TCIM
Trans Canada Insurance Marketing Inc.

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Ph: 204-925-8276
Fax: 204-925-8279

BROKER INFORMATION

1. Broker Name:
2. Address: Street: _____ City:_____Province:_____ Postal Code:_____
3. Phone: | Fax: | E-Mail:
4. Would you prefer that we contact you by e-mail _____ or by fax _____?
4. Web Address (if applicable): www.
5. Contacts: Agency Principal: _____ e-mail: _____ Contact(s) for Broking: _____e-mail: _____ _____e-mail: _____ Contact for agency accounting:_____e-mail: _____
6. No. of Employees:
7. Split %: Personal: Commercial: Commercial Volume: $
8. Insurers you currently use:
9. Wholesaler(s) do you deal with:
10. Classes of business or accounts you would like to target:
Conditions: 1. *Whether collected or not, you agree to remit payments to be received in TCIM office by the 30th of each month for that statement month, based on TCIM statement and accompanied by a detailed listing of items being paid.* 2. *You will comply with Privacy Act rules.* 3. *You will maintain Errors & Omissions insurance in accordance with provincial regulations.*

_____Dated this _____day of _____, 200__
Broker Signature