SPA, SALON, BEAUTY PARLOUR APPLICATION

General Information:

1. Name of Applicant: ______________________
2. Mailing Address: ______________________
3. Contact Name: ______________ Title: ______________
4. Do you have Additional Locations? ❑ Yes ❑ No If Yes provide address(es): ______________
5. Applicant is: ❑ Individual ❑ Corporation ❑ Partnership ❑ Other: ______________
6. Name of Spa(s): ______________ Web Site: ______________
7. Type of Location (stand-alone building, shopping mall, hotel, etc.): ______________
8. Location(s) are: ❑ Owned ❑ Leased
9. Number of Years in Operation: ______________ With current management: ______

   If two years or less, please attach resume

10. List any Spa Groups/Associations of which you are a member in good standing: ______________

Current/Most Recent Coverage Information

Insurance Company: ______________ Dates of Coverage: ______________

Any losses in the past five years for the **company and/or staff**? ❑ Yes ❑ No **If Yes, Attach Five Year Loss Record**

Was prior coverage Claims-Made? ❑ Yes ❑ No If Yes, what is Retroactive Date? ______________

Has any form of Insurance ever been cancelled/declined? ❑ Yes ❑ No If Yes, provide details: ______________

Requested Effective Date: ______________ Expiry Date: ______________

Desired Commercial General Liability Coverage

Limit: ❑ $1,000,000 ❑ $2,000,000 ❑ $5,000,000 ❑ Other: __________ Deductible: ❑ $500 ❑ $1,000

Tenant's Legal Liability ($250,000 is standard) __________ Include: Wrongful Dismissal: $100,000 limit? ❑ Yes ❑ No

Include (for same limit as CGL): Personal & Advertising Injury? ❑ Yes ❑ No Employer's Liability ❑ Yes ❑ No

Include: Professional Liability? (CGL limit) ❑ Yes ❑ No If Yes, for: ❑ Employees ❑ Independent Contractors ❑ Students

Non-Owned Auto: Limit: __________ Average Auto Value: __________ Estimated # of Days Rented: ______

Desired Property Coverage: Current Replacement Value of:

Building (if required): ______________ Equipment: ______________

Tenant's Improvements ______________ Stock: ______________

Please attach the Supplementary Property Application

Services Provided:

Service	Yes	No	Service	Yes	No
Acupuncture (non-Laser)	❑ Yes	❑ No	Make-up – Permanent	❑ Yes	❑ No
Acupressure	❑ Yes	❑ No	Microdermabrasion	❑ Yes	❑ No
Aromatherapy	❑ Yes	❑ No	Mobile/In-Home Spa Services	❑ Yes	❑ No
Body Wraps/Mud/Peat Baths	❑ Yes	❑ No	Naturopathic Medicine/Medical Clinic	❑ Yes	❑ No
Body Vibration Units	❑ Yes	❑ No	Nutrition/Diet/Wellness Counselling	❑ Yes	❑ No
Botox/Any Type of Injections/Fillers	❑ Yes	❑ No	Oxygen Bars	❑ Yes	❑ No
Carboxy Therapy	❑ Yes	❑ No	Photo Facials	❑ Yes	❑ No
Chiropractic Services/Physical Therapy	❑ Yes	❑ No	Piercing (other than ears)	❑ Yes	❑ No
Cosmetic Teeth Whitening:	❑ Yes	❑ No	Plastic/Cosmetic Surgery	❑ Yes	❑ No
If Yes, Performed by Dentist/Dental Hygienist?	❑ Yes	❑ No	Registered Massage Therapy	❑ Yes	❑ No
Deep Chemical Peels (Phenol Peels)	❑ Yes	❑ No	Reflexology	❑ Yes	❑ No
Ear Candling	❑ Yes	❑ No	Removal of Corns/Bunions/Ingrown		
Ear Piercing	❑ Yes	❑ No	Nails/Warts	❑ Yes	❑ No
Eyebrow/Eyelash Tinting	❑ Yes	❑ No	Services Requiring Invasive Cutting	❑ Yes	❑ No
Electrolysis	❑ Yes	❑ No	Services Requiring General Anesthetic	❑ Yes	❑ No
Electro-Acupuncture / TENS	❑ Yes	❑ No	Shiatsu Massage	❑ Yes	❑ No
Facials	❑ Yes	❑ No	Spa School/Technician Training Program	❑ Yes	❑ No
Glycolic Peels: ___% Glycolic Acid ___%TCA	❑ Yes	❑ No	Spray-On Tanning	❑ Yes	❑ No
Hairstyling	❑ Yes	❑ No	Spider Vein Treatment (Non-Laser)	❑ Yes	❑ No
Hormone Therapy	❑ Yes	❑ No	Tanning Beds and Booths (UV)	❑ Yes	❑ No
Hot Rock/Hot Stone Massage	❑ Yes	❑ No	Tattooing/Tattoo Removal	❑ Yes	❑ No
Hydrotherapy/Vichy Showers	❑ Yes	❑ No	Toning Beds	❑ Yes	❑ No
Ionization Foot Detoxification	❑ Yes	❑ No	Ultrasound	❑ Yes	❑ No
IPL or Laser Treatments	❑ Yes	❑ No	If Yes, Performed by RMT?	❑ Yes	❑ No
If Yes please complete Supplementary Laser Application			Threading/Sugaring	❑ Yes	❑ No
Manicures/Pedicures	❑ Yes	❑ No	Waxing	❑ Yes	❑ No

Other (list all): ______________________________

If written information is provided to clients with respect to any of these services, please attach a copy

1. If Acupuncture is offered, are single-use, pre-packaged, sterilized needles used for each treatment? ❑ Yes ❑ No
2. Is Parental Consent required for certain services for clients under the age of 18? ❑ Yes ❑ No If Yes, for which services:
   ____
3. If Nutrition/Diet/Wellness Counselling is offered, are Canada Food Guide Recommendations followed? ❑ Yes ❑ No
4. If Mobile/In-Home or Off Premises Services are offered, provide an explanation of types of services offered, locations visited, frequency of off-site/mobile services, and how equipment is transported: ______________________________
   ____
   ____
5. If you operate a School or Training Program, describe, including annual number of students, services they perform, and instructor qualifications (**also please attach a Course Outline**): ______________________________
   ____
   ____
6. 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
7. Do you provide any fitness/ exercise facilities? ❑ Yes ❑ No If Yes, describe: ______________________________

   Number of Squash Courts: ______________________________ Number of Racquetball Courts: ______________________________

8. Do you own any other business operations or rent space to others? ❑ Yes ❑ No If Yes explain: ______________________

9. Do you bring specialists onto the premises to provide additional services? ❑ Yes ❑ No If Yes explain: ________________

10. Are Minors required to be accompanied by a Parent? ❑ Yes ❑ No If No, please explain: ______________________

11. 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 the Supplementary Abuse Application

Number of Technicians/Operators:

Service	#	Minimum Required Certification/Years of Experience	Carry Own Insurance? (Minimum $2M Limits)	Employment Type (If "Other" please explain)
Acupuncture/Acupressure	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Chiropractic/Physical Therapy/Physiotherapy	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Electrolysis	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Esthetics	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Glycolic/Chemical Peel	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Hair Removal	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Massage Therapy	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Microdermabrasion	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space
Nutrition/Diet/Wellness Counselling	______	______________________	❑ Yes – GL only ❑ No ❑ Yes – GL & Prof. Liability	❑ Employees ❑ Independent Contractors ❑ N/A – Only Renting Space

For all of the above Services, are all Employees or Independent Contractors required to possess the Minimum Required Certification entered in the chart, without exception, prior to being allowed to work with clients? ❑ Yes ❑ No

If No please explain: ____

Total Number of Technicians/Estheticians/Stylists/ Operators: __________

Operating Information:

1. Hours of Operation: From: ______________________ To: ______________________
2. Annual Gross Receipts: Total: ______________ Services: ______________ Food: ______________

   Liquor: ______________ Building Rental: ______________ Hotel Rooms: ______________

   Product Sales: North American Origin: ______________ European Origin: ______________
3. Please describe your sterilization/cross-contamination prevention procedures: ______________

   ____

   ____

   ____
4. Describe Products Sold: ______________________________

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

   Where are the suppliers located? ❑ North America ❑ Europe ❑ Other: ______________

   Do you sell Vitamins, Health Supplements and/or Homeopathic Medicine? ❑ Yes ❑ No
5. What is the age of the oldest equipment on your premises? ______________________
6. Any sales of alcoholic beverages on the premises? ❑ Yes ❑ No **If Yes, attach Liquor Liability Application**
7. Are there Cooking Facilities on the premises? ❑ Yes ❑ No If Yes Describe: ______________

   Who is providing Food, Applicant or other (name)? ______________________

   If other than applicant, is a Certificate of Insurance provided? ❑ Yes ❑ No Limit: ______________

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

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

   Are the Facilities Inspected by the Board of Health? ❑ Yes ❑ No If Yes, how Often? ______________
8. Are Client Information Sheets/Records collected for each client for certain services? ❑ Yes ❑ No **If Yes, Attach a Copy**

   For which services? ______________________ How long are they kept? ______________

   Are detailed reports kept of all incidents, including customer dissatisfaction? ❑ Yes ❑ No **If Yes, Attach a Copy**
9. Is a Waiver/Hold Harmless Agreement signed by clients? ❑ Yes ❑ No **If Yes, Attach Copy of all Forms used**

   For which services? ______________________ How long are they kept? ______________
10. Are exterior/parking areas well-lit, and sidewalks/walkways checked daily and maintained regularly? ❑ Yes ❑ No
11. Who is responsible for Snow Removal? ______________________
12. Do you keep a supply of salt for de-icing outdoor areas/entrances, and apply regularly during winter? ❑ Yes ❑ No
13. Are floors and stairwells checked daily and maintained regularly? ❑ Yes ❑ No
14. Are tables, chairs and equipment in good condition and subject to regular inspection and repair? ❑ Yes ❑ No
15. Please describe precautions taken to avoid slips and falls at entrances: ______________________
16. Has any equipment been modified/rebuilt after being received from its original manufacturer? ❑ Yes ❑ No
17. Who is responsible for Maintenance and/or Repair of Equipment? ______________________
18. Is there a Maintenance Log/Schedule recording the activities in question number(s) 10 to 17 above? ❑ Yes ❑ No
19. Are there security cameras: ❑ Inside ❑ Outside

20. Is there an Emergency Evacuation Plan established for the Facility, with regular training for all staff? ❑ Yes ❑ No

21. 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	Maternity Leave Policy	❑ Yes ❑ No

22. 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 Are swimming lessons offered? ❑ Yes ❑ No

If Yes please describe, including annual number of students, ages of students, and instructor qualifications: ______________

____

21. Please indicate if your spa includes:

		# Units	Non-Slip/Skid Flooring?	Rubber Mats in Halls?
Showers	❑ Yes ❑ No	________	❑ Yes ❑ No	❑ Yes ❑ No
Jacuzzis/Whirlpools/Hot Tubs	❑ Yes ❑ No	________	❑ Yes ❑ No	❑ Yes ❑ No
Steam Rooms	❑ Yes ❑ No	________	❑ Yes ❑ No	❑ Yes ❑ No
Wet Sauna	❑ Yes ❑ No	________	❑ Yes ❑ No	❑ Yes ❑ No
Dry Sauna	❑ Yes ❑ No	________	❑ Yes ❑ No	❑ Yes ❑ No
Vichy Showers	❑ Yes ❑ No	________	❑ Yes ❑ No	❑ Yes ❑ No

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

22. How many of your Employees are trained in First Aid? ____

PLEASE ATTACH THE FOLLOWING TO THIS APPLICATION:

a. Details of your Procedures for Sterilization and steps taken to avoid Cross-Contamination
b. Brochures/Marketing Materials
c. Copy of Registration Forms, Client Information Sheets, Incident Reporting Forms, Health Forms, Waiver/Consent Forms and any Forms signed by Clients
d. Copies of Information sheets/Brochures provided to clients about services (e.g. spray tanning)
e. Course Outline if Training School is part of your operations
f. Supplementary Property Application, if Property coverage is required
g. Supplementary Liquor Liability Application or Abuse Application, if applicable

ADDITIONAL INSUREDS (*As they are to appear on the policy*)

NAME	ADDRESS	RELATIONSHIP TO YOU*
______________	______________	______________
______________	______________	______________

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: ______________________