

COMPLETE THIS BOX ONLY IF THIS APPLICATION IS BEING SUBMITTED BY AN INSURANCE BROKER

Brokerage Name: _____ **Producer's Name:** _____
Telephone: _____ **Fax:** _____ **E-mail:** _____

★ **FAILURE TO ANSWER ALL QUESTIONS MAY RESULT IN A DELAY PROCESSING YOUR SUBMISSION** ★

Legal Business Name: _____

Location Address: _____ City: _____ Province: _____ Postal: _____

Mailing (if different): _____ City: _____ Province: _____ Postal: _____

Contact Person: _____ Phone # _____ Fax # _____

Res. # _____ Cell # _____ E-mail: _____

Web Page Address: _____

Expiry Date of Policy: _____ **Previous/Current Insurance Company:** _____

Has prior coverage been on a Claims Made Basis? Yes No **Retroactive date:** _____

Have you ever been cancelled for non-payment? Yes No

How many years has salon/spa been in business? _____

PROPERTY INFORMATION

Describe your location (stand alone, strip plaza, shopping mall, etc.) _____

The Building Age: _____ No. of Stories: _____ Do you own the building? Yes No

Total Area of Building: _____ (Sq. Ft) Total Area of your Facility: _____ (Sq. Ft)

Do you operate this business / provide services out of your home? Yes No

LATEST UPDATES?...

ADVISE THE YEAR UPDATE TOOK PLACE

Roof _____

Heat _____

Plumbing _____

Electric _____

CONSTRUCTION OF BUILDING

WALL:

Concrete Block/Masonry

Brick Veneer over Wood

Frame/Siding

ROOF:

Steel Deck or Concrete

Wood Joists

Metal Clad

Sprinkler System? Yes No

Burglar Alarm? Yes No

Alarm Monitored? Yes No

Fire Alarm Yes No

number of Fire Extinguishers: _____

Smoke Detectors Yes No

Fire Hydrants within 500 feet? Yes No

Is your business smoke free? Yes No

AVERAGE Hours of Operation: _____:_____ to _____:_____ Do you operate 24 hours: Yes No

Is there Any Bar/Restaurant Adjacent to your operation? Yes No

Is there a Variety Store adjacent to your operation? Yes No

Describe precautions taken to avoid slips and falls at entrances: _____

Who does snow removal? _____

Types of steps if any? _____

Do you keep salt on hand for de-icing walkways / entrances? Yes No, Do you apply? Yes No

FINANCIAL INFORMATION

USE THE FOLLOWING CATEGORY BREAKDOWNS TO HELP DETERMINE "PROPERTY VALUES" BELOW:

STOCK: Cosmetics \$ _____ Hair Care Products \$ _____ Skin Care Products \$ _____

Clothes \$ _____ Supplements \$ _____ Lotions \$ _____ Nail Care Products \$ _____

Other Stock not mentioned \$ _____ please specify: _____

EQUIPMENT: Computers \$ _____ Laptops \$ _____ Signs \$ _____ Furniture \$ _____

Massage Tables \$ _____ Machines \$ _____ Tanning Beds \$ _____ Lasers \$ _____

LEASEHOLD/TENANTS IMPROVEMENTS: Change rooms \$ _____ A/C Units \$ _____

Beauty Styling Chairs \$ _____ Washroom / Showers \$ _____ Phone/Alarm Systems \$ _____

Offices \$ _____ Construction Costs \$ _____ Existing Tenants Improvements \$ _____

"PROPERTY VALUES" (IF YOU HAD TO REPLACE THE FOLLOWING ITEMS TODAY)

Building (if you require coverage) \$ _____ Equipment \$ _____

Leasehold Improvements \$ _____ Stock \$ _____

DESCRIPTION OF OPERATIONS

Any client under the age of 18 Yes No Do you use a deep fat fryer? Yes No

Do parents stay on premise? Yes No Snack Bar on Premises? Yes No

Do you offer Child Care? Yes No Are full records kept Yes No

Do you ever serve alcohol? Yes No How long are records kept: _____ years

Do you have a liquor license? Yes No Do clients sign a waiver Yes No

Do you own, operate, or rent space to associated businesses? Yes No

If so, Please describe: _____

Do you bring any specialists into your premise to provide additional operations? Yes No

If so, Please describe: _____

Are there any operations or activities away from the premises? Yes No

If so, Please describe: _____

Are there any Squash, Racquetball, Tennis or Basketball Courts Yes No, (please specify) _____

Please describe your sterilization / cross-contamination prevention procedures: _____

WET AREAS

of Swimming Pools? _____ Maximum Depth? _____ Diving Boards Yes No

#of units **Flooring (eg. 2" tiles, rough surface)** **Non-Slip Flooring?** **Rubber Mats In Halls?**

Showers _____ Yes No Yes No

Whirlpools _____ Yes No Yes No

Hydrotherapy Tubs _____ Yes No Yes No

Steam Rooms _____ Yes No Yes No

Vichy Showers _____ Yes No Yes No

Wet Sauna _____ Yes No Yes No

Dry Sauna _____ Yes No Yes No

Scorching behind heating unit? Yes No How far is the heating unit away from the closest wall? _____ cm

CRIME EXPOSURES

Maximum amount of cash left on Premises overnight? \$ _____

If over \$250, do you have a safe? Yes No Type of Safe? _____

EQUIPMENT

Do You Have Modified or Rebuilt/Used Equipment? Yes No If Yes, % used _____ Age _____

Is Equipment Inspected Daily? Yes No Who Does Maintenance? _____

FINANCIAL INFORMATION

LIABILITY INFORMATION Liability Limits Desired: \$2,000,000 \$3,000,000 \$5,000,000

ESTIMATED ANNUAL GROSS RECEIPTS:			
Hair Services	\$ _____	Aromatherapy	\$ _____
Esthetics Services	\$ _____	Massage Services	\$ _____
Electrolysis	\$ _____	Laser Services /IPL	\$ _____
Acid Peels	\$ _____	Product Sales	\$ _____
Tanning Bed Sales	\$ _____	Supplement Sales	\$ _____
Microdermabrasion	\$ _____	Other Sales	\$ _____
Total Yearly Gross Sales & Operation Receipts			\$ _____

Hair Cutting / Coloring	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractors on staff	<input type="checkbox"/> Yes <input type="checkbox"/> No
Body Wraps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Therapist on Staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Facials	<input type="checkbox"/> Yes <input type="checkbox"/> No	Collagen Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Waxing / Sugaring	<input type="checkbox"/> Yes <input type="checkbox"/> No	Botox Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Candling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diet / Nutrition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Makeup - Non-Permanent	<input type="checkbox"/> Yes <input type="checkbox"/> No	Follow Canada Food Guide	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Piercing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wart / Mole Removal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spray Tanning Handheld	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toning Beds	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spray Tanning Booth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattooing – Cosmetic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Manicure / Pedicure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattooing – Henna	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nails - Acrylic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattooing – Permanent Body	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gel Nails	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattooing – Spray on	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company use MMA (Methyl Methacrylate) within the Nail process	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Supplement Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you sell any metabolic supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Body Piercing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sclerotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genital Piercing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ambulatory Phlebotomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tongue Piercing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stripping (for spider veins)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aromatherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oxygen Bar	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Heat Sauna Beds	<input type="checkbox"/> Yes <input type="checkbox"/> No # _____	Makeup - Permanent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aqua Massage Beds	<input type="checkbox"/> Yes <input type="checkbox"/> No # _____	Makeup – Semi Permanent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Laser Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application - Page #5 & 6	
Massage - Registered	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #7	
Massage - Non-Registered	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #7	
Reiki	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #7	
Reflexology	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #7	
Acid/Glycolic Peels	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #7	
Microdermabrasion	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #7	
Electrolysis	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #7	
Tanning Beds & Booths	<input type="checkbox"/> Yes <input type="checkbox"/> No →	If yes, please complete application – Page #8	
LPG/Derma Nova	<input type="checkbox"/> Yes <input type="checkbox"/> No # of units _____ # of technicians _____		
Other services	<input type="checkbox"/> Yes, please list: _____		

PLEASE PROVIDE A BROCHURE OF YOUR OPERATIONS WHEN YOU SUBMIT THIS APPLICATION

★PLEASE COMPLETE ALL QUESTIONS

IF YOU REQUIRE ADDITIONAL SPACE, PLEASE ADD ADDITIONAL PAGES AS NECESSARY★

Please advise **IF** and **HOW** you provide the following operations (Please check all that apply):

SERVICE	LASER		PULSE LIGHT/ IPL		RADIO FREQUENCY EQUIPMENT	
	YES	NO	YES	NO	YES	NO
Acne						
Endovenous Laser Treatment						
Leg Veins						
Psoriasis & Vitiligo						
Skin Resurfacing						
Cosmetic Re-pigmentation						
Hair Removal						
Pigmented Lesions						
Vascular Lesions						
Other (please describe)						
Other (please describe)						

Please provide all operators who provide laser treatment and their experience:

NAME PERSON PROVIDING LASER TREATMENT	YEARS OF EDUCATION	YEARS EXPERIENCE/ QUALIFICATION	ANY PRIOR CLAIMS MADE AGAINST EACH INDIVIDUAL PLEASE GIVE BRIEF DETAILS

Complete this section for all laser machines (please list additional hand pieces separately):

MAKE	MODEL	AGE	COST TO REPLACE TODAY
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$

Please answer all questions:

- 1 Please circle what skin types you provide services on:
As per the Fitzpatrick Scale: 1 2 3 4 5 6
- 2 Percentage of gross receipts from laser operations _____ %
- 3 Do you complete a patch test at least 24 hours prior to laser hair removal operations? [] Yes [] No
- 4 Do you provide High Intensity Laser Operations? – “treatment to the skin” [] Yes [] No
- 5 Do you complete a patch test at least 7 days prior to High Intensity Laser Operations? [] Yes [] No
- 6 Do you wear surgical gloves when providing laser services to clients? [] Yes [] No
- 7 Does your client wear protective eyewear during laser services? [] Yes [] No

LASER APPLICATION (CONTINUED...)

- 8 Do you keep copies of all client service records? Yes No
- 9 How many years are service records kept on file? _____ years
- 10 Is a waiver signed, dated and kept on record? (please attach a copy) Yes No
- 11 How many years are waivers kept on file? _____ years
- 12 Do you explain to the client what steps to take prior to any laser treatment Yes No
Please describe _____

- 13 Do you explain to the client what steps to take after any laser treatment? Yes No
Please describe _____

- 14 Minimum age of clients for laser operations _____ years
- 15 Do parents stay on premise at all times? Yes No
- 16 How often do you calibrate your machines? _____
- 17 Do you provide any off-site laser treatments Yes No
If yes, list all locations, methods of transporting equipment and frequency of all off-site treatments:

Any person who knowingly and with intent to defraud any insurance company or another person, files and application containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects this person to criminal and civil penalties.

Signature: _____

Date: _____

MASSAGE/ REFLEXOLOGY/ REIKI APPLICATION

Please complete this section for all Masseuses on Staff:

NAME OF MASSEUSE	TYPE(S) OF MASSAGE THEY PERFORM (please list all)	YEARS OF EDUCATION	YEARS OF EXPERIENCE	ARE YOU AN RMT?	
				YES	NO

1 What type(s) of Massage do you perform? (Please list all) _____

- 2 Do you collect and discuss the client's health information? [] Yes [] No
- 3 How long to you keep clients' health information on file? _____ years
- 4 Is a waiver signed, dated and kept on record? [] Yes [] No
- 5 How long to you keep clients' waivers on file? _____ years
- 6 What is the minimum age of clients? _____ years
- 7 Have any of the masseuses listed above had a claim made against them? [] Yes [] No
- If so, please advise: _____

ELECTROLYSIS, ACID PEELS & MICRODERMABRASION APPLICATION

- 1 Do you use an autoclave to sterilize equipment? [] Yes [] No
- 2 Does all staff wear surgical gloves when performing services? [] Yes [] No
- 3 Do you use disposable tips for each new client? [] Yes [] No
- 4 Do you provide Medium Peels? [] Yes [] No
- 5 Do you provide Deep Peels? [] Yes [] No
- 6 Do you collect and discuss the client's health information? [] Yes [] No
- 7 How long to you keep clients' health information on file? _____ years
- 8 What is the minimum age of clients _____ years
- 9 Have you ever had a claim made against you? [] Yes [] No
- If so, please advise: _____
- 10 Please circle what skin types you provide services on:
As per the Fitzpatrick Scale: 1 2 3 4 5 6

Any person who knowingly and with intent to defraud any insurance company or another person, files and application containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects this person to criminal and civil penalties.

Signature: _____

Date: _____

TANNING APPLICATION

EQUIPMENT:

	# of Units	Intensity	Manufacturer	Type of timer (digital, manual, etc.)	Where are timing controls located?
Beds	_____	_____	_____	_____	_____
Booths	_____	_____	_____	_____	_____
Facial Units	_____	_____	_____	_____	_____
Spray Booths -	# of Units _____	_____	_____	_____	_____
Air Brush -	# of Units _____	_____	_____	_____	_____

Total cost to replace all tanning beds / booths with new equipment: \$ _____

Average age of beds? _____ Do licensed electricians service the equipment? Yes No

How often inspected? _____ Are beds cleaned after every use? Yes No

Who changes the bulbs? _____

Do you have laundry facilities for towels? Yes No

If so, how often are exterior dryer vents cleaned? _____

TANNING PROCEDURE:

Are employees permitted to touch clients? Yes No

Are clients given tanning instruction? Yes No

Do you use Accelerators? Yes No

Unlimited Tanning offered? Yes No

If yes, what system is in place to prevent over exposure? _____

Do you have clients sign a waiver? Yes No

Are children left unattended Yes No

Do you use Skin analysis/evaluation with clients? Yes No

Are staff trained or certified by Smart Tan or equivalent? Yes No

Are you a Smart Tan Member? Yes No

(more information about Smart Tan is available at www.smarttanacanada.com)

Are goggles supplied & REQUIRED to be used? Yes No

Min. age of clients _____

Do you keep a record of your clients tanning sessions? Yes No

If Yes, How? _____

Any person who knowingly and with intent to defraud any insurance company or another person, files and application containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects this person to criminal and civil penalties.

Signature: _____

Date: _____