APPLICATION FOR MEMBERS OF THE JOINT CANADIAN TANNING ASSOCIATION (JCTA)

Professional Liability Application

CLIENT INFORMATION:

1. **Name:** ____________________

2. **The Applicant is best described as:** ☐ **Corporation** ☐ **Partnership** ☐ **Joint Venture**

3. **Number of years in business:** ____________________

4. ***Please provide the following details.***

Business Location Address: ____________________

City: ____________________ **Province:** ____________________ **Postal Code:** ____________________

Phone: ____________________ **Business Phone:** ____________________

Cell: ____________________ **Email:** ____________________

Location Address *(Only if different from above)*: ____________________

City: ____________________ **Province:** ____________________ **Postal Code:** ____________________

Phone: ____________________ **Business Phone:** ____________________

Cell: ____________________ **Email:** ____________________

5. **Are there additional locations?** ☐ **YES** ☐ **NO**

If "YES", please provide complete address for each below (attach additional sheet as needed):

Location 1		**Location 2**	
Street:		Street:	
Street Continued		Street Continued	
City:	Province:	City:	Province:
Country:	Postal Code:	Country:	Postal Code:

6. **Name of Main Contact Person:** ____________________

Email: ____________________ **Website:** ____________________

Business Telephone: ____________________ **Business Fax:** ____________________

7. **Please provide details about your current insurer.**

Name: ____________________

Policy #: ____________________ **Expiry Date:** ____________________ **Premium:** ____________________

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PROPERTY INFORMATION: (TO BE COMPLETED FOR EACH LOCATION TO BE INSURED)

8. Describe your location: ☐ Strip Plaza ☐ Shopping Mall ☐ Stand-Alone Structure

9. Do you own the building? ☐ **YES** ☐ **NO**

A) Age: _________________ # of Storeys: _______________________

10. Provide the year of latest updates, if over 25 years:

A) Wiring:________________ B) Plumbing: ________________ C) Heating: ________________

11. Total Area of Building: _________________________sq. ft **Total Area of Your Facility:** __________________sq.ft

12. Construction of Walls: ☐ Concrete ☐ Steel Deck ☐ Brick Veneer over Wood ☐ Wood

13. Construction of Roof: ☐ Concrete ☐ Steel Deck Encased in Concrete ☐ Steel Deck ☐ Metal Clad ☐ Wood Joist

14. Alarm Protection – Burglar Alarm: ☐ Local ☐ Central ☐ Monitored ☐ None

15. Alarm Protection – Fire Alarm: ☐ Local ☐ Central

16. Are your Premises sprinklered? ☐ **YES** ☐ **NO** ☐ *If "YES" is there a Fire Hydrant within 500 ft.?*

LIMITS OF INSURANCE:

Co-Insurance: 90% **Deductible: $1,000** ***(unless specified otherwise)***

Type of Insurance		Limit Required	Deductible *(If Higher Than $1,000 Requested)*
Building:	If Owned		
Contents/Equipment: **(Limit Must Be Selected)**	Includes Tanning Beds, Stock, Tenants, Improvements, Etc.		
Misc. Equipment:	Please Specify Equipment		

☐ **Other –** *Please list other types of insurance you may require:* ____

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____

Co-Insurance: 90% **Deductible: $1,000** ***(unless specified otherwise)***

Type of Insurance	Standard Limit of Insurance *(Automatically Included)*	Limit *(If Higher Limit Is Required)*	Deductible *(If Higher Than $1,000 Requested)*
Equipment / Stock Off-Site:	$50,000		
Equipment Breakdown:	Total Combined of Building & Contents/Equipment		
Accounts Receivable:	$50,000		
Valuable Papers:	$50,000		
Business Interruption ALS:	Actual Loss Sustained		
Fidelity:	$25,000		
Crime:	$10,000		
Commercial Liability:	$2,000,000		
Tenants Legal Liability:	$250,000		

☐ **Other –** *Please list other types of insurance you may require:* ______________________________

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OPERATIONS OVERVIEW:

17. Tanning Equipment Information:

Number of Beds:___________ Booths:___________ Spray Booths:___________ Air Brush:__________

Other (specify): ____

18. Number of Staff: Full time: ___________ Part Time: ___________

19. Revenues: Tanning Receipts: $___________ Product Receipts: $___________ Beautician: $___________

Other: $___________ Other: $___________ Other: $___________

20. **Are health regulations followed?** ☐ **YES** ☐ **NO**

If "NO", please explain: ______________________________

____

21. **Have you ever been cited for violations of any health or safety codes?** ☐ **YES** ☐ **NO**

If "YES", please explain: ______________________________

____

22. **Is the equipment inspected and cleaned after each use?** ☐ **YES** ☐ **NO**

If "NO", please explain: ______________________________

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23. **Do all clients sign waivers?** ☐ **YES** ☐ **NO**

If "NO", please explain: ______________________________

24. **Are all staff Smart Tan certified?** ☐ **YES** ☐ **NO**

If "NO", please explain: ______________________________

____

25. **Do all clients complete a skin analysis?** ☐ **YES** ☐ **NO**

If "NO", please explain: ______________________________

____

26. **Are all clients required to wear goggles?** ☐ **YES** ☐ **NO**

If "NO", please explain: ______________________________

____

27. **How is the age of the customer verified?** ______________________________

28. **Are all clients given tanning instruction?** ☐ **YES** ☐ **NO**

If "NO", please explain: ______________________________

29. **Who sets the amount of time a client is able to tan on each bed?** ☐ **CLIENT** ☐ **STAFF**

30. **Where is the timer located which sets the amount of time a client can tan?** ☐ **FRONT DESK** ☐ **BED**

31. **Are any beds operated by Tokens and/or coins?** ☐ **YES** ☐ **NO**

If "YES", please explain: ______________________________

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SERVICES OFFERED:

Service	Response	Service	Response
Aqua Massage Beds: *If "YES"*:	☐ YES ☐ NO # of Beds _______	Mole Removal *(Invasive Cutting)*:	☐ YES ☐ NO
Body Vibration Weight loss: *If "YES"*:	☐ YES ☐ NO # of Units ______	Mole Removal *(by Solution only)*:	☐ YES ☐ NO
Body Wraps:	☐ YES ☐ NO	Oxygen Bar or Oxygen Services:	☐ YES ☐ NO
Cellulite Treatment:	☐ YES ☐ NO	Physical Therapist on Staff:	☐ YES ☐ NO
Chiropractors on Staff:	☐ YES ☐ NO	Piercing *(Ears / Nose Only)*:	☐ YES ☐ NO
Cosmetic Acupuncture:	☐ YES ☐ NO	Piercings *(Other Than Ears / Nose)*:	☐ YES ☐ NO
Diet / Nutrition:	☐ YES ☐ NO	Red Light Therapy:	☐ YES ☐ NO
Does your company use MMA *(Methyl Methacrylate)* within the Nail Manicure/Pedicure process?:	☐ YES ☐ NO	Sauna *(Wet or Dry)*: *If "YES"*:	☐ YES ☐ NO # of Units ___________
Dry Heat Sauna Beds: *If "YES"*:	☐ YES ☐ NO # of Beds _______	Sclerotherapy:	☐ YES ☐ NO
Ear Candling:	☐ YES ☐ NO	Skin Tag Removal by Solution Only:	☐ YES ☐ NO
Electroquagulation:	☐ YES ☐ NO	Skin Tag Removal *(Invasive Cutting)*:	☐ YES ☐ NO
Eyelash Extension:	☐ YES ☐ NO	Spray Tanning Booth:	☐ YES ☐ NO
Eyebrow Tinting:	☐ YES ☐ NO	Spray Tanning Handheld:	☐ YES ☐ NO
Eyelash Curling & Perming:	☐ YES ☐ NO	Steam Rooms: *If "YES"*:	☐ YES ☐ NO # of Units ___________
Facials:	☐ YES ☐ NO	Stripping Veins:	☐ YES ☐ NO
Hot Tub/Whirl Pool: *If "YES"*:	☐ YES ☐ NO # of Units_______	Swimming Pool: *If "YES"*: and please list the Maximum Depth:	☐ YES ☐ NO # of Units: __________ In M or FT: __________
Hair Cutting / Coloring	☐ YES ☐ NO	Tattooing *(Henna)*:	☐ YES ☐ NO
Hydrotherapy Tubs: *If "YES"*:	☐ YES ☐ NO # of Units _______	Tattooing *(Spray on)*:	☐ YES ☐ NO
Infrared Sauna: *If "YES"* :	☐ YES ☐ NO # of Units _______	Tattooing Body *(other than Micropigmentation)*:	☐ YES ☐ NO
Ionization Foot Detoxification:	☐ YES ☐ NO	Toning Beds: *If "YES"*:	☐ YES ☐ NO # of Units ___________
Makeup *(Non-Permanent)*:	☐ YES ☐ NO	Wart Removal *(Invasive Cutting)*:	☐ YES ☐ NO
Manicure / Pedicure:	☐ YES ☐ NO	Wart Removal *(by Solution only)*:	☐ YES ☐ NO
Micropigmentation:	☐ YES ☐ NO	Waxing / Sugaring:	☐ YES ☐ NO
Weight Loss by Supplements:	☐ YES ☐ NO		

Acid / Glycolic Peels: ☐ YES ☐ NO → If YES, please complete the Acid / Glycolic Peels Supplementary Questions on page 6.

Electrolysis: ☐ YES ☐ NO → If YES, please complete the Electrolysis Supplementary Questions on page 6.

Massage: ☐ YES ☐ NO → If YES, please complete the Massage Supplementary Questions on page 6.

Laser / IPL Treatment: ☐ YES ☐ NO → If YES, please complete the Laser / IPL Supplementary Questions on page 7 & 8.

Injectable Services: ☐ YES ☐ NO → If YES, please complete the Injectable Supplementary Questions on page 9.

Microdermabrasion: ☐ YES ☐ NO → If YES, please contact LMS PROLINK.

Do you provide other services? ☐ YES ☐ NO

If "YES", please explain: ____

____

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ACID PEELS SUPPLEMENTARY QUESTIONS (IF APPLICABLE):

Acid/Glycolic Peels (less than 30% solution concentrations) ☐ YES ☐ NO

Acid/Glycolic Peels (between 30% to 60% solution concentrations) ☐ YES ☐ NO

Acid/Glycolic Peels (greater than 60% solution concentrations) ☐ YES ☐ NO

A. Do you sterilize equipment? ☐ YES ☐ NO

B. Does all staff wear sterilized gloves when performing services? ☐ YES ☐ NO

C. Do you provide Medium Peels? ☐ YES ☐ NO

D. Do you provide Deep Peels? ☐ YES ☐ NO

ELECTROLYSIS SUPPLEMENTARY QUESTIONS (IF APPLICABLE):

A. Do you sterilize equipment? ☐ YES ☐ NO

B. Does all staff wear sterilized gloves when performing services? ☐ YES ☐ NO

C. Do you use disposable tips for each new client? ☐ YES ☐ NO

MASSAGE SUPPLEMENTARY QUESTIONS (IF APPLICABLE):

Please complete this section for all Massage Therapists on Staff:

Name of Massage Therapist	Type(s) Of Massage They Perform *(PLEASE LIST ALL)*	Years of Education	Years of Experience	Are you an RMT?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

A. What type(s) of Massage do you perform? *(PLEASE LIST ALL)* ______________________________

____

____

B. Do you collect and discuss the client's health information? ☐ YES ☐ NO

C. How long do you keep clients' health information / waivers on file? ________ Years

D. Is a waiver signed, dated and kept on record? ☐ YES ☐ NO

E. Do you offer massages to infants? ☐ YES ☐ NO

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LASER SUPPLEMENTARY QUESTIONS (IF APPLICABLE):

Please complete ALL questions. If you require additional space, please add additional pages as necessary.
Please advise IF and HOW you provide the following operations *(check all lines of operations)*:

Service	Laser	Pulse Light / IPL
Acne:	☐ YES ☐ NO	☐ YES ☐ NO
Endovenous Laser Treatment:	☐ YES ☐ NO	☐ YES ☐ NO
Leg Veins:	☐ YES ☐ NO	☐ YES ☐ NO
Psoriasis & Vitiligo:	☐ YES ☐ NO	☐ YES ☐ NO
Skin Resurfacing:	☐ YES ☐ NO	☐ YES ☐ NO
Cosmetic Re-pigmentation:	☐ YES ☐ NO	☐ YES ☐ NO
Hair Removal:	☐ YES ☐ NO	☐ YES ☐ NO
Pigmented Lesions:	☐ YES ☐ NO	☐ YES ☐ NO
Vascular Lesions:	☐ YES ☐ NO	☐ YES ☐ NO
Cellulite Treatment:	☐ YES ☐ NO	☐ YES ☐ NO
Other *(please describe)*:		

***Please provide all operators who provide laser treatment or cellulite treatment and their experience:**

Name of Person Providing Laser Treatment	Years of Education	Years Experience / Qualifications	Any Prior Claims Made Against Each Individual *(Please Give Brief Details)*

***Complete this section for all laser/cellulite machines (please list additional hand pieces separately):**

Make	Model	Age	Current Replacement Cost in Canadian Dollars
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$

A. Please indicate what skin types you provide laser treatments services on*: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

**(As based on the Fitzpatrick scale which can be found at http://dermatology.about.com/od/cosmeticprocedure/a/fitzpatrick.htm)*

B. Percentage of gross receipts from laser operations: ___________%

C. Do you complete a skin patch test prior to laser treatments? ☐ **YES** ☐ **NO**

D. How long do you wait after the patch test to perform laser treatment? ___________

E. Do you wear surgical gloves when providing laser services to clients? ☐ **YES** ☐ **NO**

F. Does your client wear protective eyewear during laser services? ☐ **YES** ☐ **NO**

G. Do you keep copies of all client service records? ☐ **YES** ☐ **NO**

H. How many years is service records kept on file? _______ **years**

I. Is a waiver signed, dated and kept on record? ***(PLEASE ATTACH A COPY)*** ☐ **YES** ☐ **NO**

J. How many years are waivers kept on file? _______ **years**

K. Do you explain to the client what steps to take prior to any laser treatment ☐ **YES** ☐ **NO**

If "YES", please describe: ____

____

L. Do you explain to the client what steps to take after any laser treatment? ☐ **YES** ☐ **NO**

If "YES", please describe: ____

____

M. How often do you calibrate your machines?____

N. Do you provide any off-site laser treatments? ☐ **YES** ☐ **NO**

If "YES", list all locations, methods of transporting equipment and frequency of all off-site treatments: ______________________

____

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INJECTABLE SUPPLEMENTARY QUESTIONS (IF APPLICABLE):

* Please complete this section for *all* ***employees & sub-contractors*** who perform Injectable services:

# of Full time *(F/T)* Employees?________ # of Part time *(P/T)* Employees? ________ # of Contract People? ________

Name	Years of Education	Years of Experience	Have Their Own Insurance For This Service	Is This Person A Doctor	Is This Person A Registered Nurse
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

***Complete this section if you require additional coverage.**

Aquamid:	☐ N/A ☐ Doctor ☐ Nurse	**Artecoll:**	☐ N/A ☐ Doctor ☐ Nurse
Bio-Alcamid:	☐ N/A ☐ Doctor ☐ Nurse	**Bionblue:**	☐ N/A ☐ Doctor ☐ Nurse
Botox:	☐ N/A ☐ Doctor ☐ Nurse	**Collegan:**	☐ N/A ☐ Doctor ☐ Nurse
Cymetra:	☐ N/A ☐ Doctor ☐ Nurse	**Deep Lines/Kiss/Ultra Deep:**	☐ N/A ☐ Doctor ☐ Nurse
Dental Blocks:	☐ N/A ☐ Doctor ☐ Nurse	**Dermadeep;**	☐ N/A ☐ Doctor ☐ Nurse
Dermalive:	☐ N/A ☐ Doctor ☐ Nurse	**Dysport:**	☐ N/A ☐ Doctor ☐ Nurse
Elastence:	☐ N/A ☐ Doctor ☐ Nurse	**Esthelis Basic/Soft:**	☐ N/A ☐ Doctor ☐ Nurse
Evolence:	☐ N/A ☐ Doctor ☐ Nurse	**Evolution:**	☐ N/A ☐ Doctor ☐ Nurse
Hylaform/Fineline/Plus:	☐ N/A ☐ Doctor ☐ Nurse	**Hydrafill 1/2/3/ Softline/Max:**	☐ N/A ☐ Doctor ☐ Nurse
IAL System:	☐ N/A ☐ Doctor ☐ Nurse	**Juvederm 18/24/24hv/30/30hv:**	☐ N/A ☐ Doctor ☐ Nurse
Juvelif:	☐ N/A ☐ Doctor ☐ Nurse	**Laresse:**	☐ N/A ☐ Doctor ☐ Nurse
Matridex:	☐ N/A ☐ Doctor ☐ Nurse	**Matridur:**	☐ N/A ☐ Doctor ☐ Nurse
Outline:	☐ N/A ☐ Doctor ☐ Nurse	**Puragen:**	☐ N/A ☐ Doctor ☐ Nurse
Puragen Plus:	☐ N/A ☐ Doctor ☐ Nurse	**Radiesse:**	☐ N/A ☐ Doctor ☐ Nurse
Restylane Sub Q:	☐ N/A ☐ Doctor ☐ Nurse	**Restylane/Touch/Perlane/Lipp:**	☐ N/A ☐ Doctor ☐ Nurse
Reviderm Intra:	☐ N/A ☐ Doctor ☐ Nurse	**Restylane Vital:**	☐ N/A ☐ Doctor ☐ Nurse
Sculptra *(Newfill)*:	☐ N/A ☐ Doctor ☐ Nurse	**Surgiderm 18/24xp/30:**	☐ N/A ☐ Doctor ☐ Nurse
Surgiderm 30xp:	☐ N/A ☐ Doctor ☐ Nurse	**Surgilift Plus:**	☐ N/A ☐ Doctor ☐ Nurse
Surgilips:	☐ N/A ☐ Doctor ☐ Nurse	**Teosyal Global Action/Touch Ups:**	☐ N/A ☐ Doctor ☐ Nurse
Teosyal Meso:	☐ N/A ☐ Doctor ☐ Nurse	**Vistabel:**	☐ N/A ☐ Doctor ☐ Nurse
Viscontour:	☐ N/A ☐ Doctor ☐ Nurse	**Voluma:**	☐ N/A ☐ Doctor ☐ Nurse
Zyderm 1/2/Zyplast:	☐ N/A ☐ Doctor ☐ Nurse		

IMPORTANT NOTICE TO APPLICANT:

32. Has any Insurer ever cancelled, restricted or refused to renew your insurance? ☐ **YES** ☐ **NO**

If "YES", please provide complete details: ______________________________

____

33. Have you ever been sued or has any claim been made against you arising out of your services? ☐ **YES** ☐ **NO**

If "YES", please provide complete details: ______________________________

____

PLEASE NOTE: **No Coverage is offered for sale and/or distribution of equipment with movable parts.**

No Coverage is offered for manufacturing/mixing/blending of products other than aromatherapy.

In order to qualify for this program the following conditions must be met:

1. Tanning beds must be less than 10 years old, or must be assessed by a qualified technician to confirm that the tanning beds are in good working order.

2. All clients must sign a waiver holding the named business and their employees harmless. Must be kept on file for NO less than seven years. (7yrs)

3. All clients prior to using a bulb tanning system for the first time must fully complete and sign a tanning skin analysis. (Must be kept on file for NO less than seven years. (7yrs)

4. Signs must be posted within the tanning room and outside the tanning room area noting that eye protection must be worn.

5. Within the client signing contract it must be noted that the client understands that they must wear eye protection.

6. All clients must be given full tanning instruction, a tour of the salon including the use/operation of all equipment.

7. All bulb tanning system timing mechanisms that set the length of time a client is permitted to tan, must be controlled from the front desk. TIMING MECHANISMS CONTROLLED WITHIN THE TANNING ROOM OR LOCATED ON OUTSIDE WALLS WILL NOT QUALIFY FOR THIS PROGRAM.

8. All tanning equipment must be cleaned after every use.

9. Only Smart tan certified employees are permitted to set the length of time a client is permitted to tan, as per the tanning skin analysis.

10. NO prior claims within the past 5 years.

11. The Named business requesting insurance MUST have a combined membership with the JCTA and Smart Tan.

PLEASE NOTE: **Non-compliance of conditions 1 through 11 will affect your insurance coverage:**

Coverage will not apply to any bodily injury claims provided under FORM # HFWSPA GL 2006 or FORM # HFW GL 2006 unless the above 11 conditions have been met.

This is an application for insurance and the insurer is not obligated to accept the applicant for coverage. If a policy is issued, one signed copy of the application will be attached to the policy or certificate. Signature on the application form and submission of a premium payment does not bind the insurer to complete an insurance transaction with the applicant. This policy provides Errors and Omissions insurance that applies on a claims-made basis. The following provides a general description of this coverage and is subject to the terms and provisions of the actual policy.

A. The policy will not cover any losses from incidents which take place before the Retroactive Date, if any, or after the expiration of the policy period (subject to the Extended Reporting Period provision).

B. The policy will provide coverage for losses from incidents which take place on or after the Retroactive Date, if any, but before the beginning of the policy period only if the insured did not know of the incident before the beginning of the policy period.

C. The policy will not cover any loss for which a claim is first made after:

1. The expiration of the policy period or its earlier termination date, if any; or
2. The Extended Reporting Period if any and then only in accordance with the terms described in the policy.

D. The policy will only cover claims which are first made:

1. During the policy period; or
2. During an Extended Reporting Period if any and then only in accordance with the terms and conditions described in the Extended Reporting Period Section of the policy.

E. Please request a copy of the Policy and review the terms and conditions to obtain more information.

F. The limits for Defence Costs are over and above the liability and will not reduce the limit of liability.

Disclosure and Consent:

As part of my application for insurance I consent to the collection and use of personal information required for the purposes of considering my application for insurance by the insurer and the authorized insurance broker for Ontario Applicants, LMS PROLINK Ltd., and/or the authorized insurance broker for applicants outside of Ontario, The PROLINK Insurance Group Inc. The insurer and the broker are authorized to collect, use, and disclose personal information and provide such personal information to third parties, as required for the purpose of underwriting this application for insurance, as permitted by the relevant provincial and federal privacy laws or other applicable laws, and as required by the applicant's association and/or governing body. I understand that at any time I may ask to review the personal information pertaining to my application for insurance and the insurer and broker will be obligated to provide me with any information I am entitled to receive under the relevant provincial and federal privacy laws or other applicable laws. I have reviewed the information in this Application, gathered information from all partners/directors/ officers/ employees/agents under this entity whether present or prior regarding their knowledge or awareness of any claims or situations which may give rise to any claims

The Claim Information Forms, if any, that are attached to this Application include the details of:

A. All facts, situations, and incidents which have occurred in the past and which may reasonably be expected to result in a claim, suit or arbitration against us (the Applicant);

B. All facts, situations, and incidents which have occurred in the past and which may reasonably be expected to result in a claim, suit or arbitration against us (the applicant) in the future. All such claims, suits and incidents have been reported to our (Applicants) current or prior insurer(s). It is understood and agreed that all such claims, suits, arbitrations, fact situations and incidents will be excluded from coverage under any policy issued by the insurer.

It is understood and agreed that failure to provide true and complete response to any of the questions, statements or request for information in this Application or to provide any other information material to this Application may, at the sole option of the insurer, result in the voiding of the insurance policy issued in reliance on this Application and /or denial of coverage for specific claims asserted against us (the Applicant) or any other insured under the policy. The undersigned on behalf of the Applicant and all other insureds under this policy issued by the insurer, hereby waives any defense to an action by the insurer for voiding or revoking of the policy based upon misrepresentation of fact or failure to disclose material information in connection with this Application. The Applicant agrees to hold the insurer harmless from all loss as a result of any such misrepresentation or failure to disclose, including, without limitation, all costs and attorney fees incurred by the insurer in connection with said action for voiding or revoking the policy.

I HEREBY DECLARE that the above statements and particulars are true to the best of my knowledge, that I have not suppressed or misstated any facts and I agree that this application shall form part of the insurance policy. I also acknowledge that I am obligated to report any changes that could affect the disclosures in this application that occur after the date of signature, but prior to the effective date of coverage.

Applicant's Signature:_______________________ **Name** ***(please print)***: _______________________ **Date:** _______________________

PLEASE COMPLETE AND RETURN THE APPLICATION THROUGH ONE OF THE FOLLOWING METHODS:

- ✓ Via **EMAIL** please send to: **JCTA@LMS.ca**
- ✓ Via **FAX** please send to: **416 595 1649 attn. JCTA PROGRAM MANAGER**
- ✓ Via **MAIL** please send to: **LMS PROLINK Ltd. 480 University Ave. Suite 800 Toronto, ON. M5G 1V2**