

BEAUTY/SPA PROGRAM APPLICATION

Brokerage: _____ Contact Person: _____ E-mail: _____

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

General Information

Name of Insured: _____

Mailing Address: _____

Location Address (if different from mailing): _____

Telephone: _____ Website: _____

Previous Insurance Company: _____ Is renewal being offered: _____

5 year loss history: _____

Years in business: _____ Years of experience: _____

Desired effective date: _____ Target/Expiring Premium: _____

Liability Information

Estimated Total Revenue: _____ Retail Receipts: _____

Any USA retail sales? Yes No If yes, please provide percentage of revenues allocated towards USA sales: _____

Do you manufacture/re-label or re-package any products for sale? _____

Do you use case history cards? _____

Types of work performed (please check all that apply), those that are bold will require an additional supplement application be provided.

Acupuncture	Eyelash Lifting/Perming	Paraffin
Aromatherapy	Facials	Permanent Makeup/Microblading
Body Wraps	Flotation Chambers # _____	Radio Frequency Treatments
Body Injections	Hairstylist/Barber	Reflexology
Cellulite Reduction	Infrared Saunas # _____	**Registered Massage
Chemical Peels (30% or less)	Laser Hair Removal	Relaxation Massage
Ear Piercing	Light Therapy/Cold Laser	Skin Tag Removal (non-invasive only)
Ear Candling	Manicure/Pedicure	Spray Tanning
Electrolysis	Microdermabrasion	Teeth Whitening (LED or Tray Only)
Energy Healing/Reiki	Micro-needling	Waxing/Sugaring
Eyebrow/Eyelash Tinting	Non-Permanent Makeup	
Eyelash Extensions	Oxygen Treatments	

Other services, please list: _____

**If Registered Massage Therapy is provided, do all therapists carry separate E&O insurance? Yes No

Do you offer mobile services? Yes No If yes, what services? _____

Do you provide any teaching operations or have students offering services to the public while under your supervision? Yes No

If yes, what services? _____

Provide teaching supplement as per attached.

Is liquor served Yes No If yes, do they have a liquor license in place? _____

Provide percentage of revenues allocated towards liquor sales _____

Please provide number of employees: Full Time _____ Part Time _____

Coverage is excluded if machines are used for medical use and must be Canada Safety Authority (CSA) rated. All products must be approved by Health Canada/Canada Food & Drug Act. Any use of caustic chemicals including Methyl Methacrylate is excluded.

Property Coverage

Construction: _____ Year Built: _____ Any Upgrades: _____

of Stories: _____ Sprinklered: Yes No Alarmed: Local Monitored None

Square Footage: _____ Other Occupancies: _____

Any additional information: _____

Property & Business Interruption Coverages	Amount of Insurance
Building	
Equipment (Including Tenants Improvements)	
Stock	
Business Interruption (Profits or ALS, please specify)	
Rent or Rental Value	
Extra Expense	
Office Contents	
Computer (Hardware/Software)	
Miscellaneous Property Floater	
Equipment Breakdown	
Property & Business Interruption Coverages	Amount of Insurance
Commercial General Liability	

Optional Coverages

Select any of the following optional coverages you require:

Sewer Back-up

Comprehensive Property Extension Endorsement

Flood

Earthquake

3D Crime

This application does not bind the applicant or the Company to complete this insurance but it is agreed that the information contained herein shall be the bases of the contract should a policy be issued.

IMPORTANT NOTICE: As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning various risk characteristics. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

It is mutually agreed between the Company and the applicant that any inspection of premises, operations or any matter pertaining to insurance afforded by the Company, is made for the use and benefit of the Company only and is not to be relied upon by the applicant in any respect.

Applicant's Signature: _____ Date: _____

ONLY COMPLETE THE FOLLOWING SUPPLEMENTS IF THEY APPLY

BEAUTY/SPA PROGRAM INJECTABLE SUPPLEMENT

Name	Years of Education	Years of Experience	Have their own insurance for this service		Is this Person a Doctor		Is this Person a Nurse	
			Yes	No	Yes	No	Yes	No
			Yes	No	Yes	No	Yes	No
			Yes	No	Yes	No	Yes	No
			Yes	No	Yes	No	Yes	No
			Yes	No	Yes	No	Yes	No
			Yes	No	Yes	No	Yes	No

Please provide a list of injectable services provided: _____

Has the company had claims against them in the last 5 years: Yes No

Has any staff (including contract staff) had claims against them in the last 5 years: Yes No

If yes to either of the above questions, please provide full details: _____

BEAUTY/SPA PROGRAM LASER SUPPLEMENT

Confirm all laser services and applications offered (ie. Laser, Pulse Light or Radio Frequency):

Hair Removal		Acne Scarring	
Wrinkles		Large Pores	
Fine Lines		Hyperpigmentation	
Loose Skin		Vascular Lesions	
Rough Texture		Tattoo Removal	
Skin Resurfacing		Other	

Please advise if OTHER: _____

Are the treatments/procedures: Invasive/Ablative Fractional Non-Invasive/Non-Ablative

Name of People Providing Laser Treatments	Years of Education	Years of Experience	Any prior claims against individual, details

Complete this section for all laser machines, if hand pieces please list separately

Make	Model	Age	Replacement Cost

Hand devices used: _____

Additional Information

Gross Receipts from laser treatments? \$ _____ Confirm minimum age of client is 18 for laser services _____

Is a patch test completed 24 or more hours prior to laser treatments? Yes No How often do you calibrate your machines? _____

Does client wear protective eyewear during procedures? Yes No Do you wear surgical gloves? Yes No

Do you keep copies of clients service records? Yes No If yes, how many years? _____

Is a waiver signed? Yes No Please attach copy for our file. How many years are the waivers kept? _____

What precare information do you provide clients? _____

What post care information do you provide clients? _____

Do you provide any off site laser treatments? Yes No If yes, please describe locations, methods, frequency, etc.

BEAUTY/SPA PROGRAM MICROBLADING/PERMANENT MAKEUP SUPPLEMENT

Names of People Providing Permanent Makeup/ Microblading Services	Years of Education	Total Hours of Practical Experience	Any prior claims against individual, details

Additional Information

Please note that the minimum age for permanent makeup/microblading services is 18

Gross Receipts from Microblading/Permanent Make-up Services? _____

Is a patch test completed 24 or more hours prior to laser treatments? Yes No

Hand devices used: _____

Are services performed with sterilized single-use, disposable needles? _____

Are all inks/pigments from Canadian or US manufacturers? Yes No If no, where? _____

Do you wear surgical gloves? Yes No _____

Do you keep copies of clients service records? Yes No If yes, for how many years? _____

Confirm that a waiver is signed for these services _____ How many years are the waivers kept? _____

Advise what pre-care & post-care information is provided to clients? Please attach copy for our file. _____

Do you provide any off site microblading treatments? Yes No If yes, please describe locations, methods, frequency, etc.

Confirm you are fully certified to provide these services (advise what certification you hold) _____

BEAUTY/SPA PROGRAM TEACHING/BEAUTY SCHOOLS SUPPLEMENT

Approximate Number of students per year:	_____
Number of hours students complete prior to graduation:	_____
Is the final exam proctored by the provincial regulator?	Yes No
Is the insured trained to certify others?	Yes No
Number of years experience the insured has teaching this course:	_____
Do student offers services to the public?	Yes No
If yes,	
1. Number of hours completed prior to offering services to public:	_____
2. Do all clients sign a waiver?	Yes No
3. Are the students supervised at all times when offering services to the public?	Yes No
4. Do students offer Micropigmentation/Permanent Makeup to the public?	Yes No
5. Do students offer Laser/IPL services to the public?	Yes No
Please confirm percentage of gross revenues allocated towards training services:	_____ %