Holman Insurance Brokers Ltd. Tel (905) 886-5630

email application to mark.holman@holmanins.com

FULL SPA OPERATIONS APPLICATION
(including all supplementary applications)

Legal Business Name: _____

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

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

Contact Person: _____ E-mail: _____

Phone #: _____ Fax # _____ Res. # _____ Cell # _____

Expiry Date of Policy: _____ Current Insurance Company: _____ Risk Ever Been Canceled: Y or N
Target Premium: S _____

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

PROPERTY INFORMATION

Describe your location (Two storey, strip plaza, shopping mall, etc.) _____ No. of Stories: _____

Do you own the building? **Y or N** Total Area of your Facility: _____Ft
The Building Age: _____ Latest Update: Roof _____ Heat _____ Plumbing _____ Electric _____
Fire Hydrants within 500 Feet? **Y or N** Restaurant within 2 adjacent units: **Y or N** Building Sprinklered? **Y or N**
Monitored Alarm System? **Y or N** Local Alarm System? **Y or N** Fire Alarm? **Y or N**
Surveillance System? **Y or N** # of Fire Extinguishers: _____

Doors have deadbolts? **Y or N** Bars on Doors/Windows? **Y or N**

What is at - Front:_____ Back:_____ Left:_____ Right_____

Wall Joists Construction: Concrete Block/Masonry Brick Veneer over Wood Frame/Siding

Roof Joists Construction: Concrete Steel Deck Metal Clad Wood Joists

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

Building (if require) $ _____ Equipment $ _____

Leasehold Improvements $ _____ Stock $ _____

Liability Limits Desired (check one): $1,000,000 $2,000,000 $3,000,000 $4,000,000 $5,000,000

NOTE: we cannot offer coverage for the following services at this time. Please advise if these services are provided:

Physical Therapist on Staff?	**Y or N**	Chiropractors on staff	**Y or N**
Piercings other than Ear / Nose	**Y or N**	Mole Removal – Invasive Cutting	**Y or N**
Tattooing – Permanent Body	**Y or N**	Skin Tag Removal - Invasive Cutting	**Y or N**
		Wart Removal - Invasive Cutting	**Y or N**

ESTIMATED ANNUAL GROSS RECEIPTS:

Hair Services	S _____	Microdermabrasion	$ _____
Esthetics Services	$ _____	Massage Services	$ _____
Electrolysis	S _____	Laser Services / IPL	$ _____
Acid Peels	S _____	Injectable (e.g. Botox, Collagen)	$ _____
Tanning Bed Sales	S _____	Product Sales	$ _____
Other Sales	S _____		
Total Yearly Gross Sales & Operation Receipts	S		

Health & Wellness Program

WET AREAS # of Swimming Pools?____ Maximum Depth? _____feet

Diving Boards	**Y or N**	Proper Signs Posted	**Y or N**
Are there any Slides	**Y or N**	Swim at your Own Risk Signs Posted	**Y or N**
Non Slip Deck	**Y or N**	Proper railings at entrance	**Y or N**
Chemicals Tested Daily	**Y or N**		

Non-Slip Flooring around wet areas? (e.g. 2" tiles, rough surface) **Y or N**

Showers	**Y or N**	#of units _____			
Hydrotherapy Tubs	**Y or N**	#of units _____			
Vichy Showers	**Y or N**	#of units _____			
Whirlpools	**Y or N**	#of units _____			
Hot Tub	**Y or N**	# of units_____			
Steam Rooms	**Y or N**	#of unit's _____			
Dry Sauna	**Y or N**	#of units _____	**Sauna –** distance of heating unit from the closest wall?	_____	**inches**
Infrared Sauna	**Y or N**	**# of units** _____			
Wet Sauna	**Y or N**	# of units_____	**Sauna -** Heat Shield behind the heating unit	**Y or N**	
			Sauna - Scorching behind heating unit?	**Y or N**	

DESCRIPTION OF OPERATIONS

Do you use a deep fat fryer?	**Y or N**	Do you ever serve alcohol free as part of your service?	**Y or N**
Snack Bar on Premises?	**Y or N**	Do you ever sell alcohol?	**Y or N**
Do you have a liquor license?	**Y or N**		

Do you rent space to associated businesses? **Y or N**
If so, Please describe: _____
Do you bring any specialists into your premise to provide additional operations? **Y or N**
If so, Please describe: _____
Are there any operations or activities away from the premises? **Y or N**
If so, Please describe: _____

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

PLEASE ADVISE WHAT SERVICES THE INSURED OFFERS:

Acid/Glycolic Peels (less than 30% solution concentrations **Y or N**
Acid/Glycolic Peels (between 30% to 60% solution concentrations **Y or N**
Acid/Glycolic Peels (greater than 60% solution concentrations **Y or N**

Aqua Massage Beds - # of beds _____	**Y or N**	Body Wraps	**Y or N**
Cellulite Treatment	**Y or N**	Acupuncture	**Y or N**
Diet / Nutrition	**Y or N**	Dry Heat Sauna Beds - # of beds _____	**Y or N**
Eyebrow Tinting	**Y or N**	Eyelash Curling & Perming	**Y or N**
Electroquagulation	**Y or N**	Ear Candling	**Y or N**
Facials	**Y or N**	Hair Cutting / Coloring	**Y or N**
Ionization Foot Detoxification	**Y or N**	Micropigmentation	**Y or N**
Makeup - Non-Permanent	**Y or N**	Manicure / Pedicure	**Y or N**

Does your company use MMA (Methyl Methacrylate) within the Nail Manicure / Pedicure process **Y or N**

Mole Removal by Solution only	**Y or N**		
Oxygen Bar	**Y or N**	Body Vibration Units - # of units _____	**Y or N**
Piercing – other than Ears / Nose	**Y or N**	Piercing -Ears / Nose	**Y or N**
Stripping (for spider veins)	**Y or N**	Skin Tag Removal by Solution only	**Y or N**
Spray Tanning Handheld	**Y or N**	Spray Tanning Booth	**Y or N**
Tattooing – Spray on Only	**Y or N**	Tattooing – Henna	**Y or N**
Toning Beds #____	**Y or N**	Sclerotherapy	**Y or N**
Waxing / Sugaring	**Y or N**	Wart Removal by Solution only	**Y or N**
Weight Loss by Supplements	**Y or N**		

Other Services **Y or N** If yes, please list:_____
_____

Health & Wellness Program

Electrolysis	**Y or N**	**→ If yes, please complete the Electrolysis Supplementary application**
Massage - Registered	**Y or N**	**→ If yes, please complete the Massage Supplementary application**
Massage - Non-Registered	**Y or N**	**→ If yes, please complete the Massage Supplementary application**
Microdermabrasion	**Y or N**	**→ If yes, please complete the Microdermabrasion Supplementary application**
Tanning Beds & Booths	**Y or N**	**→If yes, please complete the Tanning Supplementary application**
Laser / IPL Treatment	**Y or N**	**→If yes, please complete the Laser / IPL Supplementary application**
Injectable Services	**Y or N**	**→If yes, please complete the Injectable Supplementary application**

Please Complete This Section for ALL Employees & Sub-Contractors

of **Full time (F/T)** Employees? _____ **Number of years in Business:** _____
of **Part time (P/T)** Employees? _____ **Number of years Experience the Owner has:** _____
of **Contract** People? _____

NAME	YEARS OF EDUCATION	YEARS OF EXPERIENCE	OPERATIONS OF EACH INDIVIDUAL	F/T, P/T OR CONTRACT	CERTIFICATION ATTACHED?

Has the company had claims against them in last 5 years? **Y or N**
Has the any staff (including contract staff) had claims against them in last 5 years**?** **Y or N**
If yes to either of the above questions, please list full details on the cover page.

PLEASE NOTE:

The applicant agrees to notify the company of any material changes in the answers to the questions on this questionnaire which may arise during the course of this policy issued and further understands that claims may be denied if information regarding these material changes was not provided.

The purpose of this questionnaire is to assist in the underwriting process. Information contained herein is specifically relied on in determination of insurability. The under-signed, therefore, warrants that the information contained herein is true and accurate to the best of his / her knowledge, information, and belief. This questionnaire and the application shall be the basis of any insurance policy that be issued and will be part of such policy.

A consumer report containing personal, credit, factual or investigative information about the applicant may be sought in connection with this application for insurance or any renewal, extension or variation thereof. Signing of this form does not bind the Applicant to purchase the insurance or the Insurer to accept the risk, but it is agreed that this form shall be the basis of the contract should a policy be issued.

Insured Signature: _____ Date: _____
Broker Signature: _____ Date:_____ _____

☐ **ADDITIONAL INSURED** (i.e.: landlord)

_____

☐ **LOSS PAYEES** (i.e.: bank financing, equipment leases, etc.)

_____

Health & Wellness Program

LASER 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 lines of operations):

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

**Please provide all operators who provide laser treatment or cellulite 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/IPL/cellulite machines (please list additional hand pieces separately):
Laser/IPL property coverage for equipment over 3 years of age will be ACV basis

MAKE	MODEL	AGE	CURRENT REPLACEMENT COST IN CANADIAN $$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$

Health & Wellness Program

LASER APPLICATION (CONTINUED…)

Please answer all questions:

1 Please circle what skin types you provide services on for the laser treatments:
As per the Fitzpatrick Scale: 1 2 3 4 5 6

2 Percentage of gross receipts from laser operations _____%

3 Do you complete a skin patch test prior to laser treatments? [ ] Yes [ ] No

4 How long do you wait after the patch test to perform laser treatment? _____

5 Do you wear surgical gloves when providing laser services to clients? [ ] Yes [ ] No

6 Does your client wear protective eyewear during laser services? [ ] Yes [ ] No

7 Do you keep copies of all client service records? [ ] Yes [ ] No

8 How many years is service records kept on file? _____ years

9 Is a waiver signed, dated and kept on record? (please attach a copy) [ ] Yes [ ] No

10 How many years are waivers kept on file? _____ years

11 Do you explain to the client what steps to take prior to any laser treatment [ ] Yes [ ] No
Please describe

_____

_____

_____

12 Do you explain to the client what steps to take after any laser treatment? [ ] Yes [ ] No
Please describe_____

_____

_____

13 How often do you calibrate your machines?_____

14 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:

_____

_____

_____

_____

_____

_____

MASSAGE APPLICATION

Please complete this section for all Massage Therapists on Staff:

NAME OF MASSAGE THERAPIST	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 / waivers on file? _____ years

4 Is a waiver signed, dated and kept on record? [ ] Yes [ ] No

5 Do you offer massages to infants'? [ ] Yes [ ] No

6 Have any of the therapists listed above had a claim made against them? [ ] Yes [ ] No

If so, please advise: _____

MICRODERMABRASION APPLICATION

1 Do you sterilize equipment? [ ] Yes [ ] No

2 Does all staff wear sterilized gloves when performing services? [ ] Yes [ ] No

3 Do you collect and discuss the client's health information? [ ] Yes [ ] No

4 How long to you keep clients' health information on file? _____ years

5 Have you ever had a claim made against you? [ ] Yes [ ] No

If so, please advise: _____

ACID PEELS APPLICATION

1 Do you sterilize equipment? [ ] Yes [ ] No

2 Does all staff wear sterilized gloves when performing services? [ ] Yes [ ] No

3 Do you provide Acid Peels greater than 30%? [ ] Yes [ ] No

4 Do you provide Acid Peels greater than 60%? [ ] Yes [ ] No

5 Have you ever had a claim made against you? [ ] Yes [ ] No

If so, please advise: _____

ELECTROLYSIS APPLICATION

1 Do you sterilize equipment? [ ] Yes [ ] No

2 Does all staff wear sterilized gloves when performing services? [ ] Yes [ ] No

3 Do you use disposable tips for each new client? [ ] Yes [ ] No

4 Have you ever had a claim made against you? [ ] Yes [ ] No

If so, please advise: _____

Health & Wellness Program

TANNING SALON SUPPLEMENTARY APPLICATION

EQUIPMENT INFORMATION

	# of Units	Type of Timer (digital, coin, token, manual, etc.)
BEDS	_____	_____
BOOTHS	_____	_____
SPRAY BOOTHS	_____	
AIR BRUSH	_____	

Average Age of Beds? _____ Average Age of Booths? _____ Who Changes the Bulbs? _____

Is there any Massage offered?	**Y or N**	Are Clients Given Tanning Instructions?	**Y or N**
Do ALL Client Sign Waivers?	**Y or N**	Do ALL Clients Complete Skin Analysis?	**Y or N**
Do Any Beds Operate by Tokens?	**Y or N**	Do Any Beds Operate by Coins?	**Y or N**
Are Clients Required to Wear Goggles?	**Y or N**	Are Signs Posted to Wear Goggles?	**Y or N**

Are the Tanning Staff Smart Tan or Equivalently Certified? **Y or N**
Is Equipment Inspected and Cleaned After Each Use? **Y or N**

Who Sets the Amount of Time a Client is Able to Tan on Each Bed? **CLIENT or STAFF**
Where is the Timer Located, which sets the Amount of Time a Client Can Tan? **FRONT DESK or BED**

Are Tanning Sessions and Waiver Records Saved and Filed for NO Less Than 2 Years? **Y or N**
Is the Tanning Salon Listed as a Full Member of Smart Tan Canada? **Y or N**
So the insured does not have to send us a copy of all Smart Tan certifications and a copy of their Membership - - -
Please check "Y" so that we can confirm this information with Smart Tan Canada **Y or N**
(Premium advantages if each salon location is listed as a Smart Tan Member – Ask us if salons are not members)

Health & Wellness Program

INJECTABLE SUPPLEMENTAL APPLICATION

Please Complete This Section for ALL Employees & Sub-Contractors who perform Injectable services:

of **Full time (F/T)** Employees? _____ # of **Part time (P/T)** Employees?_____ # of **Contract** People? _____

NAME	YEARS OF EDUCATION	YEARS OF EXPERIENCE	HAVE THEIR OWN INSURANCE FOR THIS SERIVCE	IS THIS PERSON A DOCTOR	IS THIS PERSON A REGISTERED NURSE

COVERAGE AVAILABLE

**** PLEASE CHECK APPLICABLE SERVICES**
**** PLEASE ADVISE WHO PERFOMS SERVICE (D = doctor & N = Nurse)**
**** N/A means that we cannot offer this service**

Aquamid		Artecoll	**N/A**	Bio-Alcamid	
Bioinblue		Botox		Collegan	
Cymetra	**N/A**	Deep Lines /Kiss/Ultra Deep		Dental Blocks	
Dermadeep		Dermalive		Dysport	
Elastence		Esthelis Basic/Soft		Evolence	
Evolution		Hylaform/Fineline/Plus		Hydrafill 1/2/3/Softline/Max	
IAL System		Juvederm 18/24/24hv/30/30hv		Juvelift	
Laresse		Matridex		Martridur	
Outline		Puragen		Puragen Plus	
Radiesse		Restylane Sub Q		Restylane/Touch/Perlane/Lipp	
Reviderm Intra		Restylane Vital		Sculptra (Newfill)	
Surgiderm 18/24xp/30		Surgiderm 30xp		Surgilift Plus	
Surgilips		Teosyal Global Action /Touch Up		Teosyal Meso	
Vistabel		Viscontour		Voluma	
Zyderm 1/2/Zyplast					

Has the company had claims against them in last 5 years? **Y or N**
Has the any staff (including contract staff) had claims against them in last 5 years**?** **Y or N**
If yes to either of the above questions, please list full details on the cover page.

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A consumer report containing personal, credit, factual or investigative information about the applicant may be sought in connection with this application for insurance or any renewal, extension or variation thereof. Signing of this form does not bind the Applicant to purchase the insurance or the Insurer to accept the risk, but it is agreed that this form shall be the basis of the contract should a policy be issued. For purposes of the Insurance Companies Act (Canada), any document would be issued in the course of Lloyd's Underwriters' insurance business in Canada.

Insured Signature: _____ Date: _____
Broker Signature: _____ Date:_____ _____