|  |  |
| --- | --- |
| Business Name: |       |
| Location Address: |       |
|  | City:       | Prov.:       | P.C.:       |
| Mailing Address: |       |
|  | City:       | BC      |  |
| Owner/Operator: |       | Bus.#: |       | Fax: |       |
| Email: |       | Cell #: |       | Res.#: |       |
| Alternate Contact: (If Applicable) |       | Phone: |       | Email: |       |

|  |  |
| --- | --- |
| **Expiry Date of Current Policy:**  | **Current Insurance Company:** |
| **Number of years in business?** | **Have you ever been cancelled for nonpayment?** |  |

**PROPERTY INFORMATION**

|  |
| --- |
| Describe your location (strip plaza, shopping mall, etc.):       |
| The Building Age:       | No. Of Stories:       | Do you own the building?       |
| Total Area of Building:       sq. ft. | Total Area of your Facility:       sq. ft. |
| Sprinkler System: | [ ]  | Monitored Alarm: | [ ]  | Fire Hydrants within 500 feet: : |  [ ]  |
| Is there Any Bar/Restaurant Adjacent to your operation? | [ ]  | Are you in a basement location? | [ ]  |
| Do you operate or rent space to other businesses? | [ ]  | Annual rental income $       |
| Describe precautions taken to avoid slips and falls at entrances:       |
| Do you have any equipment stored offsite? (i.e. home office) | [ ]  | If yes, please describe:       |
| Do you distribute, manufacture, or wholesale any products/equipment? | [ ]  | \*Provide a list with application |

**CONSTRUCTION OF BUILDING**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **WALL:**  | Concrete Block/Masonry | [ ]  | Brick Veneer over Wood  | [ ]  | Frame/Siding | [ ]  |
| **ROOF:**  | Steel Deck or Concrete | [ ]  | Wood Joists | [ ]  | Metal Clad | [ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| **LATEST UPDATES** | **FULL** | **PARTIAL** | **YEAR COMPLETED** |
| Roof: | [ ]  | [ ]  |       |
| Heat:  | [ ]  | [ ]  |       |
| Plumbing:  | [ ]  | [ ]  |       |
| Electrical:  | [ ]  | [ ]  |       |

**Use the following form to help breakdown and calculate accurate replacement cost:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STOCK:**  | Clothing | $        | Supplements | $        | Other | $        |
| **EQUIPMENT:**  | Computers | $        | Laptops | $        | Signs | $        |
|  | Furniture | $        | Machines | $        | Other | $        |
| **LEASEHOLDS:** | Existing Tenants Improv. | $        | Change Rooms | $        | Styling Chairs | $        |
|  | Washrooms/Showers | $        | Phone/Alarm Sys. | $        | Construction | $        |
|  | Offices | $        | Wall Coverings | $        | Other | $        |

**TOTAL CONTENTS (including all stock, equipment & leaseholds above) = $**

**BUILDING REPLACEMENT VALUE (if required)** (sq.ft. of building       x cost/sq.ft. $     ) **= $**

**EQUIPMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Do You Have Modified/Rebuilt/Used Equipment?  | [ ]  | If Yes, % used:      % | Age:       |
| Is Equipment Inspected Daily?  | Who Does Maintenance?        |

**LIABILITY INFORMATION**

**Liability Limit Requested:** [ ]  **$2,000,000** [ ]  **$3,000,000** [ ]  **$4,000,000** [ ]  **$5,000,000**

**DESCRIPTION OF OPERATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| Any client under the age of 18? |  | Do parents stay on premise? |  |
| Do you ever serve alcohol? |  | Do you have a liquor license? |  |
| Do any specialists provide additional services? |  | Describe:       |
| Are any operations or activities done away off premises? |  | Describe:       |
| Describe sterilization/cross-contamination prevention procedures:       |
| Do you use MMA (Methyl Methacrylate) within the gel nail process? |  |
| Do you sell any metabolic supplements? |  |

#

# WET AREAS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Showers | #  | Whirlpools  | #  | Steam Rooms | #  |
| Hydrotherapy Tubs | #  | Vichy Showers | #  | Infra Red Saunas | #  |
| Dry Saunas | #  | Wet Saunas | #  | Pools | #  |
| Are all steam rooms vents/spouts covered/capped to defuse the steam?  |   |
| Any scorching behind heater? |   | Non-Slip Flooring? |   | Rubber Mats In Halls? |   |

#

**STAFF (Including Owner/Operators, Employees & Sub-Contractors)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Yrs of Exp.** | **Operations Performed (Must attached Certificates)** |  **F/T or P/T** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Is all staff certified/educated/trained in the services they perform? |  |

**ADDITIONS TO THE POLICY**

**[ ]  ADDITIONAL INSURED**

(i.e.: landlord)

[ ]  **LOSS PAYEES**

(i.e.: financing, leases, etc.)

**CLAIMS HISTORY**

Has the company &/or staff had claims against them in last 5 years? , If yes please list details:

|  |  |  |
| --- | --- | --- |
| Date of Loss | Loss Details | Amount Paid/Reserve |
|       |       |       |
|       |       |       |
|       |       |       |

**SURVEY OF OPERATIONS**

|  |
| --- |
| TYPE 1 |
| Hair  | [ ]  | Body Wraps | [ ]  | Facials | [ ]  | Waxing/Sugaring | [ ]  |
| Make-Up (Temporary) | [ ]  | Ear Piercing | [ ]  | Manicure/Pedicure | [ ]  | Acrylic Nails | [ ]  |
| Gel Nails | [ ]  | Spray Tanning | [ ]  | Supplement Sales | [ ]  | Product Sales | [ ]  |
| **Annual Receipts for Type 1 Operations (\*\*MUST HAVE ESTIMATE IN ORDER TO QUOTE): $** |

|  |
| --- |
| TYPE 2 **(Note: All Bolded Operations Require Further Information – Please Complete Attached Page)** |
| Body Piercing | [ ]  | Lashes (tinting/extensions) | [ ]  | Ear Candling | [ ]  | Dry/Infrared Saunas |  #  |
| Spray On Tattooing | [ ]  | **Teeth Whitening\*** | [ ]  | Henna Tattooing | [ ]  | Sauna Beds | #  |
| **Massage (RMT)** | [ ]  | **Non-Reg. Massage** | [ ]  | **Aromatherapy** | [ ]  | **Tanning Beds** | #  |
| **Reflexology** | [ ]  | **Reiki** | [ ]  | Electrocoagulation | [ ]  | Aqua Massage Beds | #  |
| **Acid/Glycolic Peels** | [ ]  | **Electrolysis** | [ ]  | **Microdermabrasion** | [ ]  | Vibration Machines | #  |
| **Annual Receipts for Type 2 Operations (\*\*MUST HAVE ESTIMATE IN ORDER TO QUOTE): $** |

|  |
| --- |
| TYPE 3 **(Note: All Bolded Operations Require Further Information – Please Complete Attached Page)** |
| **Laser Treatments** | [ ]  | **IPL Treatments** | [ ]  | **Cold Laser** | [ ]  | Micropigmentation | [ ]  |
| Botox/Collagen | [ ]  | Other Injectables | [ ]  | List:      |
| Permanent Body Tattooing\* | [ ]  | **\*Call to discuss with an Underwriter** |
| **Annual Receipts for Type 3 Operations (\*\*MUST HAVE ESTIMATE IN ORDER TO QUOTE): $** |

* **If you have checked any “Bolded” Operations above, please continue to next page.**

 **OR**

* **If you have not checked off any “Bolded” Operations above, you do not need to complete any further information, please sign below and remit to our office for quotation.**

I understand and agree that any policy issued will be based upon the information contained in the application and any related forms. I understand that any forms or other material submitted with the application constitute part of my application for insurance. I further understand and agree that any misrepresentation or failure to provide true and accurate information may result in the voiding of and/or denial of claims under any policy issued at the option of the company.

By submitting this application and any related forms to **Pacific insurance brokers** , you provide **Pacific insurance brokers .** with your consent to the collection, use and disclosure of your personal information, including that previously collected, for the purpose of: communicating with you; assessing your application for insurance and underwriting your policies; evaluating claims; detecting and preventing fraud; analyzing business results; and acting as required or authorized by law.

Applicant: Signature: Title:       Date:

**LASER/IPL APPLICATION**

**SERVICES OFFERED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Laser | [ ]  | IPL | [ ]  | Cold Laser | [ ]  |
|  |
| Acne | [ ]  | Skin Resurfacing | [ ]  | Hair Removal | [ ]  | Leg Veins | [ ]  |
| Psoriasis & Vitiligo | [ ]  | Pigmented Lesions | [ ]  | Vascular Lesions | [ ]  | Re-Pigmentation | [ ]  |
| Other |  | List:       |
|  |
| What Skin Types (Based on Fitzpatrick Scale) do you provide services for:  |  1 [ ]  |  2 [ ]  |  3 [ ]  |  4 [ ]  |  5 [ ]  | 6 [ ]  |
| What percentage of treatments are performed on Skin Types 5 & 6?       % |
| Do you always follow laser/IPL manufacturer guidelines regarding patch test & wait times?  |  |
| Do you keep copies of all client appointment/service records on file for at least 2 yrs? **\*\*** |  |
| Is a signed waiver kept on file for at least 2 yrs? **\*\*** |  |
| **\*\* MINORS: You need to keep these records/waivers on file for 2 yrs after client turns 18** |
| Do you have clients sign pre & post treatment info? **(MUST attach copies)** |  |
| Minimum age of clients for laser/IPL treatments:       |
| How often do you calibrate your machines?       |  |
| Do you provide any laser/IPL treatments away from premises? |  |
| List:        |

**TECHNICIANS (MUST ATTACH CERTIFICATES)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Yrs Of Exp.** | **Services Performed** | **Skin Types Performed On** | **Prior Claims** |
|  |  |  |  | [ ]  |
|  |  |  |  | [ ]  |
|  |  |  |  | [ ]  |
|  |  |  |  | [ ]  |

**MACHINES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Make** | **Model** | **Model Year**  | **Replacement Cost (CAD)** |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
| Has all equipment listed above been licensed for use by Health Canada? [ ]  Yes [ ]  No |
| \*All Lasers, IPL Machines etc. must be licensed for use/sale by Health Canada to be legally used and insured within Canada. You can check your machine(s) at [http://webprod5.hc-sc.gc.ca/mdll-limh/prepareSearch-preparerRecherche.do?type=active&lang=eng](http://webprod5.hc-sc.gc.ca/mdll-limh/prepareSearch-preparerRecherche.do?type=active〈=eng) or call (613) 957-7285 |

I understand and agree that any policy issued will be based upon the information contained in the application and any related forms. I understand that any forms or other material submitted with the application constitute part of my application for insurance. I further understand and agree that any misrepresentation or failure to provide true and accurate information may result in the voiding of and/or denial of claims under any policy issued at the option of the company.

By submitting this application and any related forms to **Pacific insurance brokers**, you provide **Pacific insurance brokers.** with your consent to the collection, use and disclosure of your personal information, including that previously collected, for the purpose of: communicating with you; assessing your application for insurance and underwriting your policies; evaluating claims; detecting and preventing fraud; analyzing business results; and acting as required or authorized by law.

**Applicant: Signature: Title:**        **Date:**

**MASSAGE / REFLEXOLOGY / REIKI OPERATIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Type Of Massage Performed** | **Yrs of Exp.** | **RMT** |  **Prior Claims** |
|       |       |       |  | [ ]  |
|       |       |       |  | [ ]  |
|       |       |       |  | [ ]  |
|       |       |       |  | [ ]  |
| List all types of massage offered:       |
| Do you discuss and keep copies of all health information/service records on file for at least 2 yrs? **\*\*** |  |
| Is a signed waiver kept on file for at least 2 yrs? **\*\*** |  |
| **\*\* MINORS: You need to keep these records/waivers on file for 2 yrs after client turns 18** |
| Minimum age of clients for massage services:       |

**ELECTROLYSIS / PEELS / MICRODERMABRASION OPERATIONS**

|  |  |
| --- | --- |
| Do you use an autoclave to sterilize equipment? |  |
| Does all staff wear surgical gloves when performing services? |  |
| Do you use disposable tips for each new client? |  |
| Do you provide Medium Peels? |  | Do you provide Deep Peels? |  |
| Do you discuss and keep copies of all health information/service records on file for at least 2 yrs? **\*\*** |  |
| Is a signed waiver kept on file for at least 2 yrs? **\*\*** |  |
| **\*\* MINORS: You need to keep these records/waivers on file for 2 yrs after client turns 18** |
| Minimum age of clients for electrolysis:       peels:       microdermabrasion:       |

**TANNING OPERATIONS**

|  |  |
| --- | --- |
| Are you a full member of SmartTan Association (or other tanning association)? WILL BE |  |
| Are all staff trained or certified through SmartTan or equivalent certifying body? WILL BE |  |
| Are clients given tanning instruction – PRE&POST |  | Minimum age of tanning clients:       |
| Are goggles supplied and required to be used? |  | Do you complete a skin analysis for every client? |  |
| Is touching of clients allowed by staff? |  | Are beds cleaned after every use? |  |
| Minimum time allowed between tans per client:       |
| Do all clients sign waivers?  |  | Vibrations Machines NO | [ ]  | How Many?       |
| Do you sell supplements? |  | Do any contain ephedra or other metabolic enhancers?  |  |
| Do you provide any services other than tanning?  |  | Please Describe:       |

#  BEDS/BOOTHS:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Beds |  #  | Booths |  #  | Spray Booths MOBILE SPRAY KIT |  #  | Air Brush Units |  #  |
| Where are timing controls located?       | Who sets timers?        |
| Do electricians service the equipment? |  | Are any beds coin operated? |  |
| Average age of beds:       yrs | Outside dryer vents cleaned at least every 6 months? |  |
| Are beds/Booths protected by ground fault interrupted (GFI) circuits? |  |

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**Applicant: Signature: Title: Date:**

**MICROPIGMENTATION (PERMANENT MAKE UP)**

|  |  |  |  |
| --- | --- | --- | --- |
| Eye Liner (Top &/or Bottom Lids) |  | Eye Brows |  |
| Lips |  | Areolas &/or Scars |  |
| Semi-Permanent (Lash Tinting/Extensions) |  | Other (Please Describe):       |  |
|  |
| Make & Model of Machine Used?       |
| Manufacturer(s) Of Pigment Used:       |
| Are All Machines & Pigments Manufactured Within North America?  |

**TEETH WHITENING**

|  |
| --- |
| Product Used:       |
| Active ingredient:       |
| Carbamide Peroxide (10%) |  | Carbamide Peroxide (more than 10%)      % |  |
| Hydrogen Peroxide (3%) |  | Hydrogen Peroxide (more than 3%)      % |  |
| Product Used:       |
| Make and Model(s) of Machine Used:       |

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**Applicant: Signature: Title:**       **Date:**