Health & wellness organizations

Insurance application form

The purpose of this application form is for us to find out more about you. You must provide us with all information which may be material to the cover you wish to purchase and which may influence our decision whether to insure you, what cover we offer you or the premium we charge you.

How to complete this form

The individual who completes this application form should be a senior member of staff at the company and should ensure that they have checked with other senior managers and colleagues responsible for arranging the insurance that the questions are answered accurately and as completely as possible. Once completed, please return this form to your insurance broker.

Section 1: Applicant Details

1.1 Please state the name and address of the individual or company for whom this insurance is required. Cover is also provided for the subsidiaries of the principal company, but only if you include the data from all of these subsidiaries in your answers to all of the questions in this form.

Name of individual or company:

Primary Address (Address, Province, Postal Code, Country):

Website Address:

1.2 a) How many directors / officers / partners are there in the company?

b) Please show details of all partners / directors:

Name:	Years in position:	Years' experience:	Qualifications:

c) Please state the number of employees:

Professional: Clerical: Contractors:

1.3 Date the business was established (DD / MM / YYYY):

1.4 Please state your revenue received in respect of the following years (in CAD):

	Last complete FY	Estimate for current FY	Estimate for next FY
Domestic revenue:	$	$	$
USA revenue:	$	$	$
Other territory revenue:	$	$	$
Total gross revenue:	$	$	$
Profit (Loss):	$	$	$

Health & wellness organizations

Insurance application form

Section 2: Activities

2.1 Please briefly describe below the nature of your business activities:
If you have a brochure, or company literature, please attach to this form.

2.2 Please provide a full breakdown of your total revenue by activity:
The total of all activities listed here should equal 100%.

	%
	%
	%
	%
	%
	%
	%
	%
	%

2.3 Do you ensure that all of your employees and independent contractors are certified in cardio pulmonary resuscitation (CPR) and first aid?

☐ Yes ☐ No

If "no", please explain why:

2.4 Please state whether you:

a) conduct criminal background checks on all applicants prior to their employment and on all independent contractors prior to their engagement: ☐ NA ☐ Yes ☐ No

If "yes", please indicate which criminal background checks are conducted:

☐ Drug Screening ☐ Fingerprints ☐ Sexual Offender Registry

b) automatically decline to employ any applicant or engage any independent contractor who tests positive to a drugs screening, has a criminal record or is on the sexual offenders register: ☐ Yes ☐ No

c) verify the professional qualifications of all applicants prior to their employment or any independent contractors prior to their engagement: ☐ Yes ☐ No

d) obtain confirmation from any applicant for employment or independent contractor that they have not had any claim made against them at any time: ☐ Yes ☐ No

e) obtain confirmation that all independent contractors maintain their own medical malpractice liability insurance: ☐ Yes ☐ No

If you have answered "no" to any of b), c), d) or e), please explain why:

2.5 a) Do you hold an appropriate and valid licence for each of the services that you provide? ☐ Yes ☐ No

If "yes", please state the licences that you hold, if "no", please explain why:

b) have you ever had any restriction or limitation imposed upon any licence that you hold or been the subject of any disciplinary action by any licensing body? ☐ Yes ☐ No

If "yes", please provide full details:

2.6 In the event that your product or service failed or delivery was delayed please describe the worst case scenario. Consider the potential for loss of life, injury to people, damage to buildings or other tangible property or financial loss (consequential or otherwise) for your clients:

Section 3: Cover for medical spas

Only complete this section if you are a medical spa

3.1 Do you maintain records of the services that you provide to your clients? ☐ Yes ☐ No

If "yes", please state how long you maintain the records for, if "no", please explain why:

3.2 Do you provide any treatment to minors? ☐ Yes ☐ No

If "yes", do you require a signed written parental agreement? ☐ Yes ☐ No

3.3 Do you provide any non-certified or unlicensed aesthetic services? ☐ Yes ☐ No

3.4 Do you provide any services away from your premises? ☐ Yes ☐ No

If "yes", please provide full details:

3.5 Please state that where it is necessary and appropriate you use sterile devices: ☐ Yes ☐ No

If "no", please explain why:

3.6 Do you ensure that all employees and independent contractors wear surgical gloves and protective eyewear whilst they are providing treatment? ☐ Yes ☐ No

If "no", please explain why:

3.7 Please provide the following information for each of your licensed employees and independent contractors:
If you need more room, please complete the ADDITIONAL LICENSED STAFF list at the end of this form

Name	Services performed	Qualifications	Years of experience

3.8 If you have declared in Q2.2 that you provide chemical peel or teeth whitening services, please answer the following:

a) do you use chemical peel solution that is more than 30% in strength? ☐ Yes ☐ No

b) do you use hydrogen peroxide that is more than 25% strength for teeth whitening? ☐ Yes ☐ No

3.9 Please provide a percentage breakdown of your clients over the past 12 months who fall into the following categories:

Fitzpatrick scale skin type	%	Fitzpatrick scale skin type	%
I	%	IV	%
II	%	V	%
III	%	VI	%

3.10 Please state whether you conduct a skin patch test on all of your clients prior to any type of laser treatment: ☐ Yes ☐ No

If "yes", please state whether:

a) the equipment is used in accordance with the manufacturer's guidelines: ☐ Yes ☐ No

b) the employees and independent contractors are trained by the manufacturer to use the equipment before they perform any treatment on a client: ☐ Yes ☐ No

3.11 Do you regularly calibrate your laser equipment? ☐ Yes ☐ No

If "yes", please state the frequency, if "no", please explain why:

Section 4: Commercial Property & Business Interruption Insurance

If you require additional cover for buildings, please complete the full property questionnaire.

4.1 Please detail the amounts to be insured below for each premises:

NOTE: The amounts insured you state below should be the full repair or replacement cost in each of the categories. If you understate these amounts you will be under-insuring and we may not pay the full amount of your claim. It is therefore essential that these amounts are as close to the true values of the insured items as possible.

ITEM	PREMISES 1	PREMISES 2
Business personal property:		
Fixtures and fittings:		
Inventory and stock:		
Portable equipment at home / away from the premises:		
Loss of income:		
Indemnity period:		

4.2 Please state whether the premises:

a) is in an area free from flooding and not near the vicinity of any rivers, streams or tidal waters: ☐ Yes ☐ No

b) is in a good state of repair and occupied solely as listed in the business activities section: ☐ Yes ☐ No

c) is self contained with a lockable entrance door and lockable ground floor windows: ☐ Yes ☐ No

d) is protected by intruder alarm systems which is subject to an annual maintenance contract: ☐ Yes ☐ No

e) is fitted with electrical installations which are inspected at least every 5 years by a qualified electrician and any defect remedied:

☐ Yes ☐ No

4.3 Would you like a quotation for either of the following extensions?

Earthquake: ☐ Yes ☐ No Flood: ☐ Yes ☐ No

Section 5: Insurance Requirements

5.1 Please provide details of your current insurance or the cover you require if this is the first time you are applying for insurance:

	Limit:	Excess	Retroactive Date:
Errors and Omissions:			
Commercial General Liability:			
Cyber and Privacy:			
Directors and Officers:			

Section 6: Claims Experience

6.1 Regarding all of the types of insurance to which this application form relates AFTER FULL ENQUIRY:

a) are you aware of any circumstances which may give rise to a claim against any of the organizations to be insured or their directors, trustees or employees, or

b) have any directors or trustees of the company to be insured, or the company itself, been found guilty of any criminal, dishonest or fraudulent activity or been investigated by any regulatory body, or

c) are you aware of any loss or damage, whether insured or not, that has occurred to any of the company to be insured within the last 5 years, or

d) have you ever suffered a loss of data that has resulted in a privacy breach?

With reference to questions a, b, c, and d above: ☐ Yes ☐ No

If the answer to the above is "yes" then please attach full details including an explanation of the background of events, the maximum amount involved or claimed, the status of the claims or circumstances and any reserves or payments made by you or by insurers, and the dates of all developments and payments.

Section 7: Additional Information

Additional licensed staff:

Name:	Services performed:	Qualifications:	Years of experience:

Section 7: Additional Information

Please provide the following information when you send the application form to us.

- Directors or principals resumes if the company has been trading for less than 3 years;
- The organization chart or group structure if any subsidiaries are to be insured including names, dates of acquisition, countries of domicile, percentages of ownership; and
- The standard form of contract, end user license agreement or terms of use issued by the company.

Name:	Date of Acquisition:	Country of Domicile:	Percentage of ownership:

Please use this space below to provide us with any other relevant information:

Important notice

By signing this form you agree that the information provided is both accurate and complete and that you have made all reasonable attempts to ensure this is the case by asking the appropriate people within your business. PAL Insurance will use this information solely for the purposes of providing insurance services and may share your data with third parties in order to do this. We may also use anonymised elements of your data for the analysis of industry trends and to provide benchmarking data. For full details on our privacy policy please visit www.palcanada.com.

Contact Name: Position:

Signature: Date (DD/MM/YYYY):