GROUPONE INSURANCE

GROUPONE INSURANCE SERVICES
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SPA/ALLIED HEALTH PROGRAM - COMMERCIAL PROPERTY AND LIABILTY APPLICATION

Brokerage: Phone:

Producer Name: Fax:

Broker Email:

GENERAL INFORMATION

Legal Business Name:

Location Address: City: Province: Postal:

Mailing (if different): City: Province: Postal:

Contact Person: E-mail: Website Address:

Phone #: Fax#: Res. #: Cell #:

Expiry Date of Policy:

Current Insurance Company: **Risk Ever Been Cancelled:** ☐YES ☐NO

Target Premium: $ # of years in business: # of years of experience:

PLEASE PROVIDE A BROCHURE OF YOUR OPERATIONS WHEN YOU SUBMIT THIS APPLICATION

Has the company had claims against them in last 5 years? ☐YES ☐NO

If yes, please explain:

Has the any staff (including contract staff) had claims against them in last 5 years**?** ☐YES ☐NO

If yes, please explain:

PROPERTY INFORMATION

Describe your location (Two storey, strip plaza, shopping mall, etc.) No. of Stories:

Do you own the building? ☐YES☐NO Total Area of your Facility: _____ Ft

The Building Age: Latest Update: Roof Heat Plumbing Electric

Fire Hydrants within 500 Feet? ☐YES ☐NO Restaurant within 2 adjacent units: ☐YES ☐NO Building Sprinklered? ☐YES ☐NO

Burglar Alarm? ☐Monitored ☐Local ☐NO Fire Alarm? ☐Monitored ☐Local ☐NO

Surveillance System? ☐YES ☐NO # of Fire Extinguishers:

Doors have deadbolts? ☐YES ☐NO Bars on Doors/Windows? ☐YES ☐NO

What is at - Front**:** Back: Left: Right

Construction of Building:

Loss Payee Information: (i.e.: bank financing, equipment leases, etc.)

"PROPERTY VALUES"

Building (if required)	$	Equipment	$	Profits / BI	$
Leasehold Improvements	$	Stock	$		

LIABILITY INFORMATION

Are all inks/pigments from US or Canadian manufacturers? ☐YES ☐NO

Do you sell any inks/pigments? ☐YES ☐NO

Do you relabel or repackage any products? ☐YES ☐NO

Do you ever re-use needles? ☐YES ☐NO

Do you dispose of your pigments after each client? ☐YES ☐NO

Description of Operations:

Liability Limits Desired: ☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000

Are you one of these Allied Health Professionals? :

Audiologist	☐YES ☐NO	Medical Laboratory Technologist	☐YES ☐NO
Dieticians	☐YES ☐NO	Medical Radiation Technologist	☐YES ☐NO

Occupational Therapist	☐YES ☐NO	Orthoptist	☐YES ☐NO
Speech Language Pathologist	☐YES ☐NO	Podiatrist	☐YES ☐NO
		Prosthetics	☐YES ☐NO

Estimated Gross Annual Receipts: $ _____

Basic Esthetics:

Estimated Gross Annual Receipts: $ _____

Acid Peels less than 31% solution concentration	☐YES ☐NO	Hydrotherapy salt floatation chambers	☐YES ☐NO
Acupuncture other than Moxibustion acupuncture	☐YES ☐NO	Hypnotherapy other than for past life regression and entertainment	☐YES ☐NO
Acupressure	☐YES ☐NO	Infrared Saunas and massage booths/beds	☐YES ☐NO
Aquatic massage beds	☐YES ☐NO	Ionization detoxification	☐YES ☐NO
Biofeedback therapy	☐YES ☐NO	Iridology	☐ YES ☐NO
Body wraps	☐YES ☐NO	Make up – non permanent	☐YES ☐NO
Brain wave harmony	☐YES ☐NO	Manicure/pedicures	☐YES ☐NO
Cellulite treatment other than cellulite reduction weight loss	☐YES ☐NO	Massage including relaxation massage, registered massage, reiki, reflexology, and aromatherapy, but does not include services to children under the age of 12 and Myofascial massage	☐YES ☐NO
Colon irrigation	☐YES ☐NO	Neuro emotional Clearing	☐YES ☐NO
Dry Cupping – Wet Cupping is excluded	☐YES ☐NO	NLP – Neurolingulistic Programming	☐YES ☐NO
Dermaplanning	☐YES ☐NO	Nutritional consulting to follow the Canada Food Guide only	☐YES ☐NO
Ear candling	☐YES ☐NO	Oxygen treatments other than hyperbaric chambers	☐YES ☐NO
Energy healing	☐YES ☐NO	Piercing – ears and nose only	☐YES ☐NO
Electrolysis	☐YES ☐NO	Shamanic healing	☐YES ☐NO
EFT – Emotional Freedom Technique/Clearing	☐YES ☐NO	Spray tanning	☐YES ☐NO
Eyebrow Tinting	☐YES ☐NO	Spray tattooing	☐YES ☐NO
Facials	☐YES ☐NO	Sugaring	☐YES ☐NO
Glitter Tattooing – non permanent	☐YES ☐NO	Threading	☐YES ☐NO
Hair cutting and related service other than hair extension, wig/hair piece fitting/ sales	☐YES ☐NO	Toning beds	☐YES ☐NO
Henna Tattooing	☐YES ☐NO	Wart removal by solution only	☐YES ☐NO
High Intensity focused ultrasound (other than vaginal tightening and incontinence treatment)	☐YES ☐NO	Waxing	☐YES ☐NO
Hydration machine	☐YES ☐NO		

Mid-Range Esthetics

Estimated Gross Annual Receipts: $ _____

Acid peels greater than 30% but less than 61% solution concentration	☐YES ☐NO	Micropigmentation	☐YES ☐NO
Arasy machines	☐YES ☐NO	Mole removal by solution only	☐YES ☐NO
BB Glow	☐YES ☐NO	Myofascial massage	☐YES ☐NO
Body vibration fitness machines	☐YES ☐NO	Oxygeneo	☐YES ☐NO
Coolsculpting	☐YES ☐NO	Plasma-Pen	☐YES ☐NO
Electrocoagulation	☐YES ☐NO	Radio frequency treatments	☐YES ☐NO
EMS – Elector Muscular Stimulation including Acuscope and Myopulse	☐YES ☐NO	Sclerotherapy	☐YES ☐NO
Endermologie	☐YES ☐NO	Skin and micro needling	☐YES ☐NO
Fluid Isometrics	☐YES ☐NO	Skin tag removal by solution or laser	☐YES ☐NO
Hyaluron Pen	☐YES ☐NO	Teeth whitening	☐YES ☐NO
		Thermolysis	☐YES ☐NO

LILT & LLLT – low intensity laser therapy for weight reduction and gain, addictions, mental illness and pain reduction	☐YES ☐NO	Thermo-Lo	☐YES ☐NO
Micro current treatment	☐YES ☐NO	Vaginal Tightening and Incontinence Treatment	☐YES ☐NO
Microdermabrasion	☐YES ☐NO	Vibrodermabrasion	☐YES ☐NO

High End Esthetics: **Estimated Gross Annual Receipts: $** _____

Cellulite reduction and body contouring and slimming by electronic device	☐YES ☐NO	Tattoo removal by Eliminik	☐YES ☐NO
Bio resonance diagnostics	☐YES ☐NO	Body injections for cosmetic purposes listed within our "injectable supplemental application"	☐YES ☐NO
Tattoo removal by Laser/IPL/EPL/LHE	☐YES ☐NO	Platelet Rich Plasma	☐YES ☐NO

Miscellaneous Professional Services: **Estimated Gross Annual Receipts: $** _____

Brow Lamination	☐YES ☐NO	Microblading	☐YES ☐NO
Eyelash Dipping	☐YES ☐NO	Tooth gems	☐YES ☐NO
Eyelash Extensions	☐YES ☐NO	Wigs and Extensions – Not attached by adhesive	☐YES ☐NO
Eyelash Tinting	☐YES ☐NO	Latisse	☐YES ☐NO
Hair Extensions	☐YES ☐NO	Hollistic Vitamins	☐YES ☐NO
Tanning – UV	☐YES ☐NO		

Teaching Operations: **Estimated Gross Annual Receipts: $** _____

Teaching and students offering service(s) to the public while under supervision ☐YES ☐NO

Other Operations: **Estimated Gross Annual Receipts: $** _____

☐YES ☐NO If yes, please describe: _____

WET AREAS # of Swimming Pools? _____

Diving Boards		☐YES ☐NO
Are there any Slides		☐YES ☐NO
Chemicals Tested Daily		☐YES ☐NO
Hot Tub / Whirl Pool / Sauna / Steam Room	# of units _____	☐YES ☐NO

ADDITIONAL INFORMATION

Do you use a deep fat fryer?	☐YES ☐NO	Do you ever serve alcohol as part of your service?	☐YES ☐NO
Snack Bar on Premises?	☐YES ☐NO	Do you rent space to associated businesses?	☐YES ☐NO

If yes, Please describe:

Do you bring any specialists into your premise to provide additional operations? ☐YES ☐NO

If yes, Please describe:

Are there any operations or activities away from the premises? ☐YES ☐NO

If yes, Please describe:

Do you provide any permanent hair straightening operations? ☐YES ☐NO

If yes, please provide name of products used:

Please confirm if any of these products contain any formaldehyde? ☐YES ☐NO

Please describe your sterilization / cross-contamination prevention procedures:

Are any of the following operations conducted?

Massage - Registered	☐ YES ☐ NO → If yes, please **complete the Massage Supplementary application**
Tanning Beds & Booths	☐ YES ☐ NO → If yes, please **complete the Tanning Supplementary application**
Laser / IPL Treatment	☐ YES ☐ NO → If yes, please **complete the Laser / IPL Supplementary application**
Injectable Services	☐ YES ☐ NO → If yes, please **complete the Injectable Supplementary application**
Teaching Operations	☐ YES ☐ NO → If yes, please **complete the Teaching Supplementary application**
Teeth Whitening	☐ YES ☐ NO → If yes, please **complete the Teeth Whitening Supplementary application**
Platelet-rich Plasma	☐ YES ☐ NO → If yes, please **complete the Platelet-rich Plasma(PRP) Supplementary application**
Plasma Pen	☐ YES ☐ NO → If yes, please **complete the Plasma Pen Supplementary application**

Full Time / Contract Employee Information:

of **Full time (F/T)** Employees? _____ # of **Part time (P/T)** Employees? _____

of **Contract** People? _____

NAME	YEARS OF EDUCATION	YEARS OF EXPERIENCE	OPERATIONS OF EACH INDIVIDUAL	F/T, P/T OR CONTRACT	CERTIFICATION ATTACHED?

- **ADDITIONAL INSURED** (i.e.: landlord)

**** CYBER LIABILITY ****

Does the Company store any medical/health information for clients? ☐ YES ☐ NO

▪ If yes, does the Company follow the minimum standards under the HIPAA (encryption and firewalls in place)? ☐ YES ☐ NO

▪ If yes, does the Company follow the minimum standards under PIPEDA or the respective PIPA requirements (encryption and firewalls in place)? ☐ YES ☐ NO

▪ Higher cyber limits may be available, please contact your underwriter for details.

PLEASE READ BEFORE SIGNING: A claim will become invalid and the Insured's right of recovery is forfeited where (a) an Applicant for this contract gives false particulars to the prejudice of the insurer or knowingly misrepresents or fails to disclose any fact in any part of this application required to be stated therein; or (b) the insured fails to inform material changes to these facts during the term of the contract; (c) the insured contravenes a term of the contract or commits a fraud; or (d) the insured willfully makes a false statement in respect of a claim.

The Applicants have reviewed all parts and attachments of this application and acknowledge that all information is true and correct and understand that this application for insurance is based on the truth and completeness of this information.

The personal information provided in this document and in the future including, but not limited to, credit information and claims history may be collected, used and disclosed by the insured's representative or insurance company, subject to local legislation, for the purpose of communicating with the insured or their representative, assessing the application for insurance and underwriting any such policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

NOTE: Insurance is not in effect until GroupOne has issued a binder or policy documents.

Insured Signature: Date:

Broker Signature: Date:

Broker Email:

**** Email application and attachments to - insureit@grouponeis.com ****

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