



BROKERS TRUST
INSURANCE GROUP INC.

THE UPS STORE

Franchise Insurance Program through
Brokers Trust Insurance Group Inc.

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OUR POLICY

CONTENTS OF EVERY DESCRIPTION **\$300,000**
 BUSINESS INCOME **ACTUAL LOSS SUSTAINABLE**
 EQUIPMENT BREAKDOWN EXTENSION **INCLUDED**
 CRIME – EMPLOYEE DISHONESTY **\$30,000**
 LOSS INSIDE PREMISES **\$10,000**
 LOSS OUTSIDE PREMISES **\$10,000**
 MONEY ORDERS/ COUNTERFEIT **\$10,000**
 DEPOSITORS FORGERY **\$10,000**
 COMMERCIAL GENERAL LIABILITY **\$2,000,000**
 GENERAL AGGREGATE \$ **5,000,000**
 PRINTERS E&O **\$1,000,000**
 PROFESSIONAL LIABILITY E&O **\$5,000**

**PROFESSIONAL LIABILITY E&O
INCLUDED**

**PRINTERS E&O
INCLUDED**

CREDIT CARD PAYMENT AVAIL

**24 HOUR CLAIMS SERVICE
(905) 695188
CLAIMS@BROKERSTRUST.CA**

ANNUAL PREMIUM

\$715

ALL YOU NEED TO DO IS COMPLETE THE ATTACHED APPLICATION AND EMAIL US AT

UPSINSURANCE@BROKERSTRUST.CA

FOR MORE INFORMATION:

GARRY HILL
ACCOUNT EXECUTIVE
DIRECT LINE: 905.695.5150
EMAIL: garry.hill@brokerstrust.ca

TANIA CASCONI
ACCOUNTS MANAGER
DIRECT LINE: 905.695.5167
EMAIL: tania.cascone@brokerstrust.ca

EFFECTIVE DATE:

APPLICANT DETAILS

NAME OF PRINCIPAL/APPLICANT:

REGISTERED BUSINESS NAME:

MAILING ADDRESS:

LOCATION ADDRESS:

BUSINESS PHONE NUMBER:

BUSINESS FAX:

PERSONAL NUMBER:

PERSONAL EMAIL:

CONSTRUCTION DETAILS

YEAR BUILT:

CONSTRUCTION: FIRE- RESISTIVE NON- COMBUSTIBLE MASONRY FRAME

OTHER OCCUPANCIES: RETAIL OFFICE RESIDENCE/ APARTMENTS

LOSS PAYEE (S): (FOR EXAMPLE A BANK LOAN, EQUIPMENT LEASE, ETC)

LOSS PAYEE (S) NAME:

LOSS PAYEE (S) ADDRESS:

ADDITIONAL INSURED (S) (FOR EXAMPLE A LANDLORD / PROPERTY MANAGER)

ADDITIONAL INSURED(S) NAME:

ADDITIONAL INSURED(S) ADDRESS:

ALARM DETAILS:

IS THERE AN ALARM SYSTEM ON THE PREMISES? YES NO WILL BE INSTALLED ON: _____
DATE

NAME OF INSTALLING COMPANY:

NAME OF MONITORING COMPANY:

ULC- LISTED NOT ULC-LISTED WITH LINE SECURITY

PAYMENT METHOD

DIRECT BILL - ONE PAY (CHEQUE)

CHEQUE TO BE MADE IN THE NAME OF AVIVA INSURANCE & MAILED TO
BROKERS TRUST INSURANCE GROUP INC. 2780 HIGHWAY 7 SUITE #201. CONCORD, ONTARIO L4K3R9

DIRECT BILL - ONE PAY (CREDIT CARD)

PAYMENT TO BE MADE DIRECTLY THROUGH THE AVIVA SECURE LINE - INSTRUCTIONS WILL BE PROVIDED ONCE POLICY IS ISSUED.

DIRECT BILL - MONTHLY PAYMENT

PLEASE COMPLETE THE ATTACHED MONTHLY PAYMENT FORM ATTACH IT WITH THIS APPLICATION AND INCLUDE A VOID CHEQUE.

COMPREHENSIVE PACKAGE AT ANNUAL \$715 PREMIUM INCLUDES:

\$300,000 CONTENTS AND EQUIPMENT COVERAGE (SUBJECT TO \$1,000 DEDUCTIBLE)

\$300,000 EQUIPMENT BREAKDOWN COVERAGE (SUBJECT TO \$1,000 DEDUCTIBLE)

\$25,000 SEWER BACK-UP (SUBJECT TO VARIOUS DEDUCTIBLES)

\$30,000 EMPLOYEE DISHONESTY

\$2,000,000 COMMERCIAL GENERAL LIABILITY

FLOOD COVERAGE DEDUCTIBLE VARIES BY PROVINCE

EARTHQUAKE COVERAGE DEDUCTIBLE VARIES BY PROVINCE – ADDITIONAL PREMIUM MAY APPLY

\$5,000 PROFESSIONAL LIABILITY ERRORS & OMISSIONS

INCREASED LIABILITY LIMITS: \$3,000,000 (+\$75.00) \$5,000,000 (+\$150.00)

ALL COVERAGES SUBJECT TO THE INSURER'S POLICY EXCLUSIONS, LIMITATIONS & CONDITIONS

CLIENT SIGNATURE

DATE



BROKERS TRUST
INSURANCE GROUP INC.

PERSONAL INFORMATION PROPERTY/CASUALTY CONSENT

As party of my application for insurance, I hereby consent to the brokerage firm named below (the "Broker") collecting, using and disclosing personal information required for purposes of considering my application for new or renewal property/casualty and/or automobile insurance coverage.

The Broker is authorized to collect, use and disclose personal information and provide such personal information to third parties, as required, including insurance companies. The Broker may also be required or permitted to disclose such personal information pursuant to relevant privacy laws or other laws.

If I wish to review personal information pertaining to my application or policy maintained by the Broker, obtain copies of the Broker's privacy policies or standards, or make other enquiries or express concerns, I understand that I may do so by contacting the Brokers Privacy Officer.

I agree that all personal information that I provide to the Broker will be complete and accurate.

FULL NAME: _____

SIGNATURE: _____

DATE: _____

NAME OF BROKERAGE: _____

BROKERAGE'S PRIVACY OFFICER: John Fil





MONTHLY PAYMENT PLAN FORM – PLEASE COMPLETE

Installment plan

Pre-authorized monthly payment from your bank account

- A 3% per installment finance charge applies to all premium processed on the Pre-Authorized Chequing plan.
- Your monthly date of withdrawal will be determined by the expiration date of your policy
- To calculate your monthly payment, simply divide your insurance premium, plus applicable taxes and finance charge, by 12.
- The first payment may actually be for an amount totaling 2 - 3 months payment depending on the date your authorization is processed. You will receive an invoice outlining your payment schedule
- Once your monthly payment plan has been set up, it will continue automatically (unless you inform us otherwise). Any premium changes will be divided equally over your remaining monthly payments, and you will receive a revised invoice and payment schedule.

To enroll in our monthly payment plan, complete, sign, and return this form along with a sample cheque marked VOID.

EFT AUTHORIZATION FORM (H1 COMPLIANT)		Policy number:	
<p>Please see below for the Rights and Obligations provided in accordance with CPA's Rule H1. MY/OUR SIGNATURE CONFIRMS THAT:</p> <ul style="list-style-type: none"> • I/We have been provided with details of and understand the terms and conditions of the payment plan by automatic withdrawals from my/our financial institution. • I/We hereby authorize the named financial institution below to debit my/our account for all payments payable to: Aviva Insurance Company of Canada or any of its associated insurance companies to which my policy may be transferred at a later date (the "Insurer"). • I/We understand that this authorization may be cancelled by me/us upon written notice, at least 15 days before the next scheduled payment. I/We may obtain a sample cancellation form, or further information on my/our right to cancel a payment authorization agreement, or more information about Pre-Authorized Debiting at my/our financial institution, by visiting www.cdnpay.ca, or through contacting my/our insurance company at www.avivacanada.com. • I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/We have the right to receive reimbursement for any debit that is not authorized or is not consistent with this payment authorization agreement. To obtain more information on my/our recourse rights, I/We may contact my/our financial institution or visit www.cdnpay.ca. • I/We warrant and guarantee that all persons whose signatures are required to sign on this account have signed this authorization below. • If there is a change in premiums due to a change in coverage or upon renewal, the amount of the monthly withdrawal will automatically be changed. • I/We will ensure that funds are available on each due date and understand that Non-Sufficient Funds transactions may result in one or all of the following: 1. A second presentation or attempt to withdraw funds 2. A second withdrawal notice 3. Cancellation of my/our policy • I/We have received a copy of this authorization and have read and understand these terms and conditions. • For pre-authorized debits, I/We shall receive, with respect to the debiting of fixed-amount payments, written notice from the Insurer, the amount to be debited and the due date(s) debiting, at least 10 calendar days prior to the date of the first payment, and such notice shall be received each time there is a change in the amount of payment. • The account that my/our financial institution is authorized to draw upon is indicated below. A specimen cheque has been marked "void" and attached to this authorization. • I/We undertake to inform my/our Insurer, in writing, of any change in the account information provided in this authorization prior to the next payment due date. • I/We understand that this authorization is continuous and will automatically apply to the renewal terms, unless instructed differently. • I/We authorize my/our Insurer to collect or use my/our personal information for the purpose of this authorization for automatic withdrawals for payment of my/our insurance premiums. I/We authorize my/our Insurer to disclose any personal information contained in this authorization form to its financial institution to the extent disclosure is directly related to and necessary for the proper execution of the pre-authorized debit transaction for the policy number(s) noted above. • I/We may withdraw my/our consent to collect, use or disclose my/our personal information for the purpose of this authorization for automatic withdrawals for payment of my/our insurance premiums. Withdrawal of my/our consent will result in cancellation of this authorization for automatic withdrawals for payment of my/our insurance premiums, in which case I/we must make other arrangements for payment of my/our insurance premiums. 			
For pre-authorized payment from your bank account:			
Branch/Transit #:	Bank #:	Bank account #:	Business: <input type="checkbox"/> Personal: <input type="checkbox"/>
Name and address of Financial Institution:			
Signature(s) as shown on bank records:			
Today's date:			

ATTACH COPY OF VOID CHEQUE HERE

Clarifying credit card payments for commercial lines policies – Ontario



We recently introduced the credit card payment facility for your commercial customers that want a single payment (one shot) option to cover their annual premium.

What you need to know

This credit card payment facility is available with no premium limit for direct bill (budget) one pay plan for commercial policies only.

Customers can pay their annual premium and any charges from endorsements or mid-term changes via VISA or MasterCard for:

- Small business
- Mid-market
- P&C
- Auto

What you need to do

For new business, you can offer this facility to your customers right away. It's an easy process. Simply call our toll-free number: **1 800 360 5009**.

For your existing customers on agency bill or on our monthly payment plan, please contact your branch to change the policy to the direct bill (budget) one pay plan on **renewal**. When the policy has been changed, you or your customer can call 1 800 360 5009 to make the payment.

How it works

Your customer, (the cardholder) can make the call or you can do it on their behalf, as long as you collect the cardholder information securely. The caller enters the credit card number, and card verification number (CVV – the 3 or 4 digits on the back of the credit card) directly into their telephone keypad. The cardholder's first and last name is also required, as well as the card's expiry date.

Our friendly, efficient Billing Team will process your credit card payments quickly and securely. They can also answer any questions that you or your customers may have about the process.