[Professional Services]

WELLNESS APPLICATION

Reset Form

[Professional Lines]

WELLNESS APPLICATION

PART 1 GENERAL INFORMATION

Broker:	Broker Phone:
Broker Contact:	Broker Email:
Applicant Name:	
Mailing Address:	Postal Code:
Telephone No.:	Email:
Branch Locations:	
Website:	

Additional Documentation to be included with your application:

- Resumes of Directors, Officers, Partners, and Key Personal
- Waiver of Liability
- Company Brochure

PART 2 COMPANY DETAILS

Date Company Established (DD/ MM/ YY):

Company Structure: Sole Proprietor: ☐ Corporation: ☐ Partnership: ☐ Joint Venture: ☐ Other: ☐ Number of Employees:

Number of Directors, Officers, or Partners (please attach resumes):

Details of Directors, Officers, or Partners:

Name	Years in Position:	Years Experience:	Qualifications:

Number of Employees: Professional: Clerical: Other (Please specify):

Are ALL Employees covered by WCB? ☐ Yes ☐ No

Has the Applicant ever been investigated by or suspended from practice by a governing body of your profession? ☐ Yes ☐ No

Description of Operations:

PART 3 REVENUE BREAKDOWN

Revenue from Applicant's Operations (CDN Dollars)			
	Prior Year: (MM/YY) _____ / _____	Last Completed Year: (MM/YY) _____ / _____	Estimate for Next Year: (MM/YY) _____ / _____
a) Total Gross Fees (=b+c+d+e+f) +Revenues	$	$	$
b) Fees for services rendered in Canada	$	$	$
c) Fees for services rendered in the USA	$	$	$
d) Fees for the rest of the World (Please specify)	$	$	$
e) Fees paid to sub consultants	$	$	$
f) Product Sales	$	$	$
g) Other (Please Specify):	$	$	$

Date of Company Financial Year End: (DD/ MM/ YY)

Annual Payroll: $

PART 4 COMPANY OPERATIONS

Breakdown of Total Revenue by Activity, including Product Sales & Training Operations **(Total must equal 100%)**	
	%
	%
	%
	%
	%
	%
	%
	%
	%
Total	0.00 %

Description of other work:

Does the Applicant sell any products? ☐ Yes ☐ No

If yes, what type of products are sold? (Please Describe)

Applicant maintains Rights of Recourse with all Wholesalers/Distributers of products: ☐ Yes ☐ No ☐ N/A

All products and/ or ingredients are obtained from North American suppliers/ manufacturers: ☐ Yes ☐ No ☐ N/A

Is the Applicant engaged in any teaching? ☐ Yes ☐ No ☐ N/A

If yes, please name the activity/ discipline and total number of students (annual) below:

Name:	Discipline:	Students annually:

Do you hold an appropriate and valid license or certificate for the service you provide? ☐ Yes ☐ No

Please list license or certificate held:

If no, please provide full details:

Does the Applicant perform any activities or provide any services **outside** of Canada? ☐ Yes ☐ No

If yes, please provide complete details including the services provided and revenue:

Activity or Service provided:	Revenue ($):
	$
	$
	$
	$
	$

Are any material changes to activities anticipated in the coming year? ☐ Yes ☐ No

If yes, please provide full details:

What professional associations does the Applicant belong to?

Is there any legislation in force which govern the Applicants operations? ☐ Yes ☐ No

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

If yes, please provide full details:

Do you engage in any business or professional activities other than the described above? ☐ Yes ☐ No

Is the Applicant controlled, owned, or associated with any other company, firm, or corporation? ☐ Yes ☐ No

Please provide the following information for each of your licensed employees and independent contractors:

Name:	Services Provided:	Qualifications:	Years of Experience:

In the event of your product or service failing, or delivery was delayed, please describe the worst-case scenario:

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:

Are waivers of liability used with all clients? ☐ Yes ☐ No

If no, please explain why:

Do you provide any treatments to minors? ☐ Yes ☐ No

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

b) If yes, will there be any exposure to children under the age of 12 where unaccompanied by a parent/ guardian? ☐ Yes ☐ No

Does the Applicant work with Professional Athletes? ☐ Yes ☐ No ☐ N/A

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

Do you or any employees perform services away from the insured premises? ☐ Yes ☐ No

If yes, please provide full details:

Please confirm that where it is necessary and appropriate you use sterile devices: ☐ Yes ☐ No ☐ N/A

Do you ensure that all employees and independent Contractors wear surgical and protective eyewear while providing treatment?
☐ Yes ☐ No ☐ N/A

The applicant and all employees are adhering to government guidelines in relation to COVID-19 protocols with safeguarding patients, heightened hygiene/ infection controls and use of PPE when required: ☐ Yes ☐ No

With regards to laser treatments, please confirm the following:

a) You conduct a skin patch test on all your clients prior to any type of laser treatment: ☐ Yes ☐ No ☐ N/A

b) The equipment is used in accordance with the manufacturer's guidelines: ☐ Yes ☐ No ☐ N/A

c) That you regularly calibrate your laser equipment: ☐ Yes ☐ No ☐ N/A

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

If you have answered 'No' to any of the above noted questions (a-d) please explain why:

PART 5 RISK MANAGEMENT

Does the applicant have:

A written Quality Assurance/ Quality Control Program? ☐ Yes ☐ No

An in-house continuing education program for professional employees? ☐ Yes ☐ No

Procedures to elevate and screen potential new clients? ☐ Yes ☐ No

Please confirm the following:

A criminal background check is conducted on all Employees and Independent Contractors prior to their employment? ☐ Yes ☐ No

Verify the professional qualifications of all Employees and Independent Contractors prior to their employment? ☐ Yes ☐ No

Obtain confirmation from all Employees and Independent Contractor that no previous claims have been made against them. ☐ Yes ☐ No

Obtain confirmation that all Independent Contractors maintain their own medical malpractice liability insurance? ☐ Yes ☐ No

PART 6 CYBER PRE-QUALIFICATION

Insured regularly backs up critical data to a "cold" or "offline" location that would be unaffected by an issue with their live environment, and they test to ensure those backups are recoverable? ☐ Yes ☐ No

Insured uses multi-factor authentication (MFA) for cloud-based services (such as cloud-based email accounts) and for all remote access to their network: ☐ Yes ☐ No

Insured does not allow remote access into their environment without a virtual private network (VPN): ☐ Yes ☐ No

Insured regularly (at least annually) provides cyber security awareness training, including anti-phishing, to all individuals who have access to their organization's network or confidential/personal data? ☐ Yes ☐ No

Insured has a Business Continuity Plan in place that has been successfully tested to confirm that following an unexpected interruption of your computer systems, all revenue-earning operations can be fully resumed within 12 hour. ☐ Yes ☐ No

PART 7 INSURANCE HISTORY & REQUIREMENTS

Please provide details or your current **Errors & Omissions** insurance policy:					
Effective Date: (MM/DD/YYYY)	Retro Date: (MM/DD/YYYY)	Limit:	Deductible:	Premium:	Insurer:
		$	$	$	
Please provide details of your required **Errors & Omissions** insurance policy:					
Effective Date: (MM/DD/YYYY)	Retro Date: (MM/DD/YYYY)	Limit:	Deductible:	Premium:	Insurer:
		$	$	$	
Please provide details of your required **Commercial General Liability** insurance policy:					
Effective Date: (MM/DD/YYYY)	Limit:		Deductible:	Premium:	Insurer:
	$		$	$	

PART 8 CLAIMS HISTORY

a) Are you aware of any loss or damage, whether insured or not, that has occurred to any of the Companies to be insured (or to any existing or previous business of the partners or directors of any Companies to be insured) within the last 5 (five) years, or: ☐ Yes ☐ No

b) Are you aware of any circumstances which may give rise to a claim against any of the Companies to be insured or any partners or directors thereof, or: ☐ Yes ☐ No

c) Have any claims or cease and desist orders been made against any of the Companies to be insured, or any partners or directors thereof, or: ☐ Yes ☐ No

d) Have any partners or directors of the Companies to be insured been found guilty of any criminal, dishonest or fraudulent activity or been investigated by any regulatory body? ☐ 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/claims, the status of the claim(s) or circumstance(s) and any reserve(s) or payment(s) made by Insurers, and the dates of all developments and payments.

TYPE OF LOSS	DATE OF LOSS	DESCRIPTION OF LOSS	$ RESERVE OR LOSS AMOUNT PAID BY INSURER	$ RETAINED LOSS OR DEDUCTIBLE PAID BY YOU
			$	$
			$	$
			$	$

*Please attach any available insurance company loss reports with this application

NOTICE TO APPLICANT:

Consumer and previous insurer reports containing personal, credit, factual or investigative information about the Applicant may be sought in connection with this Applicant for Insurance or any renewal, extension or variation thereof. All provisions contained in the various forms issued under this contract shall be deemed to be contained in the present Application of Insurance. The policy may be deemed to be void and claims may be denied where:

1) An Applicant for a contract:
   a) Gives false or erroneous information to the prejudice of the insurer, or
   b) Knowingly misrepresents or fails to disclose in the Application any fact required to be stated therein; or
2) The Insured contravenes a term of the Contract or commits a fraud; or
3) The Insured willfully makes a false statement in respect of a claim under the contract.

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND ACCURATE, I AM AUTHORIZED TO CONTRACT ON BEHALF OF THE INSURED, AND I APPLY FOR A CONTRACT OF INSURANCE BASED UPON THE TRUTH OF THESE STATEMENTS.

I AM IN AGREEMENT THAT THIS DECLARATION SHALL HEREBY FORM PART OF THE INSURANCE CONTRACT.

Applicant's Signature: Position:

Please print name: Date:

BROKER DECLARATION

How long have you known this Applicant? _____

Is this account new or renewal to you? _____

Have you personally viewed the Applicant's operations? _____

What is the condition of facilities and equipment? _____

What is the applicant's attitude toward risk management and insurance? _____

Do you recommend this Applicant? _____

Broker's Signature: Position:

Please print name: Date:

SUBMIT