



HEALTH & FITNESS CENTRE APPLICATION

General Information:

- 1. Name of Applicant:
2. Operating Name: Web Site:
3. Mailing Address:
4. Contact Name: Title:
5. Do you have Additional Locations?
6. Applicant is: Individual Corporation Partnership Other:
7. Type of Location (stand-alone building, shopping mall, hotel, etc.):
8. Location(s) are: Owned Leased Neither If rented, please attach a copy of the Lease Agreement
9. Number of Years in Operation: With current management:
If two years or less, please attach resume

Current/Most Recent Coverage Information

- Insurance Company: Dates of Coverage:
Any losses in the past five years for the company and/or staff?
Has any form of Insurance ever been cancelled/declined?
Requested Effective Date: Expiry Date:

Desired Coverages:

- Desired Limit of Liability: Deductible:
Include Professional Liability for the Trainers (same limit as CGL)?
Property: Equipment:
Non-Owned Auto: Limit: Average Auto Value: Estimated # of Days Rented:
If Property Coverage is required (other than Inland Marine/Transit) attach the Supplemental Property Application

Operating Information:

- 1. Estimated Annual Membership: Cost for Annual Membership:
2. Description of Facility and Services:
3. Management Experience and Qualifications:
4. Are classes taught?
Are Classes: Contact or Non-Contact? Sparring or Non-Combative/Fitness Only?

If Martial Arts, Yoga, Boxing or Wrestling Classes are offered, what styles are taught? _____

What are the Age Groups? _____

What are the Instructor's Qualifications? _____

What Safety Equipment is Used? _____

5. Hours of Operation: _____ Number of Days Per Week: _____

6. Gross Receipts: Services: _____ Food: _____ Liquor: _____

Building/Room Rental: _____ Pro-Shop Sales (Sports Related): _____

Other Product Sales: North American Origin: _____ European Origin: _____

Other (Describe): _____ Total Annual Gross Receipts: _____

7. Describe Retail Products Sold: _____

Do you sell Vitamins, Health Supplements and/or Homeopathic Medicine? Yes No

Are any of the Products Manufactured under your own label? Yes No If Yes, please list: _____

Where are the suppliers located? North America Europe Other: _____

8. Any sales of alcoholic beverages on the premises? Yes No **If Yes, attach Liquor Liability Application**

9. Are there Cooking Facilities on the premises? Yes No If Yes Describe: _____

Is the Restaurant or Snack Bar Open to the General Public? Yes No

Indicate Type(s): Restaurant Snack/Juice Bar Vending Other: _____

Describe the type(s) of food served: _____

Are the Facilities Inspected by the Board of Health? Yes No If Yes, how Often? _____

Who is providing food, applicant or other (name)? _____

If other than applicant, is a Certificate of Insurance provided? Yes No

10. Staffing:

Type of Service	Employees		Independent Contractors:	
	Part Time:	Full Time:	Part Time:	Full Time:
Fitness/Group Instructors	_____	_____	_____	_____
Office Staff	_____	_____	_____	_____
Managers	_____	_____	_____	_____
Personal Trainers	_____	_____	_____	_____
Other:	_____	_____	_____	_____

11. Do you own any other business operations or rent space to others? Yes No If yes explain: _____

12. Do you have any off-premises operations/activities? Yes No If yes explain: _____

13. Do you have written guidelines/procedures for addressing Human Resources or Personnel Management issues such as:

Discrimination Yes No Sexual Harassment Yes No

Discipline Yes No Employee Termination Yes No

Employment Grievances/Complaints Yes No Orientation of all new employees Yes No

If Yes to any of the above, please attach a copy

14. Do any of your Employees provide Outside Services, operating on your behalf? Yes No

If Yes, Please Explain: _____

15. Do you bring any specialists onto your premises to provide additional services? Yes No
 If Yes, Please Explain: _____
16. Are client information sheets/records collected for each client? Yes No **If Yes, Attach a copy**
 How long are they kept? _____
- (e) Is a waiver/hold harmless agreement signed by clients? Yes No **If Yes, Attach copy of all forms used**
 Are there any services for which this is not required? Yes No
 If yes, please list exempt services: _____
 How long are waivers kept on file? _____
18. Are all parking lots well-lit? Yes No
19. Are parking areas and sidewalks/walkways checked daily and maintained regularly? Yes No
20. Who is responsible for snow removal? _____
21. Do you keep a supply of salt for de-icing outdoor areas/entrances, and apply regularly during winter? Yes No
22. Are floors and stairwells checked daily and maintained regularly? Yes No
23. Are tables, chairs and equipment in good condition and subject to regular inspection and repair? Yes No
24. Please describe precautions taken to avoid slips and falls at entrances: _____
25. Has any equipment been modified/rebuilt after being received from its original manufacturer? Yes No
26. If yes, explain, and include age of equipment: _____
27. Who is responsible for Maintenance and/or Repair of Equipment? _____
28. Is there a maintenance log/schedule recording the activities in question number(s) 19 to 24 and 27 above?
 Yes No If Yes, for which activities: _____
29. Services Provided:
- | | | | |
|-----------------------------------|--|---------------------------------------|--|
| Personal Training | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nutrition / Diet/Wellness Counselling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Spa Services | <input type="checkbox"/> Yes <input type="checkbox"/> No | Registered Massage Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chiropractic / Physical Therapist | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spray-On Tanning Applications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical Clinic | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tanning Beds and Booths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Naturopathic Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ | |
- If Spa services are offered please complete Spa Application**
30. What Certifications do your Trainers/Instructors have? _____
31. Are staff available in each area of the facility for Supervision, Spotting and Emergencies? Yes No
32. What is your Minimum Age Requirement? _____ Are Minors Required to be Accompanied by a Parent? Yes No
33. Is there any child-care service? Yes No If Yes, do parents stay on premises at all times? Yes No
If there is any child-care service, please complete Supplementary Abuse Application
34. If Massage is provided, what types are available? _____
35. If massage therapy is provided, do all massage therapist's hold a Registered Massage Therapist designation and carry their own personal E&O insurance, including anyone performing Acupuncture and/or Ultrasound? Yes No
 If "No", please list any exceptions: _____
36. If Nutrition/Wellness/Diet Counselling is provided, what programs/services are offered? _____

Are the Employees Associated with these Programs Certified and Considered Professionals by the Program? Yes No

Do the Employees Associated with these Programs follow the Canada Food Guide recommendations? Yes No

37. If Spray Tanning is provided, are face masks offered to clients? Yes No Are Goggles offered? Yes No

Which are used: Booths If Yes, # Units: _____ Handheld Devices If Yes, # Units: _____ Both

38. Are detailed reports kept of all incidents, including reports of customer dissatisfaction? Yes No

If Yes please attach a copy

39. Are there any swimming pools on your premises? Yes No If Yes please answer the following:

What is the Depth of each Pool? _____ Are all Depths Clearly Marked? Yes No

Number of Pools: _____ # of Diving Boards: _____ Are Certified Lifeguards On Duty? Yes No

Is access to swimming pool locked outside of pool hours? Yes No

40. Please indicate if your health or fitness centre includes:

		# Units	Non-Slip/Skid Flooring?	Rubber Mats in Halls?
Showers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jacuzzis/Whirlpools/Hot Tubs	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Steam Rooms	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wet Sauna	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Sauna	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has there been any scorching behind Sauna heating unit? Yes No How many inches is it from the wall? _____

41. How many of your Employees are trained in First Aid? _____

42. Please provide details of any other services or activities which have not been listed on this application:

PLEASE ATTACH THE FOLLOWING TO THIS APPLICATION:

(a) Details of your Procedures for Sterilization and steps taken to avoid Cross-Contamination

(b) Your Brochure(s) of Services, Products and/or Operations

(c) Copy of Registration Forms, Health Forms, Waiver/Consent Forms, any other forms signed by Clients

(d) Copies of Information sheets/Brochures provided to clients about services (e.g. spray tanning)

Please list the organizations that require a Certificate of Insurance from you (As they are to appear on the policy)

NAME	ADDRESS	RELATIONSHIP TO YOU*
1. _____	_____	_____
2. _____	_____	_____

THIS APPLICATION IS SUBMITTED WITH THE FOLLOWING SPECIFIC UNDERSTANDING:

- (a) Applicant warrants and represents that the above answers and statements are in all respects true and material to the issuance of an Insurance Policy and that Applicant has not omitted, suppressed or misstated any facts.
- (b) The signing and filing of this Application does not bind the Applicant or the Company and no Insurance shall be deemed effective unless and until a written binder or Policy of Insurance is issued by the Company in response hereto.
- (c) All exclusions in the Policy apply regardless of any answers or statements in this Application.
- (d) Applicant understands that the Deductible under any Policy to be issued in response hereto shall include both loss payment and claim expense as defined in the Policy.
- (e) If any of the above questions have been answered fraudulently, or in such a way as to conceal or misrepresent any material fact or circumstance concerning this Insurance or the subject thereof, the entire Policy shall be void.

Applicant Signature: _____ Date: _____

Title: _____ Phone: _____