



Beauty/Spa Program Application

#103-8411 200th STREET, LANGLEY, BC V2Y 0E7 TELEPHONE: (604) 888-0050 FAX: (604) 888-1008

Brokerage: _____ Contact Person: _____ E-mail _____

★**FAILURE TO ANSWER ALL QUESTIONS MAY RESULT IN A DELAY PROCESSING YOUR SUBMISSION**★

General Information

Name of Insured: _____

Mailing Address: _____

Location Address: (if different from mailing): _____

Telephone: (____) _____ Website: _____

Previous insurance company: _____ Is renewal being offered: _____

5 year loss history: _____

Years in business: _____ Years of experience: _____

Desired effective date: _____ Target/Expiring Premium: _____

Liability Information

Estimated Total Revenue: _____ Retail Receipts: _____

Any USA retail sales? _____ If so, please provide percentage of revenues allocated towards USA sales: _____

Do you manufacture/re-label or re-package any products for sale? _____

Do you use case history cards? _____

Types of work performed, please check all that apply:

Those that are bold will require an additional supplement application be provided.

- | | | |
|---|--|---|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Eyelash Lifting/Perming | <input type="checkbox"/> Paraffin |
| <input type="checkbox"/> Aromatherapy | <input type="checkbox"/> Facials | <input type="checkbox"/> Permanent Makeup/Microblading |
| <input type="checkbox"/> Body Wraps | <input type="checkbox"/> Floatation Chambers # _____ | <input type="checkbox"/> Radio Frequency Treatments |
| <input type="checkbox"/> Body Injections | <input type="checkbox"/> Hairstylist/Barber | <input type="checkbox"/> Reflexology |
| <input type="checkbox"/> Cellulite Reduction | <input type="checkbox"/> Infrared Saunas # _____ | <input type="checkbox"/> Registered Massage ** |
| <input type="checkbox"/> Chemical Peels (30% or less) | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Relaxation Massage |
| <input type="checkbox"/> Ear Piercing | <input type="checkbox"/> Light Therapy/Cold Laser | <input type="checkbox"/> Skin Tag Removal (non-invasive only) |
| <input type="checkbox"/> Ear Candling | <input type="checkbox"/> Manicure/Pedicure | <input type="checkbox"/> Spray Tanning |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Teeth Whitening (LED or Tray Only) |
| <input type="checkbox"/> Energy Healing/Reiki | <input type="checkbox"/> Micro-needling | <input type="checkbox"/> Waxing/Sugaring |
| <input type="checkbox"/> Eyebrow/Eyelash Tinting | <input type="checkbox"/> Non- Permanent Makeup | |
| <input type="checkbox"/> Eyelash Extensions | <input type="checkbox"/> Oxygen Treatments | |

Other services, please list: _____

Do you offer mobile services? Yes No If yes what services? _____

**If Registered Massage Therapy is provided, do all therapists carry separate E&O insurance? _____

Do you provide any teaching operations or have students offering services to the public while under your supervision? _____ If yes, what services? _____

Provide teaching supplement as per attached.

Is liquor served? _____ If yes, do they have a liquor license in place? _____
Provide percentage of revenues allocated towards liquor sales _____

Please provide number of employees: # _____ Full-Time # _____ Part-Time

***** Coverage is excluded if machines are used for medical use and must be Canada Safety Authority (CSA) rated. All products must be approved by Health Canada/Canada Food & Drug Act. Any use of caustic chemicals including Methyl Methacrylate is excluded.**

Property Coverage

Construction: _____ Year Built: _____ Any Upgrades: _____

#of Stories: _____ Sprinklered: _____ Alarmed? Local: _____ Monitored: _____ None: _____

Square Footage: _____ Other Occupancies: _____

Any additional information: _____

| PROPERTY & BUSINESS INTERRUPTION COVERAGES | AMOUNT OF INSURANCE |
|--|---------------------|
| Building | |
| Equipment (Including Tenants Improvements) | |
| Stock | |
| Business Interruption (Profits or ALS, please specify) | |
| Rent or Rental Value | |
| Extra Expense | |
| Office Contents | |
| Computer (Hardware/Software) | |
| Miscellaneous Property Floater | |
| Equipment Breakdown | |
| LIABILITY COVERAGE | AMOUNT OF INSURANCE |
| Commercial General Liability | |

OPTIONAL COVERAGES: (Select any of the following optional coverages you require)

- Sewer Back-up Comprehensive Property Extension Endorsement
- Flood Earthquake 3D Crime

This application does not bind the applicant or the Company to complete this insurance but it is agreed that the information contained herein shall be the bases of the contract should a policy be issued.

IMPORTANT NOTICE: As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning various risk characteristics. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

It is mutually agreed between the Company and the applicant that any inspection of premises, operations or any matter pertaining to insurance afforded by the Company, is made for the use and benefit of the Company only and is not to be relied upon by the applicant in any respect.

Applicant's Signature: _____ Date: _____

****Only complete the following supplements if they apply****



**Beauty/Spa Program
Injectable Supplement**

#103-8411 200th STREET, LANGLEY, BC V2Y 0E7 TELEPHONE: (604) 888-0050 FAX: (604) 888-1008

| Name | Years of Education | Years of Experience | Have their own insurance for this service | Is this Person a Doctor | Is this Person a Nurse |
|------|--------------------|---------------------|---|-------------------------|------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please provide list of injectable services provided:

Has the company had claims against them in the last 5 years: Yes No

Has any staff (including contract staff) had claims against them in the last 5 years? Yes No

If yes to either of the above questions, please provide full details:

#103-8411 200th STREET, LANGLEY, BC V2Y 0E7 TELEPHONE: (604) 888-0050 FAX: (604) 888-1008

Confirm all laser services and applications offered (ie.Laser, Pulse Light or Radio Frequency):

| | | | |
|------------------|--|-------------------|--|
| Hair Removal | | Acne Scarring | |
| Wrinkles | | Large Pores | |
| Fine Lines | | Hyperpigmentation | |
| Loose Skin | | Vascular Lesions | |
| Rough Texture | | Tattoo Removal | |
| Skin Resurfacing | | Other | |

Please advise if OTHER: _____

Are the treatments/procedures: Invasive/Ablative _____ Fractional _____ Non-Invasive/Non-Ablative _____

| Names of People Providing Laser Treatments | Years of Education | Yrs of Experience | Any prior claims against individual, details |
|--|--------------------|-------------------|--|
| | | | |
| | | | |
| | | | |
| | | | |

Complete this section for all laser machines, if hand pieces please list these separately

| Make | Model | Age | Replacement Cost |
|------|-------|-----|------------------|
| | | | |
| | | | |
| | | | |

Hand devices used: _____

Additional Information:

Gross Receipts from laser treatments? \$ _____ **Confirm minimum age of clients is 18 for laser services** _____

Is a patch test completed 24 or more hours prior to laser treatments? _____ How often do you calibrate your machines? _____

Does client wear protective eyewear during procedures? _____ Do you wear surgical gloves? _____

Do you keep copies of clients service records? Yes No If yes for how many years? _____

Is a waiver signed? Yes No Please attach copy for our file. How many years are the waivers kept? _____

What precare information do you provide clients?

What post care information do you provide clients?

Do you provide any off site laser treatments? Yes No If yes, please describe locations, methods, frequency, etc.



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| Names of People Providing Permanent makeup/microblading services | Years of Education | Total Hours of Practical Experience | Any prior claims against individual, details |
|--|--------------------|-------------------------------------|--|
| | | | |
| | | | |
| | | | |
| | | | |

Additional Information:

**** Please note that the minimum age for permanent makeup/microblading services is 18**

Gross Receipts from Microblading/Permanent Make-up services? _____

Is a patch test completed 24 or more hours prior to laser treatments? _____

Hand devices used: _____

Are services performed with sterilized single-use, disposable needles _____

Are all inks/pigments from Canadian or US manufacturers? Yes No If no where? _____

Do you wear surgical gloves? _____

Do you keep copies of clients service records? Yes No If yes for how many years? _____

Confirm that a waiver is signed for these services _____ How many years are the waivers kept? _____

Advise what pre-care & post-care information is provided to clients? Please attach copy for our file. _____

Do you provide any off site microblading treatments? Yes No If yes, please describe locations, methods, frequency, etc. _____

Confirm you are fully certified to provide these services (advise what certification you hold) _____



**Beauty/Spa Program
Teaching/Beauty Schools**

#103-8411 200th STREET, LANGLEY, BC V2Y 0E7 TELEPHONE: (604) 888-0050 FAX: (604) 888-1008

- Approximate Number of students per year? _____
- Number of hours students complete prior to graduation? _____
- Is the final exam proctored by the provincial regulator? Yes No
- Is the insured trained to certify others? Yes No
- Number of years experience the insured has teaching this course _____years
- Do student offers services to the public? Yes No
- If YES,
1. Number of hours completed prior to offering services to public: _____
 2. Do all clients sign a waiver? Yes No
 3. Are the students supervised at all times when offering services to the public? Yes No
 4. Do students offer Micropigmentation/Permanent Makeup to the public? Yes No
 5. Do students offer Laser/IPL services to the public? Yes No
- Please confirm percentage of gross revenues allocated towards training services _____