SPORTS & FITNESS INSURANCE CANADA

WELLNESS CENTRE APPLICATION

Trothen & McConkey Insurance
Phone: 1-519-672-3224 Toll Free 1-888-346-6602 Fax: 1-519-439-8865
e-mail – info@sportsfitnesscanada.com

Brokerage Name:					
Broker Telephone:		E-mail:			
Business Name:					
Location Address:					
	City:		Prov.:		P.C.:
Mailing Address:					
	City:		Prov.:		P.C.:
Owner/Operator:		Bus. #:		Fax:	
Email:		Cell #:		Res.#:	
Alternate Contact:		Phone:		Email:	
Website:					
Current Insurance Company: _____			**Expiry Date of Current Policy:** _____		
Retroactive Date of Any Claims Made Policy: _____			**Target Premium:** _____		
Number of years in business? _____		**Have you ever been cancelled for nonpayment?**			___

LIABILITY INFORMATION

Liability Limit Requested: ☐ **$2,000,000** ☐ **$5,000,000**

DESCRIPTION OF OPERATIONS

Any client under the age of 18?	___	Do parents stay on premise?	___	Do you ever serve alcohol?	___
Are any operations or activities done away off premises?	___	Describe: _____			
Do you sell any supplements?	___	Do any contain ephedra or other metabolic enhancers?			___

WET AREAS

Showers	# ___	Whirlpools	# ___	Steam Rooms	# ___
Hydrotherapy Tubs	# ___	Vichy Showers	# ___	Infra-Red Saunas	# ___
Dry Saunas	# ___	Wet Saunas	# ___	Pools	# ___
Are all steam rooms vents/spouts covered/capped to defuse the steam?					___
Any scorching behind heater?	___	Non-Slip Flooring?	___	Rubber Mats In Halls?	___

EMPLOYEES - Including Owner/Operators (attach another page if necessary)

Name	Yrs of Exp.	Operations Performed	Has a Current Professional Liability Policy Y / N	F/T or P/T
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SUB-CONTRACTORS (attach another page if necessary)

Name	Yrs of Exp.	Operations Performed	Has a Current Professional Liability Policy Y / N	F/T or P/T
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICAL SPECIALIST (attach another page if necessary)

Name	Yrs of Exp.	Operations Performed	Has a Current Professional Liability Policy Y / N	F/T or P/T
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is all staff certified/educated/trained in the services they perform?	
Are all staff licensed and carry at least $1MIL in Professional Liability?	
If no, please advise why: _____	

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CRIME – Answer Yes or No to Each Question	
Cash Accounts and inventories have annual (minimum) audits by a certified auditor or accountant.	___
Reconciliation of bank statements are handled by someone other than those who have authority to handle deposits, withdrawals or sign outgoing cheques.	___
Bank accounts are reconciled on a monthly basis (minimum).	___
Background checks are completed on all employees that handle money.	___
All cheques over $5,000 must require 2 signatures, unless only the owner(s) has authority.	___

SERVICES
TOTAL ANNUAL GROSS RECEIPTS - $_____
ORDINARY MONTHLY PAYROLL - $_____

PRIMARY SERVICE(S)			
PHYSIOTHERAPY	___%	RMT	___%
SPORTS/ATHLETIC THERAPY	___%	STRESS MANAGEMENT	___%
CHIROPRACTIC	___%	ACUPUNCTURE	___%
OTHER - _____	___%	OTHER - _____	___%

OTHER SERVICES OFFERED							
Acupressure	☐	Acupuncture	☐	Alexander Technique	☐	Amatsu Medicine	☐
Aromatherapy	☐	Aurora Healing	☐	Autogenic	☐	Aqua Chi	☐
Aura Soma Colour Healing	☐	Ayurveda	☐	Bi-Aura Therapy	☐	Bach Remedies	☐
Bates Method	☐	Behavioral Analysis	☐	Bio-Chemics	☐	Biocom therapy	☐
Bio-Kinetics	☐	Boresonance	☐	Body Harmony	☐	Body Mind Balancing	☐
Bowen Technique	☐	Chakra Balancing	☐	Colour Therapy	☐	Conscious Breathing	☐
Colour Puncture	☐	Cranial Sacral Therapy	☐	Crystal Healing	☐	Cymatic	☐
Dance Movement	☐	Deep Oscillation Therapy	☐	Dietician	☐	Drama Therapy	☐
Dowsing for Stress Relief	☐	Electro-Crystal therapy	☐	Electronic Therapy	☐	EMF Balancing Technique	☐
Emotional Therapy	☐	Facilitation	☐	First Aid Trainer	☐	Healing Touch	☐
Hellerwork	☐	Hot Stone Therapy	☐	Hydrotherapy	☐	Hypnotherapy	☐
Homeopathy	☐	Iridology	☐	Infant Massage	☐	Indonesian Massage	☐
Jungian Therapy	☐	Kairos Therapy	☐	Kinesiology	☐	Life Coaching	☐
Light Touch Therapy	☐	Lymphatic Drainage	☐	Lomi Lomi	☐	Magnetic Therapy	☐
Manual Lymph Drainage	☐	Massage Therapy	☐	Meditation	☐	Metamorphic Technique	☐
Melchizedek Method	☐	Mezieres Method	☐	Moxibustion	☐	Movements Therapy	☐
Muscle Energy Techniques	☐	Myofacia	☐	Occupational Therapist	☐	Ohashiatsu	☐
Orthotics	☐	Perceptible Breath Therapy	☐	Personal Care	☐	Physical Therapy	☐
Phytotherapy	☐	Pilates	☐	Polarity Therapy	☐	Postural Integration	☐
Phytobiophysics	☐	Pranic Healing	☐	Qi Gong	☐	Radiaesthesia	☐
Radionics	☐	Raynor Therapy	☐	Reality Therapy	☐	Rebirthing - Breath Techniques	☐
Reflexology	☐	Reiki	☐	Rolfing	☐	Rubenfeld Synergy	☐
Shen Therapy	☐	Skenar	☐	Skeletal Balancing	☐	Skin Screening	☐
Somatic Movement	☐	Speech Therapy	☐	Spiritual Healing	☐	Stress Control/Management	☐
Tai Chi	☐	Thai Massage	☐	Therapeutic Touch	☐	Trager	☐
Trigger Point Massage	☐	Tuina	☐	Vega Machine	☐	Vibrational Essences	☐
Watsu	☐	Yoga	☐	Zero Balancing	☐	Zen Therapy	☐
Other: *LIST ANY& ALL OTHER SERVICES THE CENTRE PROVIDES							
	☐		☐		☐		☐
	☐		☐		☐		☐

IMPORTANT!
Any undisclosed services may not be covered under this policy.
If you need to update your service list, please contact our office

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ADDITIONS TO THE POLICY
ADDITIONAL INSURED: (Provide full name, address and interest in the policy * i.e. Landlord, contractor, etc.)
1.
2.
LOSS PAYEE: (Provide full name, address and interest in the policy * i.e. leasing co., mortgagee, etc.)
1.
2.

CLAIMS HISTORY		
Has the company &/or staff had claims against them in last 5 years? ___, If yes please list details:		
Date of Loss	Loss Details	Amount Paid/Reserve

I understand and agree that any policy issued will be based upon the information contained in the application and any related forms and correspondence. I understand that any forms or other material submitted with the application constitute part of my application for insurance. I further understand and agree that any misrepresentation or failure to provide true and accurate information may result in the voiding of and/or denial of claims under any policy issued at the option of the company.

By submitting this application and any related forms to **Sports & Fitness Insurance Canada**, you provide **Trothen & McConkey Insurance Broker Ltd.** with your consent to the collection, use and disclosure of your personal information, including that previously collected, for the purpose of: communicating with you; assessing your application for insurance and underwriting your policies; evaluating claims; detecting and preventing fraud; analyzing business results; and acting as required or authorized by law.

Applicant: Signature: _____ Title: _____ Date: _____