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## Professional and General Liability Insurance Application for: Beauty, Health and Well-being Services and Practices

For the purpose of the Insurance Companies Act (Canada), this document was issued in the course of Lloyd's Underwriters' insurance business in Canada.

**Please read and complete the application in its entirety. Blanks &/or dashes are not acceptable and will delay consideration of this application. Answer all questions, if the question does not apply, indicate "N/A" in the circle provided.**

Please read and complete the application in its entirety. Return the completed application to MedThree Insurance Group.

### SECTION 1 – GENERAL INFORMATION

1. Name of Applicant (Please print):										
Name of Business to be insured of if different from the above:										
2. Address:										
City/Town:		Province:			Postal Code:					
Phone No.:		E-Mail:								
3. Business Address if different from the above:										
City/Town:		Province:			Postal Code:					
Phone No.:		E-Mail:								
4. How long has the business been operating?										
5. Is the business a:			<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Independent Contractor	<input type="checkbox"/> Individual Practice	<input type="checkbox"/> Other (describe):			
6. Is the business operated as a:			<input type="checkbox"/> Beauty Salon	<input type="checkbox"/> Spa	<input type="checkbox"/> MediSpa	<input type="checkbox"/> Complementary Therapy Practice	<input type="checkbox"/> Homeopathic Practice			<input type="checkbox"/> Other (describe):
7. Your relationship to the business is as an:			<input type="checkbox"/> Owner/Partner	<input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor	<input type="checkbox"/> Individual Practitioner/Therapist				
8. Are there additional locations?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number of Locations:			Website:			
9. Are you a current policy holder or a new applicant?		<input type="checkbox"/> Existing Holder	<input type="checkbox"/> New Applicant							
10. In what capacity do you practice?										
Acupuncturist		<input type="checkbox"/>	Reg. Massage Therapist (RMT)		<input type="checkbox"/>	Registered Practical Nurse		<input type="checkbox"/>		
Aromatherapist		<input type="checkbox"/>	Medical Esthetician		<input type="checkbox"/>	Stylist		<input type="checkbox"/>		
Beautician		<input type="checkbox"/>	Nail Technician		<input type="checkbox"/>	TCM Practitioner		<input type="checkbox"/>		
Cosmetologist		<input type="checkbox"/>	Naturopath		<input type="checkbox"/>	Technician		<input type="checkbox"/>		
Dietician		<input type="checkbox"/>	Nutritionist Counsellor		<input type="checkbox"/>	Healthcare Therapist/Counsellor		<input type="checkbox"/>		
Esthetician		<input type="checkbox"/>	Osteopath		<input type="checkbox"/>	Other:		<input type="checkbox"/>		
Herbalist		<input type="checkbox"/>	Physiotherapist		<input type="checkbox"/>	Other:		<input type="checkbox"/>		
Homeopath		<input type="checkbox"/>	Physician		<input type="checkbox"/>	Other:		<input type="checkbox"/>		
Laser Technician		<input type="checkbox"/>	Reflexologist		<input type="checkbox"/>	Other:		<input type="checkbox"/>		
Massage Provider (Relaxation)		<input type="checkbox"/>	Registered Nurse		<input type="checkbox"/>	Other:		<input type="checkbox"/>		
11. Number of years in practice:										
12. Are you a member of an applicable professional association or professional body?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	If yes, please specify:				
13. Are you accredited and/or certified?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	If yes, please list accreditations and/or certifications:				

14. Are you a current licensed member in good standing with a professional College?  Yes  No  N/A License/Registration Number: \_\_\_\_\_ Date of Expiry (dd/mm/yyyy): \_\_\_\_\_

15. Please state sources and amounts of total revenue in respect of the following years (in CAD):

	<i>Last Complete Financial Year</i>	<i>Estimate for Current Financial Year</i>	<i>Estimate for Next Financial Year</i>
Professional Fees			
Product Sales			
Other Income (specify):			
Total Gross Revenues			

16. What percentage of clients treated are: Canadian Residents: \_\_\_\_\_ % Non-Canadian Residents: \_\_\_\_\_ %

**SECTION 2 – SERVICES PROVIDED**

**Part A – Beauty Services**

There are several categories of activities that can be covered, each of which has a separate premium banding. Check all applicable services provided in Categories 1-3 in the following table.

<b>Category 1 – Low Risk</b>					
<i>Service</i>	<i>Applicable</i>	<i>% of Revenue</i>	<i>Service</i>	<i>Applicable</i>	<i>% of Revenue</i>
All Hair Styling Services	<input type="checkbox"/>		Green Peel	<input type="checkbox"/>	
Aromatherapy	<input type="checkbox"/>		Make-Up – Non-permanent	<input type="checkbox"/>	
Body Wraps	<input type="checkbox"/>		Manicures	<input type="checkbox"/>	
Ear Piercing	<input type="checkbox"/>		Paraffin	<input type="checkbox"/>	
Eyebrow & Eyelash Tinting	<input type="checkbox"/>		Pedicures	<input type="checkbox"/>	
Eyelash Extensions	<input type="checkbox"/>		Relaxation Massage	<input type="checkbox"/>	
Facials	<input type="checkbox"/>		Reflexology	<input type="checkbox"/>	
Gel Nails	<input type="checkbox"/>		Spray Tanning	<input type="checkbox"/>	
Glycolic Peels – maximum 20% AHA content	<input type="checkbox"/>		Waxing/Sugaring	<input type="checkbox"/>	

<b>Category 2 – Medium Risk</b>					
<i>Service</i>	<i>Applicable</i>	<i>% of Revenue</i>	<i>Service</i>	<i>Applicable</i>	<i>% of Revenue</i>
Acrylic Nails	<input type="checkbox"/>		LED Technology	<input type="checkbox"/>	
Body Piercing (above the waist only)	<input type="checkbox"/>		Radiowave Skin Treatment	<input type="checkbox"/>	
Carboxy Therapy	<input type="checkbox"/>		Teeth Whitening	<input type="checkbox"/>	
Electrolysis	<input type="checkbox"/>		Ultrasound Skin Treatment	<input type="checkbox"/>	
Fitness, Nutrition or Weight Loss Programs	<input type="checkbox"/>				

<b>Category 3 – High Risk</b>					
<i>Service</i>	<i>Applicable</i>	<i>% of Revenue</i>	<i>Service</i>	<i>Applicable</i>	<i>% of Revenue</i>
Botox Injections	<input type="checkbox"/>		Medical strength Peels	<input type="checkbox"/>	
Collagen Injections	<input type="checkbox"/>		Microdermabrasion	<input type="checkbox"/>	
Corn, Bunion or Ingrown Toenail Cutting or Removal	<input type="checkbox"/>		Microneedling	<input type="checkbox"/>	
Cryolipolysis (CoolSculpting)	<input type="checkbox"/>		Micropigmentation	<input type="checkbox"/>	
Custom Contouring	<input type="checkbox"/>		Mole or Skin Tag Removal	<input type="checkbox"/>	
Dermaplaning/blading	<input type="checkbox"/>		Permanent Makeup (pigment only)	<input type="checkbox"/>	
Ear Candling	<input type="checkbox"/>		Photofacial/Non-ablative Wrinkle Reduction	<input type="checkbox"/>	

Erbium/Ablative Laser	<input type="checkbox"/>		Skin Tightening (Laser and RF)	<input type="checkbox"/>	
Eyebrow Embroidery	<input type="checkbox"/>		Spider Vein Removal (Sclerotherapy)	<input type="checkbox"/>	
Injectable Dermal Fillers	<input type="checkbox"/>		Tanning Beds	<input type="checkbox"/>	
Injectable plus Dermal Filler	<input type="checkbox"/>		Tattoo Removal (by laser only)	<input type="checkbox"/>	
Injectable vitamins	<input type="checkbox"/>				
Laser, IPL and RF Services	<input type="checkbox"/>				
Latisse	<input type="checkbox"/>				

**Part B – Health and Well-being Therapies<sup>1</sup>**

There are several categories of activities that can be covered, each of which has a separate premium banding.

Check all appropriate modalities/services provided in Categories 1 and 2 in the following tables:

<b>Category 1 Therapies – Low Risk</b>					
	<i>Applicable</i>	<i>% of Revenue</i>		<i>Applicable</i>	<i>% of Revenue</i>
<b>Massage</b> including but not limited to RMT, therapeutic, relaxation, massage & Deep Tissue, Hot Stone	<input type="checkbox"/>		<b>Biologic-based therapies</b> including but not limited to herbal medicines & teas, dietary supplements (excluding IV vitamins), probiotics	<input type="checkbox"/>	
<b>Manual Therapies</b> including but not limited to Shiatsu	<input type="checkbox"/>		Osteopathy	<input type="checkbox"/>	
<b>Mind-body practices</b> including but not limited to yoga (excluding Hot/Bikram/Moksha), meditation, biofeedback, guided imagery, art, music, dance, prayer, Trager psychophysical integration	<input type="checkbox"/>		<b>Fitness systems</b> including but not limited to Pilates	<input type="checkbox"/>	
<b>Body-based Therapies</b> including but not limited to Feldenkrais method, Alexander technique, Reflexology, Rolfing, Bowen, Onsen Therapy	<input type="checkbox"/>		<b>Therapies using cold lasers</b> including but not limited to LLLT/LILT-Low Level/Intensity Laser	<input type="checkbox"/>	
<b>Movement Therapies</b> including but not limited to dance	<input type="checkbox"/>		<b>Analytic studies</b> including but not limited to Iridology, Sclerology	<input type="checkbox"/>	
<b>Energy Therapies</b> including but not limited to, Reiki, Tai Chi, Therapeutic Touch, Body Talk, Eden, EFT (tapping), BIE, BARS therapy	<input type="checkbox"/>		<b>Body cleansing/body purifying therapies</b> such as Ionic Foot Bath Detoxification (excluding Colon Hydrotherapy (Irrigation))	<input type="checkbox"/>	
<b>Bio-electromagnetic-based therapies</b> including but not limited to pulsed fields, PEMF therapy, bio-magnetic rebalancing	<input type="checkbox"/>		Cupping	<input type="checkbox"/>	
<b>Therapy incorporating the senses</b> including but not limited to Aromatherapy, Raindrop Therapy	<input type="checkbox"/>		Other (describe):	<input type="checkbox"/>	
<b>Therapies using the Mind</b> including but not limited to Meditation, Prayer	<input type="checkbox"/>		Other (describe):	<input type="checkbox"/>	
			Other (describe):	<input type="checkbox"/>	

<sup>1</sup> Health and Well-being Therapies include alternative/complementary therapies, TCM, naturopathy and homeopathy.

Category 2 Therapies – Medium Risk					
	Applicable	% of Revenue		Applicable	% of Revenue
Acupuncture	<input type="checkbox"/>		Hypnotherapy (excluding past life regression & use in entertainment)	<input type="checkbox"/>	
Colon Hydrotherapy (Irrigation)	<input type="checkbox"/>		Indirect Moxibustion	<input type="checkbox"/>	
Diet and herbs (including Nutrition Counselling)	<input type="checkbox"/>		Intravenous Vitamin Therapy	<input type="checkbox"/>	
Dry Needling	<input type="checkbox"/>		Therapies on Animals such as animal massage, Animal Energy Work	<input type="checkbox"/>	
Ear Candling	<input type="checkbox"/>		Trigenics	<input type="checkbox"/>	
Homeopathy/Heilkunst	<input type="checkbox"/>		Other (describe):	<input type="checkbox"/>	

### SECTION 3 – PERSONNEL

(If you are an employee, independent contractor, or individual practitioner go to Section 5.)

#### Part A – Employees:

1. Indicate by type the number of full-time (F/T) and part-time (P/T) employed by the Applicant:

Type	No.	F/T	P/T	Type	No.	F/T	P/T	Type	No.	F/T	P/T
Acupuncturists		<input type="checkbox"/>	<input type="checkbox"/>	Reg. Massage Therapist (RMT)		<input type="checkbox"/>	<input type="checkbox"/>	Registered Practical Nurse		<input type="checkbox"/>	<input type="checkbox"/>
Aromatherapists		<input type="checkbox"/>	<input type="checkbox"/>	Medical Esthetician		<input type="checkbox"/>	<input type="checkbox"/>	Stylist		<input type="checkbox"/>	<input type="checkbox"/>
Beauticians		<input type="checkbox"/>	<input type="checkbox"/>	Nail Technician		<input type="checkbox"/>	<input type="checkbox"/>	TCM Practitioner		<input type="checkbox"/>	<input type="checkbox"/>
Cosmetologists		<input type="checkbox"/>	<input type="checkbox"/>	Naturopath		<input type="checkbox"/>	<input type="checkbox"/>	Technician		<input type="checkbox"/>	<input type="checkbox"/>
Dieticians		<input type="checkbox"/>	<input type="checkbox"/>	Nutritionist Counsellor		<input type="checkbox"/>	<input type="checkbox"/>	Therapist/Counsellor		<input type="checkbox"/>	<input type="checkbox"/>
Estheticians		<input type="checkbox"/>	<input type="checkbox"/>	Osteopath		<input type="checkbox"/>	<input type="checkbox"/>	Medical Director		<input type="checkbox"/>	<input type="checkbox"/>
Herbalist		<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapist		<input type="checkbox"/>	<input type="checkbox"/>	Clerical/Administrative		<input type="checkbox"/>	<input type="checkbox"/>
Homeopath		<input type="checkbox"/>	<input type="checkbox"/>	Physician		<input type="checkbox"/>	<input type="checkbox"/>	Other (describe):		<input type="checkbox"/>	<input type="checkbox"/>
Laser Technician		<input type="checkbox"/>	<input type="checkbox"/>	Reflexologist		<input type="checkbox"/>	<input type="checkbox"/>	Other (describe):		<input type="checkbox"/>	<input type="checkbox"/>
Massage Provider (Relaxation)		<input type="checkbox"/>	<input type="checkbox"/>	Registered Nurse		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

2. Do all staff have certification/credentialing for the services they provide?  Yes  No

Attach copies of certificates of qualifications for all aestheticians/technicians for which coverage is required.

#### Part B – Independent Contractors:

1. Do independent contractors work in the establishment?  Yes  No

2. Indicate by practice the number of independent contractors providing services in the following table:

Type	No.	F/T	P/T	Type	No.	F/T	P/T	Type	No.	F/T	P/T
Acupuncturists		<input type="checkbox"/>	<input type="checkbox"/>	Reg. Massage Therapist (RMT)		<input type="checkbox"/>	<input type="checkbox"/>	Registered Practical Nurse		<input type="checkbox"/>	<input type="checkbox"/>
Aromatherapist		<input type="checkbox"/>	<input type="checkbox"/>	Medical Esthetician		<input type="checkbox"/>	<input type="checkbox"/>	Stylist		<input type="checkbox"/>	<input type="checkbox"/>
Beautician		<input type="checkbox"/>	<input type="checkbox"/>	Nail Technician		<input type="checkbox"/>	<input type="checkbox"/>	TCM Practitioner		<input type="checkbox"/>	<input type="checkbox"/>
Cosmetologist		<input type="checkbox"/>	<input type="checkbox"/>	Naturopath		<input type="checkbox"/>	<input type="checkbox"/>	Technician		<input type="checkbox"/>	<input type="checkbox"/>
Dietician		<input type="checkbox"/>	<input type="checkbox"/>	Nutritionist Counsellor		<input type="checkbox"/>	<input type="checkbox"/>	Therapist/Counsellor		<input type="checkbox"/>	<input type="checkbox"/>
Esthetician		<input type="checkbox"/>	<input type="checkbox"/>	Osteopath		<input type="checkbox"/>	<input type="checkbox"/>	Medical Director		<input type="checkbox"/>	<input type="checkbox"/>
Herbalist		<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapist		<input type="checkbox"/>	<input type="checkbox"/>	Clerical/Administrative^		<input type="checkbox"/>	<input type="checkbox"/>
Homeopath		<input type="checkbox"/>	<input type="checkbox"/>	Physician		<input type="checkbox"/>	<input type="checkbox"/>	Other (describe):		<input type="checkbox"/>	<input type="checkbox"/>
Laser Technician		<input type="checkbox"/>	<input type="checkbox"/>	Reflexologist		<input type="checkbox"/>	<input type="checkbox"/>	Other (describe):		<input type="checkbox"/>	<input type="checkbox"/>
Massage Provider (Relaxation)		<input type="checkbox"/>	<input type="checkbox"/>	Registered Nurse		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

3. Do all Independent Contractors carry their own Professional Liability (Medical Malpractice) insurance? If no, are you responsible for providing Professional Liability Coverage for these individuals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are the professional licenses or certificates of all employees and independent contractors verified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you ensure that all staff are adequately supervised under the appropriate management?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 4 – GENERAL LIABILITY – OCCURRENCE-BASED**

1. Complete a brief description of the premises in the table below:

<i>Name of Building</i>	<i>Location</i>	<i>Year Built</i>	<i>Size (Sq. Ft.)</i>	<i># of Storeys</i>

**SECTION 5 – DESCRIPTION OF OPERATIONS**

**PART A – BEAUTY SERVICE PROVIDERS:**

1. Is a client informed about the steps to follow to prepare the skin for specific types of cosmetic treatments (e.g., chemical peel) to ensure it is safe and effective?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is a client told what post-procedure at-home care is required following specific cosmetic procedures/treatments e.g., laser skin rejuvenation, peel, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is a patch test for allergies performed before applying permanent makeup to mitigate reactions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is a client's dermatological history with an emphasis on wound healing and scar formation taken prior to treatment using a laser and IPL treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you evaluate a client's skin using a recognized (e.g., Fitzpatrick skin type classification) skin analysis/evaluation tool before treatments using lasers to prevent skin damage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are all employees and independent contractors trained by the manufacturer to use the equipment before they perform they perform any treatment on a client?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Is equipment requiring calibration done in accordance with manufacturer' recommendations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are clients required to wear protective eyewear during laser services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Do you keep copies of all client service records for a minimal 7 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have all operators listed had training on the machine(s) they use (e.g., IPL, Laser)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you use disposable products only where appropriate (e.g., permanent makeup)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are staff required to wear gloves when performing dermabrasion, peels, etc.at all times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Is reusable equipment reprocessed in accordance with current provincial best practices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Is alcohol ever served on the premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you operate a school or training facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, describe, including the number of students, services they perform, and instructor qualifications (please attach course outline):

16. Is equipment inspected daily and before each use to ensure it is in good working order?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Does equipment have routine and scheduled preventive maintenance in keeping with manufacturers' recommendations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Do you sell products (e.g., cosmetics, nail care, hair care, supplements, skin care etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please list:

**Part B – Health and Well-being Therapies:**

1. Is a client's informed consent obtained in writing prior to starting treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you provide health and/or well-being services to Professional Sports persons and/or dancers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you teach and/or certify another to teach others?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, how often and to whom:

<i>To Whom</i>	<i>How Often</i>

4. Are you in compliance with all regulatory workplace health & safety requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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5. Do you dispose of all waste in accordance with regulatory requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you sterilize instruments in accordance with current provincial best practice guidelines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you comply with manufacturer guidelines with respect to single-use products, devices or equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you make or sell products that are directly related to your treatment modalities?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 6 – INSURANCE AND CLAIMS HISTORY**

NOTE: All questions must be answered. Failure to disclose claims history could invalidate coverage.

**Part A – Current Insurance Information:**

Coverage	Occurrence or Claims-made policy?	Retroactive Date (Claims-made policy)	Exp. Date	Current Limit	Current Deductible	Annual Premium
Professional Liability						
General Liability						
Management Liability						

**Part B – Claims Information:**

1. Please attach a claims history from your current insurer providing the following details:

Date of Loss/ Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding (reserve)	Details Including Nature of Allegations and Claimant Details

2. Do you have knowledge of an event, circumstance or occurrence (other than listed above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence?  
 Yes  No If "Yes," please provide details below:

Professional or General Liability	Date of Incident/ Circumstance or Complaint	Details and Facts (including nature of Incident/Circumstance or Complaint & details of complainant)

3. Please indicate which limit(s) of indemnity you require quotation for:  
Professional Liability (Claims Made)  \$1,000,000  \$2,000,000  \$5,000,000  
 \$10,000,000
4. Please indicate which limit(s) of indemnity you require quotation for:  
General Liability (Occurrence)  \$1,000,000  \$2,000,000  \$5,000,000  
 \$10,000,000

**NOTICE CONCERNING PERSONAL INFORMATION**

By purchasing insurance from Medthree Insurance Group, a customer provides Medthree Insurance with his or her consent to the collection, use and disclosure of personal information, including that previously collected, for the following purposes:

- the communication with underwriters;
- the evaluation of claims;
- the analysis of business results;
- the underwriting of policies;
- the detection and prevention of fraud;
- purposes required or authorized by law.

For the purposes identified above, personal information may be disclosed to MedThree Insurance and any affiliated companies and service providers. Further information about Medthree Insurance personal information protection policy may be obtained by contacting their privacy officer at 416-477-2340.

**WARRANTY STATEMENT**

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. The undersigned also warrants that they have not suppressed or misstated any material facts. It is further agreed by the undersigned that each policy or renewal thereof, if issued, is issued in reliance upon the truth of the representations and information in this Application. If the information provided in this Application should change between the date of the Application and the effective date of the policy, the undersigned warrants he or she will immediately report such changes to the Insurer and the Insurer may modify or withdraw any quotation or agreement to bind or modify insurance.

Signing of this Application does not bind the undersigned to purchase this insurance, nor does it bind the Insurer to complete this insurance. However, should the Insurer bind and issue a policy, this Application shall serve as the basis of such contract and will be attached to and form part of the policy.

Any person who knowingly or with intent to defraud or to facilitate a fraud against any insurance company or other person submits an application or files a claim for insurance containing false, deceptive or misleading information may be guilty of insurance fraud.

**IMPORTANT: THE APPLICANT MUST SIGN THIS APPLICATION. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.**

**QUEBEC AND NEW BRUNSWICK RESIDENTS ONLY:**

I hereby confirm my request that the present document and any other document and correspondence pertaining to the present insurance be in the English language.

**SIGNATURE**

Signature:		Date (mm/dd/yyyy):	
	(Authorized Representative)		
Name (please print):		Title/Position:	