GESTIONNAIRES D'ASSURANCES | SUM | STRATEGIC UNDERWRITING MANAGERS INC

A subsidiary of ONE80 INTERMEDIAIRES

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APPLICATION – **TANNING SALON**

1. GENERAL INFORMATION

Company Name: ______________________________

Mailing Address: Street ______________________________

City ______________________________

Province ______________ Postal code ______________

Website: ______________________________

Owners: ______________________________

Phone: ______________ Email: ______________________________

☐ Corporation ☐ Partnership ☐ Individual ☐ Other: ______________

2. IN BUSINESS SINCE: __________

Experience in this field: ______________________________

If new to this field, did the salon exist before? ______________________________

3. RECEIPTS:

Tanning Treatments: $__________

Products: $__________

Other: ______________ $__________

TOTAL: $__________

4. LIST OF PRODUCTS SOLD BY THE INSURED:

____

____

5. EMPLOYEE INFORMATION

a) Number of full time employees: ___________ Part Time employees: ___________

b) Describe training provided:

____

____

c) Are all employees covered under WSIB? ☐ Yes ☐ No

If No, please list numbers by job description and estimated payroll:

____

____

____

d) Total Payroll: $____________ Number of Employees: ____________

6. SUNTANNING UNITS:

a)

NUMBER OF UNITS	LIE DOWN OR STAND UP	INCL. FACIAL TANNER?	YEAR CONSTR.	MANUFACTURER	NUMBER OF TUBES	YEARS OF USEFUL LIFE
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				

b)

NUMBER OF UNITS	SPRAY BOOTH FOR COSMETIC TANNING	YEAR CONSTR.	MANUFACTURER	NUMBER OF TUBES	YEARS OF USEFUL LIFE

c) Do units have a blue protective filter? ☐ Yes ☐ No

d) Does the applicant use medical tubes? ☐ Yes ☐ No

e) Types of rays used: ____

f) Are there any special tanning equipment used (i.e. facial only)?

☐ Yes ☐ No If Yes, please describe:

____

____

7. MAINTENANCE:

a) What type of maintenance contract do they have? Ex. Manufacturer, electrician, etc.:

____

____

b) How often are bulbs checked? ____

How often are they changed? ____

c) Are beds cleaned after each session? ☐ Yes ☐ No

d) Are beds cleaned with a proper germicide? ☐ Yes ☐ No

e) Is bed base plexiglass cracked? ☐ Yes ☐ No

f) Are protective goggles disinfected after each session? ☐ Yes ☐ No

8. SAFETY PROCEDURES:

a) Is there a mandatory goggle policy in effect? ☐ Yes ☐ No

b) Are units equipped with an emergency stop button? ☐ Yes ☐ No

c) Does a computer control the starting time and finishing time? ☐ Yes ☐ No

d) Is there a time switch at the reception desk? ☐ Yes ☐ No

e) Is there a physical barrier to protect neon tubes in covers? ☐ Yes ☐ No

f) If so, is it damaged? ☐ Yes ☐ No

g) Maximum duration of a session: ______ minutes

h) Is there a chart of recommended exposure time and types of skin posted? ☐ Yes ☐ No

i) Does the applicant fill out a customer's record/medical form? ☐ Yes ☐ No
If Yes, please attach a copy.

j) Does the applicant have customers sign a waiver? ☐ Yes ☐ No
If Yes, please attach a copy.

k) Does the applicant have coin-operated machines? ☐ Yes ☐ No

9. ANY OTHER OPERATIONS (i.e. massage therapists, hairdressers, beauticians, etc.)?

If so, please state: ____

10. ARE THE PREMISES SHARED WITH OTHER OCCUPANTS?

☐ Yes ☐ No If Yes, who are they: ____

Do they have their own insurance? ☐ Yes ☐ No

11. ARE INDEPENDENT CONTRACTORS USED FOR ANY OPERATIONS?

☐ Yes ☐ No If Yes, please specify receipts and activity:

____

____

Is proof of insurance obtained from contractor?

☐ Yes ☐ No If No, please explain:

____

____

If Yes, please provide what limits they are required to provide: $_______________

12. DOES APPLICANT HAVE ANY AGREEMENTS ASSUMING LIABILITY?

☐ Yes ☐ No If Yes, please describe and provide copies:

____

____

13. DOES APPLICANT PRESENTLY CARRY INSURANCE? ☐ Yes ☐ No

a) If Yes, present Insurer: ____

Premium: $______________

Is present insurance Claims Made? ☐ Yes ☐ No If Yes, state retrodate: _______________________

b) Are they willing to renew? ☐ Yes ☐ No If No, please explain:

____

c) Does the policy cover all operations of the Insured? ☐ Yes ☐ No If No, please describe:

____

____

14. NON-OWNED AUTOMOBILE

Number of employees using their cars on company business: __________

Regularly: __________ Occasionally: __________

Estimated annual cost of:

Hired cars: __________ Cars operated under contract: __________

15. ACCIDENT PREVENTION AND FIRST AID

a) Are employees trained in first aid?

☐ Yes ☐ No If Yes, please describe:

____

____

b) Fire alarm – other warning systems:

____

____

c) Is there a security officer or are there loss prevention engineers employed? ☐ Yes ☐ No

16. PLEASE INDICATE:

Limit(s) of liability required: $________________

Deductible required: $________________

Proposed effective date: ________________

Expiry Date: ________________

17. A) HAVE ANY CLAIMS EVER BEEN MADE TO THE KNOWLEDGE OF THE APPLICANT AGAINST THE APPLICANT, ANY BUSINESS PREDECESSORS, ANY OF THE PRESENT OR FORMER PARTNERS OR OFFICERS? ☐ Yes ☐ No

B) IS THE APPLICANT AWARE OF ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM AGAINST THE APPLICANT OR ANY PREDECESSOR IN BUSINESS, OR ANY PRESENT OR FORMER PARTNER OR OFFICER? ☐ Yes ☐ No

If the answer to either 17 a) or 17 b) is Yes, complete the enclosed CLAIMS HISTORY FORM.

Note: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 17 A) AND/OR 17 B) OR ANY ERROR, ACT, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

18. HAS ANY PARTNER, EXECUTIVE OFFICER, DIRECTOR OR PROFESSIONAL EMPLOYEE HAD THEIR LICENSE SUSPENDED, BEEN FINED OR REPRIMANDED DURING THE PAST FIVE YEARS?

☐ Yes ☐ No If Yes, please provide details: ______________________________

____

19. TO THE APPLICANT'S KNOWLEDGE, HAS ANY COMPANY DECLINED OR TERMINATED THE INSURANCE, FOR THE APPLICANT, ANY PRESENT PARTNER OR OFFICER OR FOR ANY PREDECESSOR IN THE BUSINESS, PAST PARTNERS OR OFFICERS?

☐ Yes ☐ No If Yes, please provide details: ______________________________

20. PLEASE NOTE THE PROFESSIONAL ASSOCIATIONS TO WHICH THE APPLICANT BELONGS:

____

____

We hereby declare that the above statements and particulars are true and that we have not suppressed or misstated any material facts and we agree that this declaration shall be the basis of any binder or contract of insurance with the Insurance Company, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this declaration does not bind the Insurance Company to the issue of the insurance nor the Applicant to the purchase of this insurance.

It is further understood and agreed that if, following submission of this application to the insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 17 a) or 17 b) of this application, the Insurer shall be immediately notified in writing of such information.

Signature of Applicant: ______________________ Dated: ______________

Print Name and Title: ______________________

BROKER NAME: ______________________

ADDRESS: ______________________

____

____

PHONE NO: ______________________

EMAIL ADDRESS: ______________________

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CLAIMS HISTORY FORM

Applicant Name: ______________________ Date: ______________

Claimant Name: ______________________

Project Name & Location: ______________________

Date of Loss: ______________________

Description of Claim:

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________

Project Name & Location: ______________________

Date of Loss: ______________________

Description of Claim:

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________

Project Name & Location: ______________________

Date of Loss: ______________________

Description of Claim:

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________

Project Name & Location: ______________________

Date of Loss: ______________________

Description of Claim:

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________

Project Name & Location: ______________________

Date of Loss: ______________________

Description of Claim:

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$