all supporting documentation, if the **Applicant** is aware of any other information which it considers may alter, influence or prejudice the Insurers’ appraisal of the risk being proposed, this information must be disclosed in conjunction with this application form.

By signing this application form the **Applicant** is consenting to the use of information, including sensitive personal information. Where personal information relates to third parties, the **Applicant** confirms that it has been given the requisite consent to disclose such information to the Insurers for processing.

If there is insufficient space to complete an answer to any question in this application form, please continue on the continuation space (and additional page) provided, which should then be signed, dated, and attached to this application form.

PROFESSIONAL LIABILITY – “Claims Made” and reported, costs inclusive

What is Professional Liability?

Professional Liability is liability coverage designed to protect professionals against liability incurred as a result of errors and omissions in performing their professional services. Our professional liability policy covers economic or financial losses suffered by third parties, as a result of your professional services rendered.

This insurance is underwritten on a “claims made” basis, which means that if a claim is made against the **Applicant** then the **Applicant** MUST have a current policy in force. Any claims brought against the **Applicant** after the expiry of the policy period (or any specific run-off extension or extended reporting period) will NOT be covered.

This insurance is underwritten on a “claims made” basis, which means that if a claim is made against the **Applicant** then the **Applicant** MUST have a current policy in force. Any claims brought against the **Applicant** after the expiry of the policy period (or any specific run-off extension or extended reporting period) will NOT be covered.

- A. The policy will NOT cover any claims from incidents which take place before the Retroactive Date, if any, or after the expiration of the policy period (subject to the Extended Reporting Period provision).
- B. The policy will provide coverage for claims from incidents which take place on or after the Retroactive Date, if any, but before the beginning of the policy period only if the insured did not know of the incident before the beginning of the policy period.
- C. The policy will NOT cover any loss for which a claim is first made after: 1. The expiration of the policy period or its earlier termination date, if any; or 2. The Extended Reporting Period if any and then only in accordance with the terms described in the policy.
- D. The policy will only cover claims which are first made: 1. During the policy period; or 2. During an Extended Reporting Period if any and then only in accordance with the terms and conditions described in the Extended Reporting Period Section of the policy.
- E. The limits for Defence Costs are included in the limit of liability.

Highlights of Professional Liability:

Policy Limits up to \$5,000,000 per Claim, \$10,000,000 in the aggregate are available across the following covers:

- Professional Liability - Optional Limit
- Libel & Slander \$100,000
- Personal Information Protections and Electronic document Act \$25,000 / \$50,000 aggregate
- Infringement of Copyright \$100,000
- Criminal Proceedings Defence Cost \$25,000
- Defence Cost and Expenses \$150,000
- Legal Representation Costs \$50,000
- Disciplinary Action Reimbursement \$100,000
- Duty to Defend \$100,000
- Coroner’s Inquest \$50,000
- General Liability \$1,000,000
- Sexual Harassment / Abuse \$100,000
- Expert Witness \$500 per day maximum \$10,000 annual aggregate
- Loss of Earnings to Attend Trial \$500 per day maximum \$25,000 annual aggregate.
- Products Liability \$250,000 annual aggregate
- Loss of Documents \$250,000
- Rescuers & Good Samaritan Acts \$1,000 annual aggregate
- Cancellation Extended Reporting 90 days
- Communicable Disease Exclusion
- Deductible \$1,000

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OPTIONAL - COMMERCIAL GENERAL LIABILITY POLICY – “Occurrence Basis”

Commercial General Liability is available as an optional addition. Coverage under Professional Liability must be purchased for this additional coverage to apply. Insurance under Commercial General Liability is on an “Occurrence Basis”.

What is Commercial General Liability Insurance?

Insurance to protect a person against legal responsibility arising out of a negligent act or failure to act as a prudent person would have acted to which results in bodily injury or property damage to another party, such as slip and fall on premises.

Highlights of Commercial General Liability – “Occurrence Basis”

- Bodily Injury and Property Damage Liability - optional limits up to \$5,000,000
- Personal Injury and Advertising Liability \$1,000,000
- Medical Payments \$2,500 per person
- Tenants Legal Liability \$1,000,000
- Non- Owned Automobile Liability \$1,000,000

Extensions:

- Employee Benefits Extension \$1,000,000
- Employer’s Liability Extension \$1,000,000

Optional Coverages Available:

- Cyber Expense
- Worldwide Coverage

Optional Coverages Available:

- Entity Coverage
- Online / Internet Training

Qualifications

In the event of a claim, the **Applicant** will be required to produce qualification certificates.

Approved Associations

This application applies only to the individual members for Ontario qualified under **the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario - CTCMPAO**. If the **Applicant** is in any doubt as to whether an individual activity or association is approved for cover under this policy, the **Applicant** must discuss this with Holman Insurance Brokers Ltd. prior to accepting cover hereunder.

Applicant Acknowledgement

Signature

Date

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WARNING

If the Applicant receives a claim or becomes aware of a circumstance that may give rise to a claim, the Applicant must contact Holman Insurance Brokers Ltd. immediately to ensure that the claim notification provisions under the policy are adhered to. Failure to do so could prejudice the Applicant's ability to claim under the Applicant's insurance policy.

If the Applicant is a new client to Holman Insurance Brokers Ltd. and the Applicant's previous liability policy was not on a "claims made" basis with the same "retro-active date" to that provided under this insurance application please call Holman Insurance Brokers Ltd. for advice as the Applicant may be exposed to a gap in cover. It is the responsibility of the Applicant to understand the type of insurance they are applying for.

Personal Information of The Applicant (You) - Please provide the following specific information:

Any **Applicant** who has qualified overseas shall also have to be individually approved prior to cover being authorized by Insurers.

1. Full Name of Applicant: (legal name as shown on CTCMPO documents)

First Name	Middle Name (s)	Last Name
Date of Birth (mm/dd/yyyy)		<input type="checkbox"/> Male <input type="checkbox"/> Female

Address:		
City	Province	Postal Code
Business Telephone #	Cell #	Fax #
Email Address	Website:	

- 2.a. Do you operate under a Business Entity or Partnership? Yes No
If yes, Full Name of Business:

Note for Incorporated Business Entity or Partnership Coverage:

This policy being applied for will cover the Business Entity or Partnership if incorporated and up to 2 administrative non-professional staff that do not provide any of the insured services. No additional charge for sole proprietor acting under a company name. There is an additional charge for an Incorporated companies and partnerships. All professionals must apply for individual coverage separately.

*PLEASE NOTE: Legal Entity: In the event of a claim, both the Professional and the Business Name could be named in a statement of claim or lawsuit. Legal Entity Coverage protects the business and its assets in such circumstances. This coverage is applicable if you are either a business owner operating on a Legal Entity name and /or employ or subcontract other people.

2 b. Telephone Number: Business # Cell #

2.c. Email Address: Fax #

3. a. Relevant Canadian Qualifications – **PLEASE ATTACH CERTIFICATES**

Name of Association, School or Centre	Course Title	Date Qualified: MM/DD/YY

3. b. Relevant Non-Canadian Qualifications -**PLEASE ATTACH CERTIFICATES**

Name of Association, School or Centre	Course Title	Country	Date Qualified: MM/DD/YY

Any **Applicant** who has **Non-Canadian qualifications** will have to be individually approved prior to cover being authorized by Insurers.

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3.c. Associations that you are a current subscribing member of (Including membership Nos):-

Name of Association	Membership No.	Date First Joined	Membership Type

Please provide evidence of current membership (e.g. Annual Certificate). **Please note that if the Applicant is not a member of any of the approved associations, there is no automatic cover and the application will have to be reviewed and specifically authorized by the Insurers, and even if the authorization is approved the above premiums may not still apply.**

4. Date Of Birth:

MM/DD/YY

5.a. Date Started Practice:

Are you registered with the College of Traditional Medicine Practitioners and Acupuncturists of Ontario (CTCMPAO)? Yes No

Date of Registration	Registration #	Designation
		<input type="checkbox"/> R. TCMP <input type="checkbox"/> R.AC

5.b. What is your annual revenue?

Past 12 months:

Anticipated for next 12 months:

What is your % revenue split between Canada, US and World-wide

\$ _____	\$ _____	_____	World-wide %
Canada %	United States %		

5.c. Number of Employees:

Professional	Clerical	Other

6. Is any of your work supervised?

Yes No

If **YES**, Please advise by whom and under what circumstances:

Name of Supervisor	Address	Tel #	Email
Please provide qualifications of supervisor			

7.a. Do you work with animals?

Yes No

If **YES**, please advise when this would happen and with what types of animal.

b. Do you work with children under the age of 16?

Yes No

If **YES**, Please advise what age and under what circumstances:

c. Are you a student or a candidate for admission to a profession, or an intern or any such other occupation that includes elements of educational tutelage?

Yes No

Where the **Applicant** is a student or candidate for admission to a profession, or an intern or any such other occupation that includes elements of educational tutelage, it is a condition precedent to the right to be indemnified under this policy that the **Applicant** be under the supervision of a practitioner/instructor qualified within the activities covered and is restricted to performing practice treatments or case work only, and that the **Applicant** advises the recipient of such treatments (or their parent or legal guardian, if the recipient has not attained the age of 16) that they are receiving treatment as part of a training program. The **Applicant** must not offer treatments outside of their capabilities which shall at all times be governed by the phase reached in their training program and their supervising instructor/practitioner's assessment.

If **YES**, Please advise name of qualified practitioner of instruction.

Name	Address
Phone #	

d. Do you provide any teaching or instructing? If **YES**, how often and to whom.

Yes No

Attach relevant qualifications.

To Whom?	How often?

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e.

Yes No

If yes, you must purchase Part B – Commercial General Liability coverage.

It is requested the following entities are to be added to the policy as Additional Insured, but only with respect to the operation of the Named Insured. The certificate applies to the named insured while operating within the scope of your Professional Services.

Name and complete address, including postal code AND email of Additional Insured:			Interest in the insurance:
Name:			<input type="checkbox"/> Corporate Name <input type="checkbox"/> Municipality <input type="checkbox"/> Studio <input type="checkbox"/> Sponsor <input type="checkbox"/> Landlord
Email :			
Address: (Street)	Province:	Postal Code:	

Name:			<input type="checkbox"/> Corporate Name <input type="checkbox"/> Municipality <input type="checkbox"/> Studio <input type="checkbox"/> Sponsor <input type="checkbox"/> Landlord
Email:			
Address: (Street)	Province:	Postal Code:	

8.a. The policy being applied for provides \$250,000 limited liability coverage for the retail sale to your clients s for natural supplements, herbal remedies, creams, gels, powders, essential oils, spritzers, tinctures, homeopathic or flower remedies and/or any bottles, jars or dispensers provided in connection thereto.

Do you require additional products liability coverage in excess of \$250,000? Yes No

b. Do you manufacture or distribute any products? Yes No

If yes, please note these products are specifically excluded. You may apply separately for additional coverage. Please contact our office for a supplementary application.

c. Do you require these coverages for contents, stock, crime, business interruption theft and fire coverage? Yes No

If yes, these coverages are specifically excluded, however you may apply separately for these additional coverages. Please contact our office for a supplementary application.

A commercial package policy is bundled business insurance coverage for various perils, such as commercial contents, business interruption, crime and commercial general liability.

9. Do you operate your business outside of Canada? Yes No

10. Do you do Online Internet training and/or Videos? Yes No

11. Do you require Cyber Legal Expense coverage? Yes No

If Yes, a separate application will be required. Please request a copy from the broker.

NOTE: If the answers to item 7, 8, 9,10 and 11 are **YES**, an additional premium loading will apply. Please refer to premium calculation page.

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12. Do you currently purchase Medical Malpractice Professional Liability Insurance? If **YES**, please give full details: Yes No

INSURER	LIMIT	DEDUCTIBLE	EXPIRY DATE MM/DD/YY	#RETRO-DATE MM/DD/YY	PREMIUM

If retro coverage is required, please provide evidence of prior insurance policy.

13. Do you keep records for at least 7 years for all patients? Yes No
If **NO**, please advise why the answer is **NO**.

14. Do you obtain satisfactory consent in writing from each patient prior to starting treatment? Yes No
If **YES**, please attach sample copy of consent form, intact form or client waiver.

15. Have any negligence claims ever been made against you whether successful or otherwise? Yes No

16. Have any claims for dishonesty ever been made against you whether successful or otherwise? Yes No

17. Have any complaints or investigations ever been made or undertaken against you? Yes No

18. Have you ever had a document relating to the **Applicant's** activities unintentionally destroyed, damaged, lost or mislaid? Yes No

19. Have you ever been convicted of a criminal offence, other than a motoring offence, or have any prosecution pending? Yes No

20. Have any libel or slander claims, infringement of copyright or breach of confidentiality ever been made against you? Yes No

21. Have any sexual harassment and/or abuse claims ever been made against you? Yes No

22. Are you aware of any other circumstances which may give rise to a potential claim or request for indemnity under this medical malpractice insurance or professional liability policy? Yes No

23. Has any insurer ever cancelled, declined, refused to renew or accepted on special terms your Medical Malpractice Professional Liability Insurance? If **YES**, please give full details: Yes No

NOTE: If the answer to any of 13-23 above is **YES**, please provide full details:

24. Do you sell, manufacture, distribute or wholesale any products? Yes No
If yes, do you sell to others that are not your clients? Yes No
If yes, please give full details and describe products.

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The policy you are applying for covers the scope of practice for Traditional Chinese Medicine (TCMA) and Acupuncture (R.A.C.) as defined by College of Traditional Chinese Medicine and Acupuncturists of Ontario CTCMPO.

Premium Calculation (Ontario Only)

COVERAGE –“ Claims Made” Professional & General Liability				
▼ Check off one. Please select and check off the required limit. Write the applicable premium in the column. ▼				
Professional Liability / General Liability LIMIT OF INDEMNITY	Deductible	Premium Registered Acupuncturist R.AC ONLY	Premium Registered Traditional Chinese Medicine Practitioner including Acupuncturist R.TCMP	PREMIUM
<input type="checkbox"/> \$1,000,000 Per Claim, \$5,000,000 Aggregate	\$1,000	\$320	\$400	\$
<input type="checkbox"/> \$2,000,000 Per Claim, \$5,000,000 Aggregate	\$1,000	\$500	\$550	
<input type="checkbox"/> \$3,000,000 Per Claim, \$5,000,000 Aggregate	\$1,000	\$600	\$650	
<input type="checkbox"/> \$5,000,000 Per Claim, \$5,000,000 Aggregate	\$1,000	\$700	\$750	
If the following activity is undertaken the above premiums will be increased with the following additional premium loading: Check off all that apply.				
<input type="checkbox"/> Business Entity – Question 2.a.		ADD	\$100	\$
<input type="checkbox"/> Working With Animals - Question 7.a.		ADD	50%	\$
<input type="checkbox"/> Student Status – Question 7.c.		ADD	30%	\$
<input type="checkbox"/> Teaching - Question 7.d.		ADD	30%	\$
<input type="checkbox"/> Increased product liability coverage - Question 8.a.		ADD	30%	\$
<input type="checkbox"/> Worldwide- Question 9.		ADD	\$150	\$
<input type="checkbox"/> Online Internet Training or Videos - Question 10		ADD	\$150	\$
<input type="checkbox"/> Related Professional Services Please <input checked="" type="checkbox"/> all therapies that you are qualified for: <input type="checkbox"/> Allergy Testing <input type="checkbox"/> Bio Feedback <input type="checkbox"/> Ear Candling <input type="checkbox"/> Iridology <input type="checkbox"/> Nutrition Therapy <input type="checkbox"/> Reflexology <input type="checkbox"/> Reiki <input type="checkbox"/> Shiatsu <input type="checkbox"/> Yoga Loading ADD \$50 for each Service				\$
TOTAL PART PROFESSIONAL & GENERAL LIABILITY				\$
COVERAGE (OPTIONAL) – Commercial General Liability – “Occurrence Basis”				
▼ Check off one. Please select and check off the required limit. Write the applicable premium in the column. ▼				
Limit	Annual Premium		PREMIUM	
<input type="checkbox"/> \$1,000,000 per Claim / \$1,000,000 Aggregate	\$150		\$	
<input type="checkbox"/> \$2,000,000 per Claim / \$2,000,000 Aggregate	\$200			
<input type="checkbox"/> \$3,000,000 per Claim / \$3,000,000 Aggregate	\$300			
<input type="checkbox"/> \$5,000,000 per Claim / \$5,000,000 Aggregate	\$400			
<input type="checkbox"/> Additional Insured Q 7.e)	\$50 each		\$	
TOTAL PART COMMERCIAL GENERAL LIABILITY				\$
			Policy Fee	\$ 50.00
TAXABLE TOTAL PROFESSIONAL LIABILITY & COMMERCIAL GENERAL LIABILITY & POLICY FEE				\$
			Ontario add 8% TAX	\$
TOTAL INCLUDING TAX				\$

All premiums are annual and 100% retained. Policy is subject to a \$1,000 Deductible.
Please retain a copy for your records as no other invoice will be provided. Rates are subject to change without notice.

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Please advise the date insurance required is to be effective:	(MM/DD/YYYY)
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NOTE: COVERAGE CAN ONLY BE BOUND AND CONFIRMED BY HOLMAN INSURANCE BROKERS LTD.

Protection of the Applicant's Personal Information:

By completing this application and returning it to Holman Insurance Brokers Ltd., the **Applicant** agrees and consents to the collection, use and disclosure of such information, including any personal information, by Holman Insurance Brokers Ltd. for the following purposes:

- Communicating with the **Applicant**
- Assessing the **Applicant's** application for insurance
- Disclosing information to Insurance Companies
- Negotiating, maintaining or renewing insurance on the **Applicant's** behalf
- Providing claims assistance and service.
- Advising the **Applicant** of other products or services
- Complying with regulators and legal authorities

For more information about our privacy policies and practices or for a copy of our Privacy Policy please visit our web site www.holmanins.com or contact our Privacy Officer at Holman Insurance Brokers Ltd.

DISCLOSURE OF MATERIAL FACTS

It is essential that every **Applicant** when seeking a quotation, taking out or renewing an insurance policy reveals to the prospective Insurer(s) any material facts or information (including any material circumstances or change in circumstances) which might influence the judgment of Insurer(s) in determining the premium or in determining whether they will accept the risk. Failure to do so may render the contract of insurance voidable from inception at the option of the Insurer(s) and enable them to repudiate liability there under. If you have any doubt as to what constitutes a material fact or circumstance, seek professional advice.

PROGRAM DISCLOSURE

Your coverage will be placed with a program administered by Holman Insurance Brokers Ltd. We have engaged in a marketing process to offer a competitive product on a group basis with insurers but we have not acted as a broker for any individual participant. Should your application not be accepted for whatever reason by the insurer, the information may be used by Holman to seek an alternative insurer if available.

EMAIL AUTHORIZATION

In an effort to bring our policy holders the most cost effective insurance plan, all of our correspondence is completed electronically, including renewal applications, invoicing and the delivery of the policy documents. The email address supplied by you in this application will be used. We must be notified of any change to your email address. The policy holder agrees that it will hold Holman Insurance Brokers Ltd. harmless with respect to any e-mail changes caused by the policy holder's failure to provide current and valid information for the receipt of documents.

The Applicant/policy owner further agrees that the policy documents transmitted electronically by Holman Insurance Brokers Ltd. to the electronic address supplied are in lieu of all other forms of communication. The policy Owner accepts that electronic delivery of policy documents is sufficient to meet all reporting requirements of the policy.

The email address supplied may be used to notify you of other related insurance products of interest to you.

DECLARATION

I/we declare that the above statements are true in every respect. I/we hold qualification certificate(s) for the therapy(ies) stated on this application form. I/we have not withheld or misrepresented any material fact. I/we agree that this application will form the basis of the contract between me/us and Holman Insurance Brokers Ltd.

Applicant's Signature

Date

Print name

Return completed application and additional materials requested to:

Holman Insurance Brokers Ltd.
1 Valleywood Drive, Suite #100, Markham ON L3R 5L9
Telephone:(905) 886-5630
Email: programs@holmanins.com

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Ontario Traditional Chinese Medicine Professional and General Liability Checklist

- Application completed in full. All questions must be answered.
- All pages must be returned.
- Relevant new certificates and qualifications attached.
- Membership Documentation (e.g. Certificate of Membership).
- Copy of prior policy if retro coverage is required
- Therapies – all applicable have been checked off.
- Premium calculation – page 6
- Method of Payment (must accompany application, instructions next page)
- cheque attached (your cancelled cheque is your receipt)
- online payment Bank confirmation # _____ Name of Bank _____ confirmation receipt provided by bank provider
- Visa/Master Card - email confirmation receipt will be sent provider upon transaction

Please keep a copy your application and payment receipt (ie cheque, Bank confirmation or online payment receipt).

An invoice will not be issued.

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PAYMENT OPTIONS**

Credit Card, Visa or Mastercard

1. Go to <https://www.policypayments.com/Holman?step2>

Note: There is a administrative fee of 2.50% charge.

Internet Banking

Each bank has designed a unique format for their web site. However, the necessary procedures are generally similar.

1. Under Bill Payment: Choose Add Payee/Bill.
 2. Enter Holman. Choose All Categories and province Ontario and submit.
 3. Under Bill company/Payee - Select Holman Insurance Brokers Ltd. and enter your account number which is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
 4. Select the account you wish to withdraw the funds from. (i.e. credit card, savings, chequing, line of credit). Indicate the amount of payment and submit. A confirmation and reference number will be displayed to acknowledge your payment.
-

Telephone Banking

1. Request your bank set up a new Payee/Bill to do a Bill Payment.
 2. Request the addition of a new Payee/Bill Company: Holman Insurance Brokers Ltd.
 3. Your account number is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
 4. Your banking institution will then take your payment over the telephone by your choice of payment method.
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Debit Card Payments

1. Contact your bank by telephone or visit in person. Request that they set up an option to allow you to make Bill Payments by Debit Card.
 2. Request the addition of a new Payee/Bill Company: Holman Insurance Brokers Ltd.
 3. Your account number is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
 4. Once you have set up Holman Insurance Brokers Ltd., you are able to proceed with payments via your branch ATMs with your debit card.
 5. Choose banking option: Bill Payment and follow your bank instructions.
-

In Person at the Bank

1. At your own bank, request they set up a new Payee/Bill to do a Bill Payment.
2. Request the addition of a new Payee/Bill Company: Holman Insurance Brokers Ltd.
3. Your account number is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
4. You can choose to pay via the different accounts you hold with that particular bank or by other financial institution credit cards.
5. When paying in person at different financial institutions, bring your invoice/statement and request to make a Bill Payment.
6. Advise the teller that the Payee is Holman Insurance Brokers Ltd. and follow the prompts from step #2.

Note: Do not ask for a wire transfer or funds transfer, the banks charge you extra for this service and charge us extra for which we do not reimburse. These additional fees can range as high as \$50 or more.

By Mail

Cheque or money order payable to:
Holman Insurance Brokers Ltd.,
1 Valleywood Drive, Suite #100,
Markham ON L3R 5L9

Please note: NSF Payments – there will be an additional \$25 service charge