



**NACORA ALTERNATIVE EASTERN MEDICINE**  
**INSURANCE PROGRAM**



**Application**

1. Name of Applicant: \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_

Location Address: \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_ Home Fax: ( ) \_\_\_\_\_ Bus. Telephone: ( ) \_\_\_\_\_

Bus. Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

3. a. Date established: \_\_\_\_\_ Individual: \_\_\_ Partnership: \_\_\_ Corporation: \_\_\_

b. Is the entity owned, controlled by or affiliated with any other entity: Yes \_\_\_ No \_\_\_  
(If yes, please provide detail on a separate sheet.)

c. Has the name of the company ever been changed or has there been any acquisition, consolidation, dissolution, merger or change in the business organization? Yes \_\_\_ No \_\_\_

4. Does the applicant use Informed Consent forms with all Clients prior to administering treatment? Yes \_\_\_ No \_\_\_

If No. Explain: \_\_\_\_\_

5. Does the Applicant use Disposable Needles ? Yes \_\_\_ No \_\_\_

If No. Explain: \_\_\_\_\_

6. Has any principal/employee ever been subject to disciplinary actions or suspended by any regulatory agency or association? Yes \_\_\_ No \_\_\_

7. Has any Insurer ever cancelled, declined or refused to renew similar insurance during the last five years? Yes \_\_\_ No \_\_\_ If Yes, give details: \_\_\_\_\_

\_\_\_\_\_

8. a. Have any professional liability claims (for complementary health-related activities) been made during the last five years against the applicant or any past or present partner, executive officer, directors or employees or predecessors in business?

Yes \_\_\_ No \_\_\_

b. Does the applicant have knowledge or information of any circumstance or any allegations or contentions of any incident which may result in a claim being made against the applicant or any of its past or present partners, executive officers, directors or employees or predecessors in business?

Yes \_\_\_ No \_\_\_ (If Yes to a. or b. above, please provide details) \_\_\_\_\_

9. Have you carried Professional Liability insurance (covering complementary health-related modalities) prior to applying for this policy? Yes ( ) No ( ) If Yes, please complete the following:

(a) Insurance Company: \_\_\_\_\_

(b) Policy No.: \_\_\_\_\_

(c) Limit of Liability: \_\_\_\_\_

(d) Retroactive date: \_\_\_\_\_ (if Previous Policy was a Claims Made wording)

**(PLEASE NOTE THAT IN ORDER TO HONOUR YOUR PREVIOUS RETROACTIVE DATE WE WOULD REQUIRE PROOF OF CONTINUOUS COVERAGE E.G PREVIOUS POLICY DECLARATION PAGE OR CERTIFICATES)**



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The following are the modalities covered under the Nacora Alternative Eastern Medicine Program.

- |                              |                           |                         |
|------------------------------|---------------------------|-------------------------|
| Acupressure                  | Electro Therapy           | Qi Gong                 |
| Acupuncture incl. Soft Laser | Herbology (Classical TCM) | Skin Scraping (Gua Sha) |
| Auriculotherapy              | Herbs)                    | Tai Chi                 |
| Auricular Needling           | Holistic Counseling       | Therapeutic Touch       |
| Cupping                      | Magnetic Therapy          | Tuina                   |
|                              | Moxibustion               |                         |

Coverage is available for the following Modalities for an Additional Premium of \$75.00 per modality:

- Ayurveda
- Homeopathy
- Shiatsu
- Yoga
- BioEnergetic Intolerance Elimination (BIE)

Note: Definition of modalities available on request from Nacora.

**Warranty: Practitioners in Acupuncture must have a minimum 1500 hours of related training, or have completed a 4-year educational course in Naturopathy. Please note warranties must be complied with and failure to do so will invalidate the policy.**

The undersigned hereby declares that the above statements are true and that I have not omitted, suppressed or misstated any material facts. The undersigned further agrees that if any significant change in the condition of the applicant is discovered between the date of this application form and the effective date of the policy, which would render this application form inaccurate or incomplete, notice of such change will be reported in writing to Lombard General Insurance Company of Canada immediately. Although the signing of this application form does not bind the undersigned, the undersigned agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued, and that the warranty statements (Question 9a. & 9b.) are true and accurate, and this form will be attached to and become part of the policy. **The effective date of insurance shall be the date upon which the completed and signed application and payment are received by the office of Nacora Insurance Brokers Ltd., and is subject to the insurer's acceptance of the application. The effective date of insurance shall be indicated on the Certificate of Insurance provided to the undersigned. Coverage is subject to the Master Policy wordings and copies of the master policy wording are available by contacting Nacora Insurance Brokers Ltd.**

\_\_\_\_\_  
Print Name

Signature: \_\_\_\_\_  
(Must be signed by the Applicant)

\_\_\_\_\_  
Date





## MONTHLY PRE-AUTHORIZED PAYMENT PLAN

### HOW DOES THE MONTHLY PLAN WORK?

THE AUTOMATIC WITHDRAWALS ARE DIVIDED EQUALLY OVER THE POLICY TERM.

THE FIRST SCHEDULED WITHDRAWAL IS THE EFFECTIVE MONTH OF THE POLICY.

THE LAST SCHEDULED WITHDRAWAL IS ONE MONTH BEFORE THE EXPIRY MONTH OF THE POLICY.

A NEW BILLING NOTICE WILL BE ISSUED WHEN THE PAYMENT SCHEDULE CHANGES.

A MODEST SERVICE FEE WILL BE ADDED TO YOUR WITHDRAWALS

### HOW DO YOU SIGN UP FOR THE MONTHLY PLAN?

COMPLETE, SIGN, DETACH AND RETURN THE AUTHORIZATION FORM BELOW WITH A VOIDED SAMPLE CHEQUE AND YOUR PAYMENT FOR OUTSTANDING INSTALMENTS.

**N.B.** FOR JOINT ACCOUNTS, ALL PAYORS MUST SIGN IF MORE THAN ONE SIGNATURE IS REQUIRED ON CHEQUES ISSUED AGAINST THE ACCOUNT.

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Insured Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ Prov: \_\_\_\_\_

Payor(s): \_\_\_\_\_

Bank / Financial Institution: \_\_\_\_\_

Branch Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ Prov: \_\_\_\_\_

Branch #: \_\_\_\_\_ Account #: \_\_\_\_\_ DB Account #: \_\_\_\_\_

Signature(s): (1) \_\_\_\_\_ (2) \_\_\_\_\_

SPSIC 7403E B P



Lombard General Insurance Company of Canada

Lombard Insurance Company  
(herein referred to severally as "the Company")

### PRE-AUTHORIZED PAYMENT PLAN - AGREEMENT CONDITIONS

1. In this Authorization, "I", "me" and "my" refer to each account-holder who signs below.
2. I agree to participate in this pre-authorized debit plan and I authorize the Company indicated above (the "Company") to draw a debit, on paper, electronic or other form on my account indicated (the "Financial Institution") for the purpose of paying the monthly premium instalments, including all applicable service charges and taxes for the Insurance Policy(ies) indicated (the "Policy(ies)").
3. I agree that a pre-authorized debit in the amount shown above to pay the total monthly premium instalments, with applicable service charges and taxes, for the Policy(ies) indicated, may be drawn on my account monthly. This amount may be increased / decreased at a future date as described in the Policy Declarations issued to me by the Company. The Company will advise me in writing of the revised amount in advance of its effective date.
4. I agree that the Financial Institution is not required to verify that any pre-authorized debit has been drawn in accordance with this Authorization, including the amount, frequency and fulfilment of purpose of any pre-authorized debit.
5. I may revoke this authorization at any time by delivering a written notice of revocation to the Company. The Company may notify me at any time that it will no longer accept payment of the insurance premiums by pre-authorized payment. I agree that revocation of this Authorization does not terminate any contract of insurance that exists between me and the Company. If this Agreement is terminated or if premiums due are not actually paid hereunder, the regular premiums payable on the Policy(ies) specified will be payable directly to the Company thereafter in accordance with the current minimum premium requirements of the Company.
6. I may dispute a pre-authorized debit (a "Disputed Debit") by providing a signed declaration to the Financial Institution under the following conditions:
  - (i) An Authorization was never provided to the Company;
  - (ii) The Pre-Authorized Debit was not drawn in accordance with this Authorization, including failure to provide prior notification in case of variable amounts;
  - (iii) This Authorization was cancelled;
  - (iv) or The Pre-Authorized Debit was posted to the wrong account due to invalid or incorrect information supplied by the Company.

On receipt of a written declaration from me up to 10 business days after the date of a Disputed Business Debit or up to 90 days after the date for all other Disputed Debts was posted to my account that condition a., b., c. or d. occurred, the Financial Institution will immediately reimburse me for any Disputed Debate. I agree that, after this period, I shall resolve any dispute that I may have concerning a Pre-Authorized Debit solely with the Company.
7. I agree that delivery of this Authorization to the Company constitutes delivery by me to the Financial Institution.
8. I will inform the Company, in writing, of any change in the account information provided in this authorization prior to the next due date of the pre-authorized debit.
9. I warrant that all persons whose signatures are required to sign on the account have signed this authorization.
10. I understand and agree to the foregoing terms and conditions and I acknowledge receipt of a copy of this authorization.
11. Applicable to the Province of Quebec only: It is the express wish of the parties that this authorization and any related documents be drawn up and executed in English. Les parties conviennent que la présente autorisation et tous les documents s'y rattachant soient rédigés et signés en anglais.

### CONSENT FOR PRE-AUTHORIZED PAYMENT FORM

#### Privacy Disclosure and Consent

I have provided personal information in this document. This personal information includes banking information. I authorize Lombard Canada Ltd., to collect, use and disclose any of this personal information as permitted by law for the purposes necessary to establish and maintain contact with my bank, and facilitate payment of premiums or fees owed by me under my insurance policy.