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Kinesiologist Professional and General Liability Insurance Application

www.holmanins.com
www.kinesiologistinsurance.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 overleaf 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 – PROFESSIONAL LIABILITY – "Claims Made" and reported, costs inclusive.

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 \$100,000 annual aggregate
- Loss of Documents \$250,000
- Rescuers & Good Samaritan Acts \$1,000 annual aggregate
- Therapy and Counselling Expense \$25,000
- Cancellation Extended Reporting 90 days
- Communicable Disease Exclusion
- 5 year run off
- Deductible \$1,000

Kinesiologist Professional and General Liability Insurance Application

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

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

Qualifications

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

COMMERCIAL GENERAL LIABILITY POLICY – “Occurrence Basis”

- Bodily Injury and Property Damage Liability
\$1,000,000- 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

Optional Coverages Available:

- Cyber Expense
- Worldwide Coverage

Extensions:

- Employee Benefits Extension \$1,000,000
- Employer's Liability Extension \$1,000,000
- Non- Owned Automobile Liability \$1,000,000

Optional Coverages Available:

- Entity Coverage
- Online / Internet Training

Approved Associations - Policy meets the requirements of the College of Kinesiologists of Ontario

This application applies only to the activities specifically detailed below by the **Applicant**, AND for which the **Applicant** has an approved relevant qualification from the **College of Kinesiologists of Ontario**. 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.

Kinesiology is a regulated health profession in Ontario under the *Regulated Health Professions Act (1991)*. This policy is not intended to cover practitioners operating outside of Ontario.

Applicant Acknowledgement

Signature

Date

Kinesiologist Professional and General Liability Insurance Application

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
a. Address	Street Address		
	City	Province	Postal Code

- 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.

2 b.	Telephone Number:	Business #	Cell #
2.c.	Email Address:	Fax #	

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

Name of Association	Membership No.	Date First Joined	Membership Type
College of Kinesiologist of Ontario			

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 detailed premiums may not still apply.**

4. Date Of Birth:-	MM/DD/YY	Male <input type="checkbox"/>	Female <input type="checkbox"/>
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5.a. Date Started Practice:	MM/DD/YY		
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	Canada %	United States %	World-wide %
5.c. Number of Employees:	Professional	Clerical	Other

Kinesiologist Professional and General Liability Insurance Application

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. 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 or instructor.

Name of qualified practitioner or instructor	Address	Tel #	Email

Please provide qualifications of qualified practitioner or instructor.

b. Do you provide services to Professional Sports persons and/or dancers?

☐ Yes ☐ No

c. Do you teach and/or certify or qualify another to teach others?

☐ Yes ☐ No

Where an applicant is a teacher, teaching is considered certifying and/or qualifying another to teach others. (This should not be confused with instruction of others in participation of an activity.)

Your policy does not extend coverage to the actions of your students. Examples of this would be:

- i) a student or graduate injuring another student during practical training;
- ii) a student or graduate causes harm to a patient and an allegation is made that the damages were in whole or in part as a result of insufficient or deficient training.

If **YES**, please indicate relationship to whom and how often.

Attach relevant qualifications.

To Whom?	How often?
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Kinesiologist Professional and General Liability Insurance Application

- e. 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. ☐ Yes ☐ No

Note: Additional Insured

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
Email:			

NOTE: If the answers to item 7 a – e are **YES**, an additional premium loading will apply. Please refer to premium calculation page.

- 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. ☐ Yes ☐ No

- b. Do you require additional products liability coverage in excess of \$250,000?
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, you will be required to complete a separate Cyber application form

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.

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

LIMIT:	DEDUCTIBLE	EXPIRY DATE MM/DD/YY	RETRO-DATE if applicable MM/DD/YY	PREMIUM

Kinesiologist Professional and General Liability Insurance Application

13. Do you keep records for at least 7 years for all patients/clients? ☐ Yes ☐ No
If **NO**, please advise why.
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14. Do you obtain satisfactory consent in writing from each patient prior to starting treatment?
If **YES**, please attach sample copy of consent form, intake form or client waiver. ☐ Yes ☐ No
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. Has the **Applicant** 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 circumstances which may give rise to a potential claim or request for indemnity under this professional liability insurance? ☐ Yes ☐ No
23. Have you ever had a claim made against you whether successful or otherwise in respect of bodily injury, property damage, premises (including tenant's liability), liability, personal injury, advertising liability or medical expenses? ☐ Yes ☐ No
24. Have you ever been declined, non-renewed or cancelled by any insurer for any type of Liability, Professional Liability, Medical Malpractice or Errors and Omissions insurance. ☐ Yes ☐ No

NOTE: If the answer to any of 15-24 above is YES, please provide full details here or attached sheet if space insufficient:

25. Do you operate a retail store? ☐ Yes ☐ No
If yes, please contact Holman Insurance Brokers Ltd.
26. Do you sell manufacture, distribute or wholesale any products? ☐ Yes ☐ No
If yes, please give full details.

Kinesiologist Professional and General Liability Insurance Application

☒ Kinesiologist Professional Services – Ontario

The policy being applied for covers Kinesiologist Services defined as: The assessment of human movement and performance and its rehabilitation and management to maintain, rehabilitate or enhance movement and performance, including Health Promotion, clinical/Rehabilitation, Ergonomics, Health and Safety and Disability Management/Case Coordination, as defined by the College of Kinesiologists of Ontario (CKO).

The following is a list of well-established modalities and services that members are permitted to utilize in their practice, provided they are qualified to practice:

- Electrical Therapy techniques including IFC, TENS,
- Therapeutic Ultrasound,
- Pulsed High Frequency,
- Low Intensity Laser Therapy,
- Therapeutic application of heat and cold,
- Athletic training,
- Therapy and interventions,
- Completion of insurance assessment forms,
- General nutritional counselling,
- Fitness & Health Evaluations,
- Exercise prescription.

CONTROLLED ACTS are specifically EXCLUDED from the Kinesiology Scope of Practice. Restriction of controlled acts is listed under Regulated Health Professions Act (RHPA) section 27(2).

If the Insured has been approved by the College of Kinesiologists of Ontario to provide the following. (Additional charge applies)

<input type="checkbox"/>	<p>Osteopathic Manual Practitioner – Osteopathic Manual Practitioners who are registered with the College must practice within the scope of their completed education in manual osteopathy. Despite any osteopathic training in the performance of Controlled Acts as listed under Regulated Health Professions Act (RHPA) section 27(2), osteopathic practitioners registered with the College are not permitted to perform any Controlled Acts without proper delegation, and the performance of any Controlled Act will be excluded under this insurance policy. Please attach certification if coverage is required.</p>
<input type="checkbox"/>	<p>Other Services If an individual service does not appear in the list above and requires cover, 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 this application to Holman Insurance Brokers Ltd. for rating</p> <p>Please provide detailed description of service:</p> <hr/> <hr/>

Kinesiologist Professional and General Liability Insurance Application

PREMIUM CALCULATION AND INVOICE

COVERAGE Professional & General Liability "Claims Made"

Write the applicable premium in the column ▼ .

LIMIT OF INDEMNITY ▼ Please select and check off the required limit	Annual Premium	PREMIUM
<input type="checkbox"/> \$1,000,000 Per Claim / \$3,000,000 Aggregate	\$160	\$
<input type="checkbox"/> \$1,000,000 Per Claim / \$5,000,000 Aggregate	\$185	
<input type="checkbox"/> \$2,000,000 Per Claim / \$4,000,000 Aggregate	\$180	
<input type="checkbox"/> \$3,000,000 Per Claim / \$5,000,000 Aggregate	\$210	
<input type="checkbox"/> \$5,000,000 Per Claim / \$5,000,000 Aggregate	\$240	

If the following activities are undertaken the above premiums will be increased with the **following additional premium loading:**

Check off all that apply. ▼ If you answered YES to the following questions loading applies.	LOADING	
<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.b.	ADD	30% \$
<input type="checkbox"/> Working with Professional Athletes or Dancers - Question 7.c.	ADD	100% \$
<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"/> Osteopathic Manual Practitioner	ADD	100% \$
<input type="checkbox"/> Other services – please complete and submit to broker		

Total PROFESSIONAL LIABILITY \$

COVERAGE – (OPTIONAL) – Commercial General Liability – "Occurrence Basis"

Write the applicable premium in the column ▼ .

Limit ▼ Check select and check off the required limit.	Annual Premium	PREMIUM
<input type="checkbox"/> \$1,000,000 per Occurrence / \$1,000,000 Aggregate	\$150	\$
<input type="checkbox"/> \$2,000,000 per Occurrence / \$2,000,000 Aggregate	\$200	\$
<input type="checkbox"/> \$3,000,000 per Occurrence / \$3,000,000 Aggregate	\$300	\$
<input type="checkbox"/> \$5,000,000 per Occurrence / \$5,000,000 Aggregate	\$400	\$

▼ If you answered YES to questions 7.e loading applies.

<input type="checkbox"/> Additional Insured – Question 7.e.	\$50 per additional insured	\$
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Total COMMERCIAL GENERAL LIABILITY \$

TOTAL Professional Liability and Commercial General Liability

POLICY FEE \$ 50.00

TOTAL BEFORE TAX \$

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

Kinesiologist Professional and General Liability Insurance Application

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

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 as 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.

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

Print Name

Ontario Kinesiologist Professional and General Liability Checklist

- Application completed in full. All questions must be answered. ☐
- All pages #1 to #6 must be returned. (including page #1). ☐
- Membership Documentation (e.g. Certificate of Membership). ☐
- Copy of prior insurance policy if prior retro date is required. ☐
- Premium calculation including tax for options– page 8. ☐

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 retain a copy for your records as no other invoice will be provided.

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

PAYMENT OPTIONS

Credit Card

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

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

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 (NO CREDIT CARDS)

1. Contact your bank by telephone or visit bank 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.
1 Valleywood Drive, Suite #100
Markham ON L3R 5L9

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