**SALON / SPA**

**PROFESSIONAL LIABILITY APPLICATION**

**APPLICANT**

1. Name of the Insured:

Address:

1. Trading Name (if different from above):

Practice / Trading Address (if different from above):

* **If cover is required for more than one location, please attach a list of all addresses.**

1. Have you ever engaged in a similar activity under a different name?  Yes  No

**If yes**, please give full details:

1. Is this a new company (formed within the past 3 years)  Yes  No If yes, please attach resume(s) of principal(s)
2. Is the applicant controlled, owned or associated with any other company?  Yes  No If yes, describe:

1. Web Site Address:

**OPERATIONS**

1. Fees from all operations: Last 12 months (expiring) $      Next 12 months (estimates) $

(If new business please state estimated income for the forthcoming 12 months)

1. Estimate the split of revenue by type of treatment performed:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **% Income** |  | **% Income** |  | **% Income** |
| **Facials** | | **Hair Removal** | | **Tattooing** | |
| Laser |  | Waxing |  | Permanent |  |
| Lights |  | Sugaring |  | Removal |  |
| Peels |  | Lasers |  | Black Henna |  |
| Injections |  | Electrolysis |  | Other Henna |  |
| Microdermabrasion |  | Light |  | Branding |  |
| General |  | Shortwave |  | Scarification |  |
| **Make Up** | | **Spa / Water** | | **Body Modification** | |
| Permanent |  | Bath Treatments |  | Scalpeling |  |
| Temporary |  | Sauna |  | Implants |  |
| Eyelash extensions |  | Shower |  | Ear Shaping |  |
| Microblading |  | Steam Room |  | Ear Stretching |  |
| Botox injections |  | Hydrotherapy |  | Piercing |  |
|  |  | Float |  | Tongue Splitting |  |
| **Other** | | | | | |
| Acupuncture/pressure |  | Aromatherapy |  | Body Slimming/Reduction |  |
| Body Wraps / Polishing |  | Body Treatment - Electrical |  | Fish Treatment |  |
| Chiropody |  | Ear Candling |  | Hair – Cut/Colour/Perm |  |
| Hydrotherapy |  | Massage Therapy |  | Mani/Pedicure |  |
| Physiotherapy |  | Plastic Surgery |  | Reflexology |  |
| Reiki |  | Removal of Warts/Moles |  | Teeth Bleaching |  |
| Tanning – UV |  | Tanning – Spray |  | Vein Treatments / Injections |  |
|  |  |  |  |  |  |

1. Does applicant work with children under the age of 16?  Yes  No If yes, describe ages(s) and circumstances:

1. Do you provide teaching or instruction?  Yes  No If yes, please advise:

Approx # students/year       approx # hours/week       annual income/year from instruction $

1. a) Is the applicant currently enrolled as a student/apprentice?  Yes  No
2. Are any of the employees currently students/apprentice?  Yes  No
3. Are all student/apprentices supervised by licensed professionals?  Yes  No
4. Do any students/apprentices operate (perform services) outside of the school or program?  Yes  No
5. # of Employees: Full time (licensed)       Part time(licensed)       Students/Apprentices
6. Does the applicant sell any products?  Yes  No If yes,
7. estimated annual revenue: $
8. Are any products imported?  Yes  No If yes, please attach details
9. Are any products exported?  Yes  No If yes, please attach details
10. Are any products manufactured by applicant?  Yes  No If yes, please attach details
11. Are any products repackaged or relabelled for resale?  Yes  No If yes, please attach details
12. Are all products approved for use under the Canada Food and Drug Act?  Yes  No
13. Does the applicant have an locations OR operations outside of Canada?  Yes  No If yes,

Country Revenue # of Employees

      $

      $

      $

1. Does applicant administer or recommend any form of anesthetic, analgesic or tranquilizer medication?  Yes  No If yes, describe:
2. Does applicant provide written or oral advice on the use or healing qualities of herbal, organic or

drug items or supplements?  Yes  No If yes, describe:

1. Is alcohol sold or served on the premises?  Yes  No If no, explain:
2. Is the applicant engaged in any business or profession other than described above?  Yes  No If yes, describe:

1. Is a license required in order for the applicant to practice?  Yes  No License #:
2. Do all employees carry a valid license  Yes  No

* **Please provide on a separate piece of paper, full details of all qualifications and courses that you have undertaken, on all treatments provided**

1. Is the business operated in accordance with regulations stipulated by Health Canada,

the province/territory and municipality in which operated?  Yes  No If no, explain:

1. Are all machines used CSA or ULC and Health Canada approved?  Yes  No If no, explain:
2. Is an operator always present during business hours who has a valid First Air Certificate?  Yes  No
3. Do you obtain satisfactory consent/waiver in writing from each patient prior to starting treatment?  Yes  No (attach form)
4. How long are patients records kept for?
5. Does the applicant have a record of disciplinary action with the applicableprofessional association?

(including revocation or suspension of a license)  Yes  No If Yes, please explain:

**INSURANCE** (see Property Supplement for additional coverages)

1. Insurance required:

EACH CLAIM LIMIT: $      AGGREGATE LIMIT: $      DEDUCTIBLE: $      CGL:  Yes  No $

1. Are you currently insured for Medical Professional Liability?  Yes  No
2. **If yes**, please indicate the name of the Insurer:
3. Is coverage through an association:  Yes  No
4. Is such coverage offered on:  Occurrence Basis  Claim-made Basis
5. If the current coverage is on a claim-made basis, what is the retroactive date?
6. What is your current policy limit? $      deductible? $
7. If you are presently insured, are renewal terms being offered?  Yes  No

**If no**, please state reason:

1. To your knowledge, has any company declined or terminated the insurance for you, any

present partner or officer or for any predecessor in the business, past partners or officers?  Yes  No

**If yes,** provide details:

1. Has any order to cease & desist, claim, written demand, or civil proceeding for compensatory

damages or ever been made to your knowledge against you, any business predecessors, or

any of the present or former partners or officers?  Yes  No

1. Are you aware of any act, error, omission or circumstances which could give rise to a claim

against you or any predecessor in business, or any present or former partner or officer?  Yes  No

**IF THE ANSWER TO EITHER 29 OR 30 IS YES, ATTACH LIST OF ANY INCIDENTS OCCURING IN THE PAST 5 YEARS**

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 29 OR 30 OR ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

1. Additional Interests

Name Address Interest

I/We hereby declare that the above statements and particulars are true and that I/we have not suppressed or misstated any material facts and I/we agree that this declaration shall be the basis of any binder or contract or insurance with the Insurer, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this application does not bind the Insurer to the issue of the insurance nor the Applicant to the purchase of the insurance.

It is further understood and agreed that if, following submission of this application to the Insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 29 or 30 of this application, the Insurer shall be immediately notified in writing of such information.

NAME OF APPLICANT:

Signature (Signing Officer) Title Date

**BROKER**

Agent/Broker Name:       Company:

Phone:       Email:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_