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

Ontario Professional and General Liability Insurance Application Form – Traditional Chinese Medicine and Acupuncture

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
 - \$100,000 Official Proceedings
 - \$250,000 Loss Of Documents
 - \$100,000 Sexual Harassment / Abuse
 - \$25,000 Personal Information Protections and Electronic Document Act Coverage (S.C.,2000, C.5)

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

Commercial 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 under Part B 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 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 the Coverholder prior to accepting cover hereunder.

Applicant Acknowledgement

_____ Signature

_____ Date

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:

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

2.

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

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: _____

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. 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.

19. If you are selecting the optional Commercial General Liability coverage, do you require liability coverage for any additional Insured's? Please indicate the relationship, state name and full address. If more space is required, please complete on a separate form. Additional charge will apply. Yes No

Professional Services

- Traditional Chinese Medicine (TCMA) and Acupuncture (R.A.C.) as defined by College of Traditional Chinese Medicine and Acupuncturists of Ontario CTCMPAO.

Premium Calculation (Ontario Only)

Policy coverage starts at \$1,000,000 for any one claim, capped at \$5,000,000 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 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:				
<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 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 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	\$95	\$
<input type="checkbox"/> \$2,000,000 per Claim / \$2,000,000 Aggregate	\$160	
<input type="checkbox"/> Additional Insured	\$50 each	\$
included above: \$1,000,000 Personal & Advertising Injury Liability \$5,000 per person / \$10,000 per claim Medical Expenses \$500,000 Tenants Legal Liability		

TOTAL PART B	\$
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Policy Fee	\$20.00
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TAXABLE TOTAL PART A + PART B + POLICY FEE	\$
For residents of 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.

Please advise the date insurance required is to be effective:

(MM/DD/YYYY)

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.

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

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
 - etransfer - answer to security question _____ confirmation email provided by bank provider
- Please keep a copy your application and payment receipt (ie cheque, Bank confirmation or online payment receipt).
An invoice will not be issued.

PAYMENT OPTIONS

Credit Card

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

Note: There is a administrative fee of 2.50% charged, however it does qualify for points and Air Miles.

Interac e-Transfer

1. All you need is an email address, access to online or mobile banking at 200+ participating financial institutions.
2. Email transfer to Holman at etransfer@holmanins.com (not the email of the employee).
3. Notify Holman at etransfer@holmanins.com by a separate email the answer to the security question or write on checklist above

Note: There is typically a fee of \$1.50 per transfer (please check with your financial institution).

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.
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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.
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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

By Credit Card – Visa or Mastercard

If you wish to pay by VISA or Mastercard, <https://www.policypayments.com/Holman?step2> Please note there is an administration/convenience fee charged for this option.