



Professional and General Liability Application

Effectuated with certain Lloyd's Underwriters ("Insurers")
through Lloyd's approved Coverholder:

Holman Insurance Brokers Ltd.

3100 Steeles Ave. E Suite 101, Markham, Ontario L3R 8T3

(Defined herein as "THE COVERHOLDER")

**Professional And General Liability Insurance
Application Form – Traditional Chinese Medicine**

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.

COVERAGE PART A – PROFESSIONAL LIABILITY – "Claims Made"

This insurance under Part A, 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.

Insuring Clauses Available

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

- Professional Negligence
- Libel & Slander
- Infringement Of Copyright
- Breach Of Confidentiality
- General Liability To Third Parties
- Rescuers & good Samaritan Acts

In addition, the following are automatically included:

- \$250,000 Duty To Refer To Healthcare Service Providers
- \$100,000 Products Liability For e.g. Herbal Remedies
- \$250,000 Loss Of Documents

COVERAGE PART B – OPTIONAL - COMMERCIAL GENERAL LIABILITY POLICY – "Occurrence Basis"

Comprehensive General Liability is available as an optional addition to coverage part A. Coverage under part A must be purchased for this additional Part B to apply. Insurance is on an "Occurrence Basis".

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 of Ontario College of Traditional Chinese Medicine (OCTCM), The Chinese Medicine and Acupuncture Association of Canada (CMAAC), The Canadian Society of Chinese Medicine and Acupuncture (CSCMA) and any Ontario member qualified under Transitional Council of 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 the Coverholder prior to accepting cover hereunder.

Applicant Acknowledgement

Signature

Date

For Office Use Only

PN	E	C	L	R	A	P
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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.

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

First Name	Initial	Last Name
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2a.

Address:	Street Address		
City	Province	Postal Code	

b. Telephone Number: Business # Cell #

c. Email Address Fax #

Telephone Number:		Business #	Cell #
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.

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.

MM/DD/YY

4. Date Started Practice: _____

5. Is any of your work supervised? Yes No
 If **YES**, Please advise by whom and under what circumstances:

Name of Supervisor	Address	Tel #	Email

6. **PLEASE ANSWER THE FOLLOWING:**
 a. Do you work with children under the age of 16? Yes No
 If **YES**, Please advise what age and under what circumstances:

- b. 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 #	

- c. Do you provide any teaching or instructing? If **YES**, how often and to whom. Attach relevant qualifications. Yes No

To Whom?	How often?

7. Do you keep records for at least 7 years for all patients? Yes No
 If **NO**, please advise _____
 why the answer is **NO**: _____
8. 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.
9. Have any negligence claims ever been made against you whether successful or otherwise? Yes No
10. Have any claims for dishonesty ever been made against you whether successful or otherwise? Yes No
11. Have any complaints or investigations ever been made or undertaken against you? Yes No
12. Have you ever had a document relating to the **Applicant's** activities unintentionally destroyed, damaged, lost or mislaid? Yes No
13. Have you ever been convicted of a criminal offence, other than a motoring offence, or have any prosecution pending? Yes No

14. Have any libel or slander claims, infringement of copyright or breach of confidentiality ever been made against you? Yes No
15. Have any sexual harassment and/or abuse claims ever been made against you? Yes No
16. Are you aware of any circumstances relating to the questions 9-15 above which may give rise to a potential claim or request for indemnity under this medical malpractice insurance? Yes No

NOTE: If the answer to any of 9-16 above is **YES**, please provide full details:

17. 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

18. 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.

Therapies

The following therapies are covered by our Traditional Chinese Medicine program:

Please all therapies that you are qualified

<u>Traditional Chinese Medicine</u>	<u>Related Professional Services</u>
<ul style="list-style-type: none"> <input type="checkbox"/> Acupuncture – single use disposable needles * <input type="checkbox"/> Acupuncture – using laser / electro devices <input type="checkbox"/> Acupressure <input type="checkbox"/> Aroma Therapy <input type="checkbox"/> Auriculotherapy <input type="checkbox"/> Chinese medicine counseling including the dispensing of herbs and herb granules <input type="checkbox"/> Cupping <input type="checkbox"/> First Aid <input type="checkbox"/> Heat Therapy <input type="checkbox"/> Holistic Counseling <input type="checkbox"/> Magnetic Therapy <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Moxibustion <input type="checkbox"/> Qi Gong <input type="checkbox"/> Skin Scrapping <input type="checkbox"/> Spiritual Therapy <input type="checkbox"/> Tai Chi <input type="checkbox"/> Tapas Acupressure <input type="checkbox"/> Therapeutic Touch <input type="checkbox"/> Tuina <input type="checkbox"/> Wu Head Massage <input type="checkbox"/> Zen Therapy 	<ul style="list-style-type: none"> <input type="checkbox"/> Allergy Testing <input type="checkbox"/> Ayurveda <input type="checkbox"/> Bio Feedback <input type="checkbox"/> Ear Candling - \$50 loading applies <input type="checkbox"/> Homeopathy - \$50 loading applies <input type="checkbox"/> Iridology - \$50 loading applies <input type="checkbox"/> Naturopathy - \$50 loading applies <input type="checkbox"/> Nutrition Therapy <input type="checkbox"/> Reflexology - \$50 loading applies <input type="checkbox"/> Reiki <input type="checkbox"/> Shiatsu <input type="checkbox"/> Yoga <input type="checkbox"/> Others (please list) – additional load may apply <div style="margin-top: 10px;"> <hr style="border: 0; border-top: 1px solid black; width: 100%;"/> <hr style="border: 0; border-top: 1px solid black; width: 100%;"/> <hr style="border: 0; border-top: 1px solid black; width: 100%;"/> </div>

*Warranty: Practitioners in Acupuncture must have a minimum 2000 hours of related training, or have completed a 4 year educational course in Acupuncture and meet the new requirement of Transitional Council.

If an individual activity does not appear in the list above and requires coverage, please provide full details below including details of training, accreditation and course syllabus details. (Such activity will have to be specifically agreed and approved by Insurers prior to cover being granted). Please submit application to coverholder for rating.

Premium Calculation

Policy coverage starts at \$1,000,000 for any one claim, capped at \$2,000,000 for all claims (aggregate) made during the policy period. Higher limits as detailed below are available and the **Applicant** should discuss specific requirements with the Coverholder if in any doubt as to the adequacy of the limits being considered. Subject to a satisfactory application, the **Applicant** will be charged the following:-

COVERAGE – A – “ 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	PREMIUM
<input type="checkbox"/> \$1,000,000 Per Claim, \$2,000,000 Aggregate	\$1,000	\$360	\$
<input type="checkbox"/> \$1,000,000 Per Claim, \$5,000,000 Aggregate***	\$1,000	\$400	
<input type="checkbox"/> \$2,000,000 Per Claim, \$4,000,000 Aggregate	\$1,000	\$515	
<input type="checkbox"/> \$2,000,000 Per Claim, \$5,000,000 Aggregate	\$1,000	\$550	
<input type="checkbox"/> \$3,000,000 Per Claim, \$6,000,000 Aggregate	\$1,000	\$620	
<input type="checkbox"/> \$5,000,000 Per Claim, \$5,000,000 Aggregate	\$1,000	\$700	
<input type="checkbox"/> \$5,000,000 Per Claim, \$10,000,000 Aggregate	\$1,000	\$775	
*** \$1M per Claim, \$5M Aggregate - new - Ontario's minimum requirement in year 2013			
If the following activity is undertaken the above premiums will be increased with the following additional premium loading:			
<input type="checkbox"/> Student Status – Question 6.b	Loading ADD	30%	\$
<input type="checkbox"/> Teaching – Question 6.c	Loading ADD	30%	\$
<input type="checkbox"/> Related Professional Services	Loading ADD—for each chargeable Service	\$50 each	\$
TOTAL PART A			\$

COVERAGE – B – (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	\$125	\$	
<input type="checkbox"/> \$2,000,000 per Claim / \$2,000,000 Aggregate	\$195		
included above:			
<ul style="list-style-type: none"> \$1,000,000 Personal & Advertising Injury Liability \$5,000 per person/\$10,000 per claim Medical Expenses \$500,000 Tenant's Legal Liability 			
TOTAL PART B			\$
TOTAL PART A & B			\$
For residents of Manitoba add 7% Quebec add 9% Ontario add 8%			TAX
TOTAL INCLUDING TAX			\$

All premiums are annual and 100% retained. No premium refund for mid-term cancellation.

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.

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

Canadian 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).
- Therapies – all applicable have been checked off.
- Premium calculation – page 6
- Premium payment : attached online Banking confirmation # _____ Name of Bank: _____

PAYMENT OPTIONS

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.

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.
3100 Steeles Ave. East Suite 101
Markham ON L3R 8T3