



Personal Care Application

Full Service Operations including Tanning, Spa, Electrolysis, Massage Therapy & Permanent Makeup

Unison Insurance & Financial Services Inc.
2077 Dundas Street e., Suite 103
Ontario, Canada
Phone: 905-624-5300
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This application form is best viewed with Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader installed, you can download it at "<http://get.adobe.com/reader>".

COMPLETION OF THIS APPLICATION IS FOR QUOTATION PURPOSES ONLY.

Legal Business Name

Mailing Address

City Province Postal Code Country

Business Address

City Province Postal Code Country

Do you have Additional Locations YES NO

If Yes, please provide the address

Business Address

City Province Postal Code Country

Contact Person Phone Number Fax Number

Res. Number Cell Number Email

Web Site Address

Do you currently have insurance? YES NO

Insurance Company

Have you had insurance previously? YES NO

Policy Number

If yes, how long ago?

Has prior coverage been on a Claims Made Basis YES NO

If Yes, retroactive date

Have you ever been cancelled for non-payment? YES NO

How long have you been in business?

PROPERTY INFORMATION

Please choose your location description

Do you own the building/Unit? YES NO

Age of Building Number of Storeys

Total Area of Building (Approx Square Feet) Area of your Facility (Approx Square Feet)

LATEST UPDATES IF BUILDING IS OVER 25 YEARS OLD?

Roof Heating

Plumbing Electric

Construction of Building

Wall Type Concrete Block/Masonry Brick Veneer over Wood Frame/Siding

Roof Type Steel Deck or Concrete Wood Joists Metal Clad

Is there a sprinkler system? YES NO Number of Fire Extinguishers Number of Smoke Detectors

Fire Hydrants within 500 Feet? YES NO Fire Alarm? YES NO

Is there a burglar Alarm? YES NO Alarm monitored 24 hours? YES NO Please attach Alarm Certificate

Average Hours of Operaton to Do you Operate 24 hours? YES NO

Is there any Bar/Restaurant adjacement to your operation? YES NO

Is there a Variety Store adjacent to your operation? YES NO

Do you own, operate, or rent space to associated businesses? YES NO

If yes, please describe

Describe precautions taken to avoid slips and falls at entrances

Who does snow removal?

Type of steps if any?

Do you keep salt on hand for de-icing walkways / entrances? YES NO

Do you apply salt and de-icie walkways / entrances? YES NO

FINANCIAL INFORMATION

USE THE FOLLOWING CATEGORY BREAKDOWNS TO HELP YOU DETERMINE YOUR "PROPERTY VALUES" BELOW

STOCK

Cosmetics <input type="text"/>	Hair Care Products <input type="text"/>	Skin Care Products <input type="text"/>
Clothes <input type="text"/>	Supplements <input type="text"/>	Lotions <input type="text"/>
Nail Care Products <input type="text"/>	Other Stock not listed <input type="text"/>	
Please specify <input type="text"/>		

EQUIPMENT

Computers	<input type="text"/>
Furniture	<input type="text"/>
Tanning Beds	<input type="text"/>

Laptops	<input type="text"/>
Massage Tables	<input type="text"/>
Lasers/IPL/RF	<input type="text"/>

Signs	<input type="text"/>
Machines	<input type="text"/>

LEASEHOLDS/TENANTS IMPROVEMENTS

Offices	<input type="text"/>
Beauty Styling Chairs	<input type="text"/>
Construction Costs	<input type="text"/>

A/C Units	<input type="text"/>
Change Rooms	<input type="text"/>
Existing Tenants Improvements	<input type="text"/>
Other, please specify	<input type="text"/>

Phone/Alarm Systems	<input type="text"/>
Washrooms/Showers	<input type="text"/>

PROPERTY VALUES - COVERAGE YOU REQUIRE (TOTALS FROM THE ABOVE CATEGORIES)

Building (only if you require coverage) UNIT	<input type="text"/>	Stock	<input type="text"/>	Leasehold/Tenant Improvements	<input type="text"/>	
Equipment	<input type="text"/>	Other, please specify	<input type="text"/>		Value	<input type="text"/>

THE QUOTATION WILL BE BASED ON THE ABOVE INFORMATION. PLEASE COMPLETE ACCURATELY

DESCRIPTION OF OPERATIONS

Are client cards/records kept	<input type="checkbox"/> YES <input type="checkbox"/> NO	How long are records kept	<input type="text"/>
Do clients sign a waiver (Laser Only)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any clients under the age of 18?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you offer Child Care?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do parents stay on premise at all times?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a Liquor License?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you ever serve alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Snack Bar on Premises?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use a deep fat fryer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are there any operations or activities away from the premises?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you attend any trade shows/exhibits with your equipment?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you bring any specialists into your premise to provide additional operations?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If so, please advise operations:	<input type="text"/>		
Number of Swimming Pools?	<input type="text"/>	Maximum Depth in feet?	<input type="text"/>
Is there Diving Boards	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Showers	<input type="checkbox"/> YES <input type="checkbox"/> NO	# of Units	<input type="text"/>
Non-Slip Flooring	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rubber Mats in Halls?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Whirlpools	<input type="checkbox"/> YES <input type="checkbox"/> NO	# of Units	<input type="text"/>
Non-Slip Flooring	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rubber Mats in Halls?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Steam Rooms	<input type="checkbox"/> YES <input type="checkbox"/> NO	# of Units	<input type="text"/>
Non-Slip Flooring	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rubber Mats in Halls?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Saunas	<input type="checkbox"/> YES <input type="checkbox"/> NO	# of Units	<input type="text"/>
Non-Slip Flooring	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rubber Mats in Halls?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Wet or Dry Sauna?	<input type="text"/>	Any scorching behind Sauna heating Unit?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How many inches is the heating unit away from the closet wall? (in inches)	<input type="text"/>		
Are there any Squash, Racquetball, Tennis or Basketball Courts?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If so, please specify	<input type="text"/>

CRIME EXPOSURES

Maximum amount of cash left on Premises overnight? <input type="text"/>	
If over \$250, do you have a safe?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please specify safe type <input type="text"/>	

EQUIPMENT

Do you have modified or Rebuilt/Used Equipment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please specify age of equipment (years)	<input type="text"/>
Is Equipment Inspected Daily?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Who does the maintenance on the equipment?	<input type="text"/>

STERILIZATION

Is staff required to wear sterilized gloves at all times?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have an autoclave premise?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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PLEASE ATTACH A SUPPLEMENTARY PAGE OUTLINING ALL OF YOUR STERILIZATION PROCEDURES AS WELL AS POLICIES IN PLACE TO PREVENT CROSS-CONTAMINATION

FINANCIAL INFORMATION

LIABILITY INFORMATION	Liability Limits Desired	<input type="checkbox"/> \$2,000,000	<input type="checkbox"/> \$3,000,000	<input type="checkbox"/> \$5,000,000
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Please provide approximate annual revenues for each of the following services:

Hair Cutting/Styling	<input type="text"/>	Nail Services	<input type="text"/>	Acid Peels	<input type="text"/>
Aromatherapy	<input type="text"/>	Electrolysis	<input type="text"/>	Laser/IPL/RF	<input type="text"/>
Massage Services	<input type="text"/>	Product Sales	<input type="text"/>	Supplement Sales	<input type="text"/>
Clothing Sales	<input type="text"/>	Tanning Bed	<input type="text"/>	Other	<input type="text"/>

Body Wraps	<input type="checkbox"/> YES <input type="checkbox"/> NO	Botox Injections	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chiropractors on staff	<input type="checkbox"/> YES <input type="checkbox"/> NO	Collagen Injections	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ear Candling	<input type="checkbox"/> YES <input type="checkbox"/> NO	Facials	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ears Piercing Only	<input type="checkbox"/> YES <input type="checkbox"/> NO	Electrolysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Makeup - Non-Permanent	<input type="checkbox"/> YES <input type="checkbox"/> NO	Manicure / Pedicure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you perform Pedicures on Diabetics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please attach separate page describing procedures and precautions	
Nails - Acrylic	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gel Nails	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you use MMA (Methyl Methacrylate) within the Nail process?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Physical Therapist on Staff?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hot Stone Massage	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tattooing - Henna	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tattooing -Permanent Body	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tattooing - Spray on	<input type="checkbox"/> YES <input type="checkbox"/> NO	Toning Beds	<input type="checkbox"/> YES <input type="checkbox"/> NO
Spray Tanning Booth	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spray Tanning Handheld	<input type="checkbox"/> YES <input type="checkbox"/> NO
Wart / Mole Removal	<input type="checkbox"/> YES <input type="checkbox"/> NO	Waxing / Sugaring	<input type="checkbox"/> YES <input type="checkbox"/> NO
Body Piercing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Face/ Tongue Piercing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Genital Piercing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Makeup - Semi Permanent	<input type="checkbox"/> YES <input type="checkbox"/> NO
Supplemental Sales	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you sell any Metabolics	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sell Products under own label?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, attach brochure of products available	
Hair Cutting / Coloring	<input type="checkbox"/> YES <input type="checkbox"/> NO	Number of Chairs	<input type="text"/>
		Number of Operators	<input type="text"/>

Diet/Nutrition	<input type="checkbox"/> YES <input type="checkbox"/> NO	Follow Canada Food Guide	<input type="checkbox"/> YES <input type="checkbox"/> NO
Reflexology	<input type="checkbox"/> YES <input type="checkbox"/> NO	Percentage of gross income	
Aqua Massage Beds	<input type="checkbox"/> YES <input type="checkbox"/> NO	Number of Aqua Massage Beds	
Acid Peels	<input type="checkbox"/> YES <input type="checkbox"/> NO	% of gross income	# of operators
Aromatherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	% of gross income	# of operators
Sclerotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	% of gross income	# of operators
Laser/Light/RF Treatments	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please complete "Laser/IPL/RF" Application on page 5	
Massage - Registered	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please complete Massage Therapy Section on page 7	
Massage - Non-Registered	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please complete Massage Therapy Section on page 9	
Microdermabrasion	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please complete Microdermabrasion Section on page 10	
Permanent Makeup	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please complete Permanent Makeup Section on page 11	
Tanning Beds & Booths	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please complete Tanning Operations Section on page 12	
Operate a school or training Facility	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please attach a copy of course outline including instructors qualifications and number of students	

Any other services (Not mentioned Above)

Please provide a brochure of your operations, if available, when submitting this application

LASER/IPL/RF APPLICATION

Please advise if you provide the following laser/IPL operations:

Laser	<input type="checkbox"/> YES <input type="checkbox"/> NO	RF	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pulse Light	<input type="checkbox"/> YES <input type="checkbox"/> NO
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Please provide all operators who provide Laser/RF/Light treatment and their experience:

Name of Persons providing Laser/IPL Treatments	Years of Education	Years of Experience/Qualification	Any prior claims made against each individual Please give details

Please select what skin types you provide services on as per the Fitzpatrick Scale:

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
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Do you complete a patch test at least 24 hours prior to laser hair removal operations?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you wear surgical gloves when providing laser services to clients?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does your client wear protective eyewear during laser services?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you keep copies of all client service records for a minimal 7 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is a waiver signed, dated and kept on record for 7 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you explain to the client what steps to take prior to any laser treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you explain to the client what steps to take after any laser treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are machines used to correct red/spider veins?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sclerotherapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stripping?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Acne?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Other Treatments? Please describe	
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What is the minimum age of clients?	
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Complete this section for all Laser/IPL/RF systems

Make	Model & Serial Number	Age Years	Cost to Replace Today Including Attachments/Hand Pieces

Have all operators listed had training on the above Laser/IPL/RF machine(s)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Is your laser machine(s) leased or financed?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If leased or financed, Provide Company Name and Address:				
Please list all locations, methods of transporting equipment and frequency of off-site treatments:				
Do you lease or rent your machine to other individuals or businesses?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, to whom and how often?				
Is the laser equipment being used in accordance with the Manufactures specifications?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

Any person who knowingly and with intent to defraud any insurance company or another person, files and application containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects this person to criminal and civil penalties.

Date

Signature

MASSAGE THERAPY

What type(s) of Massage do you perform?		
Do you offer Hot Stone massage?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Number of years of experience>		
Are you a RMT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you collect and discuss the client's health information?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the client's health information saved for at least 7 years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is a waiver signed, dated and kept on record for at least 7 years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever had a claim made against you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please advise:		

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ELECTROLYSIS, ACID PEELS & MICRODERMABRASION

Do you use an autoclave to sterilize equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does all staff wear surgical gloves when performing services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you use disposable tips for each new client?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you provide Medium Peels?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you provide Deep Peels?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you collect and discuss the client's health information?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
The number of year's client's information is saved?		
Have you ever had a claim made against you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If yes, please advise:

Please select what skin types you provide services on as per the Fitzpatrick Scale:

1
 2
 3
 4
 5
 6

What is the minimum age of clients?

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PERMANENT MAKEUP

Number of Staff that are providing this service?		
Estimated Receipts for Permanent Make-Up		
Years of experience for each individual	<input type="text"/>	<input type="text"/>
Education/Training: Where were you Trained?		
Do you have a certificate for this service?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, from who?	<input type="text"/>	
Do all clients sign a waiver/release form?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you perform a patch test for allergies?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you use disposable products only?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Describe your sterilization procedure?		
Other than eyes and lips, do you perform services on any other areas of the body?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please specify		
What type of dye do you use?		
Who do you purchase the dye from?		
Do you manufacture or sell your own permanent makeup products to others?		<input type="checkbox"/> YES <input type="checkbox"/> NO

PLEASE ATTACH A SUPPLEMENT PAGE OUTLINING ALL OF YOUR STERILIZATION PROCEDURES AS WELL AS POLICIES IN PLACE TO PREVENT CROSS-CONTAMINATION

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Signature

TANNING OPERATIONS

Equipment	#of Units	Intensity	Manufacturer	Type of Timer	Where are timing controls located?
Beds				<input type="text"/>	
Booths				<input type="text"/>	
Facial Units				<input type="text"/>	
Spray Booths				<input type="text"/>	
Air Brush				<input type="text"/>	

Total cost to replace all tanning beds/booths with new equipment

Average age of beds?

How often is the equipment inspected?

Do licensed electricians service the equipment? YES NO

Are the beds cleaned after every use? YES NO

Who changes the bulbs?

Do you have laundry facilities for towels? YES NO

If yes, how often are exterior dryer vents cleaned?

TANNING PROCEDURE

Are employees permitted to touch clients? YES NO

Are clients given tanning instructions? YES NO

Do you use Accelerators? YES NO

Unlimited Tanning offered? YES NO

If yes, what system is in place to prevent over exposure?

Average number of clients annually?

Do you have all clients sign a waiver? YES NO

Are children left unattended? YES NO

Do you use Skin analysis/evaluation with clients? YES NO

Are staff trained and certified by Smart Tan? YES NO

Are goggles supplied and REQUIRED to be used? YES NO

What is the minimum age or clients?

Do you keep a record of your clients tanning sessions? YES NO

If yes, how?

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COMPLETION OF THIS APPLICATION IS FOR QUOTATION PURPOSES ONLY AND DOES NOT PLACE COVERAGE IN FORCE

Date

Signature

PRIVACY CLAUSE

Our brokerage and the insurance industry have a solid track record of respecting your right to privacy and safeguarding your personal information. As a result of federal legislation, we've further strengthened our privacy commitment by informing you of why and how we collect, use and disclose your personal information. You can be assured that we'll only handle your personal information in a manner that a reasonable person would consider appropriate in the circumstances.

The Client hereby acknowledges that by competing and returning the application to Unison Insurance & Financial Services Inc., you agreed to and consent to the collection, use and disclosure of such information, including any personal information, by Unison Insurance & Financial Services Inc. for the following purposes:

- Communicating with you
- Assessing your application for insurance
- Disclosing information to the Insurance Companies
- Negotiating, maintaining or renewing insurance on your behalf
- Providing claims assistance and service
- Advising you of other products or services
- Complying with regulations and legal authorities

Please do not hesitate to contact our Privacy Officer should you have any questions.

Our Privacy Officer may be contacted as follows:

Name of Organization:	Unison Insurance & Financial Services Inc.
Address:	2077 Dundas Street E., Unit 103 Mississauga, ON L4X 1M2
Telephone:	905-624-5300
Fax:	905-624-8500
Email:	privacy@unisonins.com

For more information about our privacy policies or to obtain a copy of our privacy policy, please visit our website at www.unisonins.com