Salon/Spa Application

Please complete this application in its entirety, as the responses given are material to the provision of terms. There is space for more details in the Additional Information Section at the end of the application. Coverage(s) may be provided on a claims-made basis.

Named Insured: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Contact: _____ Email: _____ Phone: _____

Section 1: About Your Organization

1. What year was your organization established: _____
2. Is your organization incorporated? Yes ☐ No ☐
3. Has your business named changed in the past 5 years? If Yes, please provide details.* Yes ☐ No ☐
4. Please provide your gross revenue: _____
5. Do you expect a material change in your operations in the next 12 months? If Yes, please provide details.* Yes ☐ No ☐
6. Please list any subsidiaries or related entities of your organization that are controlled by or control your organization:

Entity Name	Description of Operations	Relationship to Applicant

Section 2: Operations

1. Please indicate what percentage (%) of your operations would include the following (**total of all sections should equal 100%):**

	Basic Esthetics		Level One Esthetics Continued		Level Three Esthetics Continued
	Body Wraps, Ears/Nose Piercing, Exfoliation, Eyebrow and Eyelash Tinting, Eyelash Extensions, Facials, Gel and Acrylic Nails, Hairdressing and Extensions, Manicures and Pedicures, Microdermabrasion, Non-Permanent Make Up, Paraffin, Sugaring, Threading, Waxing		Mediation, Biofeedback		Ear and Body Candling
			Movement Therapies, Fitness (e.g., Alexander Technique, Feldenkrais, Tai Chi, Yoga)		Laser Acupuncture
					Low-Level Laser Therapy (LLLT, Cold Laser)
			Moxibustion		Mole and Skin Tag Removal
			Nutrition (Canadian Food Guide)		Myofascial Release Therapy
			Level Two Esthetics		Radio Frequency (RF) Skin Tightening
	Level One Esthetics		Acid Peels < 31% concentration		
	Acupuncture, Dry Needling		Carboxytherapy		**Level Four Esthetics**
	Acupressure, Reflexology		Colonic Irrigation		Ablative Erbium Laser
	Aromatherapy		Dermabrasion, Dermaplaning		Cellfina
	Brow Lamination		Ear Irrigation		High Intensity Focused Ultrasound
	Cupping		Endermologie		Injection Services
	Electrolysis		Hydrotherapy		Injectable Minerals / Vitamins, IV Therapy with Minerals / Vitamins
	Electric Epilation		Massage Therapy, Shiatsu		
	Energy Healing (e.g., Reiki)		Massage with Movement / Alignment (e.g., Rolfing, Onsen)		Laser, IPL, EPL, LHE
	Energy Therapies (e.g., Therapeutic Touch, Body Tapping)				Platelet Rich Plasma
			Micro Needling		Semi-Permanent Make Up, Microblading, Micropigmentation
	Henna Tattooing		**Level Three Esthetics**		
	Hypnotherapy (excluding past life regression)		Acid Peels > 31% & <61% concentration		Tanning
					Teeth Whitening
	Ionization Detoxification		Cellulite Reduction (SculpSure via Lapex, Zerona, VaserShape or similar device)		Vaginal Rejuvenation and Incontinence Treatment
	Iridology				
	LED Light Therapy				**Other**
			Cellulite Treatment (RF, Ultrasound)		Please see next page

*Please provide further details in the space provided under the Additional Information Section.

	Electromagnetic Therapies, Radionics		Coolsculpting		

If you were not able to find one or more of your services above, please indicate the service and provide the percentage (%) or revenue:

%	*Service*				

2. Do you provide services away from your premises? Yes ☐ No ☐
3. Do you conduct employment reference checks on all employees? Yes ☐ No ☐
4. Do you have a formal written policy that prohibits abuse and sexual misconduct? Yes ☐ No ☐
5. Do you have a formal complaints procedure for potential abuse for clients and employees? Yes ☐ No ☐
6. Do you provide services to minors? Yes ☐ No ☐
7. If Yes to 6., do you obtain parental permission prior to providing services? Yes ☐ No ☐
8. Do you have a formal training process for all new employees? Yes ☐ No ☐
9. Do you have a written procedural manual for all services provided? Yes ☐ No ☐
10. Do you review your policies, procedures, protocols, and guidelines at least every three years and are there systems in place to disseminate them to staff? Yes ☐ No ☐
11. Do you have formal procedures in place to manage complaints? Yes ☐ No ☐
12. Are all procedures preceded by obtaining informed consent? Yes ☐ No ☐
13. Are records maintained on all clients for at least 10 years? Yes ☐ No ☐
14. Are all machines used CSA or ULC compliant and approved for use by Health Canada? Yes ☐ No ☐
15. Is alcohol served as part of your services? If Yes, please provide details.* Yes ☐ No ☐
16. Is food served as part of your services? If Yes, please provide details.* Yes ☐ No ☐

Section 3: Staffing

1. Please provide details of your staff (please use the Additional Information section if more room is required):

Name	Professional Designation	Years of Education	Years of Experience	FT/PT, Contract	Services Provided	Carries Own Insurance

Section 4: Products

1. Do you sell any products as part of your operations? Yes ☐ No ☐
2. Please indicate how much revenue comes from the sale of these products:
3. Are any of these products sold outside of Canada? Yes ☐ No ☐
4. Are any of these products sold under your organization's name or brand(s)? Yes ☐ No ☐
5. Please indicate what type of products you sell?*

*Please provide further details in the space provided under the Additional Information Section.

Section 5: Claims History

1. Have you ever had a claim against your organisation's insurance policies? If Yes, please provide details including date of loss, amount paid or held in reserve, and description of allegation.* Yes ☐ No ☐
2. Are you aware of any claims that were made against any of your staff or contractors in the past 5 years? Yes ☐ No ☐
3. Are you aware of any incidents or circumstances that could potentially give rise to a claim? If Yes, please provide details.* Yes ☐ No ☐

Section 6: Prior Insurance

1. Have you ever been declined coverage, cancelled or non-renewed for insurance requested in this application? Yes ☐ No ☐
2. Please provide details of your expiring insurance policy:

Coverage	Insurer	Limit	Aggregate	Deductible	Retroactive Date	Premium
General Liability						
Professional Liability						

Section 7: Requested Insurance Coverage

1. Please indicate the coverage limit, aggregate, retroactive date, and deductible are requested:

Coverage	Limit	Aggregate	Deductible	Retroactive Date
General Liability				
Professional Liability				

2. Confirm coverage has been in place continuously from Retroactive Dates requested? Yes ☐ No ☐

Privacy Policy

By signing this form, you are consenting to the collection, use, disclosure, and retention of your personal information for the purposes of underwriting and rating, policy issuance, processing and remitting premium, reporting claims, complying with applicable laws and governing bodies, reporting and monitoring results and fraud and criminal prevention. Please see www.signalunderwriting.com/privacy-statement for our External Privacy Policy.

Declarations

I/We, the undersigned, do declare and warrant that all statements and responses provided in this application and the attached addenda are to the best of my/our knowledge are true. Further, I/we warrant that no information has been withheld, suppressed or misstated any material facts that the underwriters may come to rely upon. I/We will notify the underwriters as soon as practicable if anything material is to change. I/We hereby agree and accept that this Declaration shall be the basis of such contract and will form part of the policy. Signing this application does not bind the underwriters or insurers to complete the insurance, nor does it bind the me/us to purchase the quoted coverage.

For British Columbia residents: SIGNAL Underwriting Inc. operates as SIGNAL Underwriting Services in British Columbia.

For Quebec and New Brunswick residents: Signing this Declaration confirms your request that all documentation and correspondence pertaining to the insurance coverage be in the English language.

Name (please print)	Title	Date

Signature

Additonal Information Section

Please use this space to provide any additional information from the questions above, from the addenda or anything you feel is material to your operations:

*Please provide further details in the space provided under the Additional Information Section.

SIGNAL UNDERWRITING

Application Addenda

Please complete the relevant section(s) to your operations. More space is available in the Additional Information section.

Addendum: Injection Services, Platelet-Rich Plasma (PRP)

1. Do you keep batch numbers of products used and take before and after photos of the procedure? Yes ☐ No ☐
2. Do you perform injectable service on persons under 18 or on pregnant or breast-feeding women? Yes ☐ No ☐
3. Are all injections provided by a suitable medical professional (e.g., Physician, Registered Nurse, Nurse Practitioner) Yes ☐ No ☐
4. Please list the specific injection services that you provide by percentage (%) of total injection services:

%	*Injection Service*				

5. Please list specific injectable products by percentage (%) of volume of sales:

%	*Injectable Product*				

6. Please indicate what Platelet-Rich Plasma (PRP) services are offered by percentage (%) of PRP services:

	Cellulite Reduction		Neck Rejuvenation		Vampire Facial
	Erectile Dysfunction (P Shot)		PRP with Injectable Products		Other, please indicate below:
	Hair Restoration		Vaginal Rejuvenation (O Shot)		

Addendum: Laser (IPL, EPL, LHE) Services

1. Please indicate the Laser/IPL services you provide:

Laser	IPL		Laser	IPL		Laser	IPL	
☐	☐	Acne	☐	☐	Incontinence Treatment	☐	☐	Vaginal Rejuvenation
☐	☐	Cosmetic Re-pigmentation	☐	☐	Leg Veins	☐	☐	Vascular Lesions
☐	☐	Cellulite Treatment	☐	☐	Pigmented Lesions	☐	☐	Other, please indicate:
☐	☐	Endovenous Ablation	☐	☐	Psoriasis, Vitiligo			
☐	☐	Hair Removal	☐	☐	Tattoo Removal			

2. Please indicate the Fitzpatrick Scale skin types Laser/IPL services are performed on:
3. Do you complete skin patch tests as per the equipment manufacturers instructions? Yes ☐ No ☐
4. Are all vaginal rejuvenation and incontinence treatments provided by a suitable medical professional (e.g., Physician, Registered Nurse, Nurse Practitioner) Yes ☐ No ☐
5. Are all clients provided with pre- and post-care instructions? Yes ☐ No ☐
6. Do you ensure protective equipment is worn by all of your staff and clients? Yes ☐ No ☐
7. Do you provide any of the services in 1., above, off premises? Yes ☐ No ☐
8. How often do you have your equipment calibrated?
9. Please provide details of all the Laser, IPL, EPL, LHE, RF and Cellulite Machines:

Make	Model	Age	Leased/Owned	Replacement Value	Date of Last Maintenance

*Please provide further details in the space provided under the Additional Information Section.

Addendum: Semi-Permanent Make Up, Microblading, Micropigmentation

1. Do you conduct patch tests prior to application?	Yes ☐	No ☐
2. If No to 1., do you obtain a waiver detailing the client's refusal and potential risks?	Yes ☐	No ☐
3. Do you use inks and/or pigments that are manufactured outside of North America?	Yes ☐	No ☐
4. Do you use anything besides single-use needles?	Yes ☐	No ☐
5. Do you dispose of all needles and inks and pigments after use?	Yes ☐	No ☐

Addendum: Tanning

1. The undersigned confirms that they understand that any coverage bound will **exclude claims for cancer**, and similar medical conditions arising from, or contributed to by, the use of a sun bed.	Confirmed ☐	
2. Does your tanning equipment only emit UVA and UVB rays?	Yes ☐	No ☐
3. Do timers shut the beds off automatically?	Yes ☐	No ☐
4. Is the tanning equipment used, maintained, and serviced as per the manufacturer's guidelines?	Yes ☐	No ☐
5. Are the manufacturer's warning signs clearly displayed in the tanning area?	Yes ☐	No ☐
6. Have all tanning supervising employees taken the manufacturer's training?	Yes ☐	No ☐
7. Are the tanning area and the timer settings operated by a qualified staff member?	Yes ☐	No ☐
8. Do your employees ensure that the timers are switched off after each use?	Yes ☐	No ☐
9. Do you provide an information package to each client containing precautions of use and contraindications prior to their treatment?	Yes ☐	No ☐
10. Are clients all provided with protective eye wear prior to treatment?	Yes ☐	No ☐

11. Please provide the following details on your tanning equipment:

Equipment	Age	Leased/Owned	Number of Units	Type of Timer	Date of Last Maintenance
Beds					
Booths					
Spray Booths					
Air Brush					

Addendum: Teeth Whitening

1. Are the products used for teeth whitening manufactured in North America? If No, please provide details.*	Yes ☐	No ☐
2. Do you produce or fit any teeth whitening appliance for your clients?	Yes ☐	No ☐
3. Please indicate the maximum precent (%) of Carbamide Peroxide Solution used:		
4. Please indicate the maximum percent (%) of Hydrogen Peroxide Solution used:		
5. Please indicate the maximum length of treatment in minutes:		
6. Please indicate the number of treatments allowed per visit:		

Addendum: Training

1. Please provide the name(s) of the person conducting the classes:		
2. Is the person conducting the classes certified to teach?	Yes ☐	No ☐
3. Please provide the number of years of teaching experience they have?		
4. Will you be certifying the students?	Yes ☐	No ☐
5. Are your classes open to the public (versus those in the beauty industry)?	Yes ☐	No ☐
6. Is there additional training offered for participants without aesthetics experience?	Yes ☐	No ☐
7. Please indicate the courses offered:		
8. Please indicate the person or organisation responsible for generating the course material:		
9. How many students do you expect to take part in a year:		

*Please provide further details in the space provided under the Additional Information Section.

10. What is the annual tuition gross revenue that you expect:				
11. Please provide the number of hours each student completes:				
12. Is the final exam proctored by a provincial regulator or professional body?	Yes	O	No	O
13. If the students provide spa services, please indicate which ones:				
14. Please indicate the number of hours students complete before offering spa services to the public:				
15. Do all clients sign a waiver before receiving services from a student?	Yes	O	No	O
16. Are students supervised at all times while providing services?	Yes	O	No	O
17. Do you clearly indicate to students with whom the course(s) are accredited with, or, if the course is not accredited?	Yes	O	No	O

Addendum: Childminding

1. Do you provide childminding as part of your services to your patients?	Yes	O	No	O
2. If yes to 1., what is the range of age of the children?				
3. Do you obtain written instructions from parents on allergic or medical problems?	Yes	O	No	O
4. Are all childminding staff trained in first aid?	Yes	O	No	O

*Please provide further details in the space provided under the Additional Information Section.