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Page 1 of 8

**BODY WORKS INSURANCE PROGRAM  
 BEAUTY / ESTHETICS / SPA APPLICATION**

COMPLETION OF THIS APPLICATION IS FOR QUOTATION PURPOSES ONLY AND DOES NOT PLACE COVERAGE IN FORCE

Legal Business Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal: \_\_\_\_\_

Location Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal: \_\_\_\_\_

Do you have Additional Locations? ( ) YES ( ) NO    Do you operate from home? ( ) YES ( ) NO  
 If Yes, Provide Address(es) \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal: \_\_\_\_\_

Please attach a separate page if additional space is needed

Contact Person: \_\_\_\_\_ Business Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Res. # \_\_\_\_\_ Cell # \_\_\_\_\_ E-mail: \_\_\_\_\_

Web Page Address: \_\_\_\_\_

Do you currently have insurance? ( ) YES ( ) NO    Expiry Date: \_\_\_\_\_  
 If no, have you had insurance previously? If yes how long ago? \_\_\_\_\_  
 If yes, please provide Insurance Company & Policy #: \_\_\_\_\_  
 Has prior coverage been on a Claims Made Basis?    [ ] Yes [ ] No    Retroactive date: \_\_\_\_\_  
 Have you ever been cancelled for non-payment?    [ ] Yes [ ] No  
 How long have you been in business? \_\_\_\_\_

**PROPERTY INFORMATION**

Describe your location ( strip plaza, shopping mall, stand alone structure, etc.) \_\_\_\_\_  
 Do you own the building?    [ ] Yes [ ] No    Age of Building \_\_\_\_\_ # of storeys \_\_\_\_\_  
 Total Area of Building(Approx): \_\_\_\_\_ (Sq. Ft)    Area of your Facility: \_\_\_\_\_ (Sq. Ft)

**LATEST UPDATES IF BUILDING IS OVER 25 YEARS OLD ?**

**CONSTRUCTION OF BUILDING**

Roof _____	<b><u>WALL:</u></b>	<b><u>ROOF:</u></b>
Heat _____	[ ] Concrete Block/Masonry	[ ] Steel Deck or Concrete
Plumbing _____	[ ] Brick Veneer over Wood	[ ] Wood Joists
Electric _____	[ ] Frame/Siding	[ ] Metal Clad

Sprinkler System?    [ ] Yes [ ] No    # of Fire Extinguishers: \_\_\_\_\_  
 Burglar Alarm?    [ ] Yes [ ] No    Smoke Detectors    [ ] Yes [ ] No  
 Alarm Monitored 24 hours? [ ] Yes [ ] No    Fire Hydrants within 500 feet? [ ] Yes [ ] No  
**Please Attach copy of Alarm Certificate**    Fire Alarm    [ ] Yes [ ] No

AVERAGE Hours of Operation: \_\_\_\_:\_\_\_\_ to \_\_\_\_:\_\_\_\_    Do you operate 24 hours: [ ] Yes [ ] No  
 Is there Any Bar/Restaurant Adjacent to your operation?    [ ] Yes [ ] No  
 Is there a Variety Store adjacent to your operation?    [ ] Yes [ ] No  
 Do you own, operate, or rent space to associated businesses?    [ ] Yes [ ] No  
 If yes, please describe: \_\_\_\_\_

Describe precautions taken to avoid slips and falls at entrances: \_\_\_\_\_

Who does snow removal? \_\_\_\_\_ Types of steps if any? \_\_\_\_\_

Do you keep salt on hand for de-icing walkways / entrances? [ ] Yes [ ] No,    Do you apply? [ ] Yes [ ] No

## FINANCIAL INFORMATION

Page 2 of 8

USE THE FOLLOWING CATEGORY BREAKDOWNS TO HELP YOU DETERMINE YOUR "PROPERTY VALUES" BELOW:

**STOCK:** Cosmetics \$ \_\_\_\_\_ Hair Care Products \$ \_\_\_\_\_ Skin Care Products \$ \_\_\_\_\_  
Clothes \$ \_\_\_\_\_ Supplements \$ \_\_\_\_\_ Lotions \$ \_\_\_\_\_ Nail Care Products \$ \_\_\_\_\_  
Other Stock not mentioned \$ \_\_\_\_\_ please specify: \_\_\_\_\_

**EQUIPMENT:** Computers \$ \_\_\_\_\_ Laptops \$ \_\_\_\_\_ Signs \$ \_\_\_\_\_ Furniture \$ \_\_\_\_\_  
Massage Tables \$ \_\_\_\_\_ Machines \$ \_\_\_\_\_ Tanning Beds \$ \_\_\_\_\_ Lasers/IPL/RF \$ \_\_\_\_\_

**LEASEHOLDS/TENANTS IMPROVEMENTS:** Offices \$ \_\_\_\_\_ A/C Units \_\_\_\_\_  
Phone/Alarm Systems \$ \_\_\_\_\_ Beauty Styling Chairs \$ \_\_\_\_\_ Change rooms \$ \_\_\_\_\_  
Washroom / Showers \$ \_\_\_\_\_ Construction Costs \$ \_\_\_\_\_  
Existing Tenants Improvements \$ \_\_\_\_\_ Other, please specify \_\_\_\_\_

### **PROPERTY VALUES – COVERAGE YOU REQUIRE (Totals From the Above Categories)**

Building (only if you require coverage) \$ \_\_\_\_\_ Stock \$ \_\_\_\_\_  
Leasehold/Tenant Improvements \$ \_\_\_\_\_ Equipment \$ \_\_\_\_\_  
Other (please specify) \_\_\_\_\_ \$ \_\_\_\_\_

**THE QUOTATION WILL BE BASED ON THE ABOVE INFORMATION. PLEASE COMPLETE ACCURATELY**

### DESCRIPTION OF OPERATIONS

Are client cards/records kept <input type="checkbox"/> Yes <input type="checkbox"/> No	How long are records kept: _____	
Do clients sign a waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	Any client under the age of 18	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you offer Child Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do parents stay on premise at all times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a liquor license? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever serve alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snack Bar on Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use a deep fat fryer?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Are there any operations or activities away from the premises?**  Yes  No

**Do you attend any trade shows/exhibits with your equipment?** ( ) Yes ( ) No

**Do you bring any specialists into your premise to provide additional operations?**  Yes  No

If so, Please advise operations: \_\_\_\_\_

# of Swimming Pools? \_\_\_\_\_ Maximum Depth? \_\_\_\_\_ Diving Boards  Yes  No

	#of units	Non-Slip Flooring?	Rubber Mats In Halls?
Showers <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Whirlpools <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Steam Rooms <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Saunas <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wet or Dry Sauna? \_\_\_\_\_  
Any scorching behind Sauna heating unit?  Yes  No  
How many inches is the heating unit away from the closest wall? \_\_\_\_\_ Inches  
Are there any Squash, Racquetball, Tennis or Basketball Courts  Yes  No, (if yes, please specify) \_\_\_\_\_

### CRIME EXPOSURES

**Maximum amount of cash left on Premises overnight?** \$ \_\_\_\_\_  
If over \$250, do you have a safe?  Yes  No Type of Safe? \_\_\_\_\_

### EQUIPMENT

Do You Have Modified or Rebuilt/Used Equipment?  Yes  No If yes, what is age \_\_\_\_\_  
Is Equipment Inspected Daily?  Yes  No Who Does Maintenance? \_\_\_\_\_

### STERILIZATION

Is staff required to wear sterilized gloves at all times?  Yes  No  
Do you have an autoclave premise?  Yes  No

**★ PLEASE ATTACH A SUPPLEMENTARY PAGE OUTLINING ALL OF YOUR STERILIZATION PROCEDURES AS WELL AS POLICIES IN PLACE TO PREVENT CROSS-CONTAMINATION**

**FINANCIAL INFORMATION**

**LIABILITY INFORMATION** Liability Limits Desired:  \$2,000,000  \$3,000,000  \$5,000,000

Please Provide Approximate Annual Revenues for Each of the Following Services:			
Hair Cutting/Styling	\$ _____	Nail Services	\$ _____
Acid Peels	\$ _____	Aromatherapy	\$ _____
Electrolysis	\$ _____	Laser/IPL/RF	\$ _____
Massage Services	\$ _____	Product Sales	\$ _____
Supplement Sales	\$ _____	Clothing Sales	\$ _____
Tanning Bed	\$ _____	Other -Specify	\$ _____

Body Wraps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Botox/Filler Injection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chiropractors on staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tattoo Removal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear Candling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Facials	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ears Piercing Only	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Electrolysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Makeup - Non-Permanent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Manicure / Pedicure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you perform Pedicures on Diabetics ( ) Yes ( ) No.			If yes please attach separate page describing procedures and precautions.		
Nails - Acrylic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Tag Removal	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you use MMA (Methyl Methacrylate) within the Nail process			Gel Nails	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Therapist on Staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hot Stone Massage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tattooing - Henna	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tattooing –Permanent Body	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tattooing – Spray on	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Toning Beds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spray Tanning	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Acupuncture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wart / Mole Removal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Waxing / Sugaring	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Body/Genital Piercing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Face/ Tongue Piercing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Yoga/Fitness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Naturopath/Homeopath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Supplemental Sales	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ Do you sell any Metabolics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sell products under own label	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ If yes, attach brochure of products available		
Hair Cutting / Coloring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ # of chairs _____ # of operators _____		
Diet / Nutrition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ Follow Canada Food Guide	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reflexology	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ % of gross income _____		
Aqua Massage Beds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ # of units _____		
Acid Peels	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ % of gross income _____ # of operators _____		
Aromatherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ % of gross income _____ # of operators _____		
Sclerotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ % of gross income _____ # of operators _____		
Laser/Light/RF Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ <b>If yes, please complete application - Page #5</b>		
Massage - Registered	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ <b>If yes, please complete application – Page #6</b>		
Massage - Non-Registered	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ <b>If yes, please complete application – Page #6</b>		
Microdermabrasion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ <b>If yes, please complete application – Page #6</b>		
Permanent Makeup	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ <b>If yes, please complete application – Page # 6</b>		
Tanning Beds & Booths	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ <b>If yes, please complete application – Page #7</b>		
Operate a school or training Facility.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	→ <b>If yes attach copy of course outline including instructors qualifications &amp; number of students</b>		

**Any other Services (Not Mentioned Above)** \_\_\_\_\_

Please provide a brochure of your operations, if available, when submitting this application



**LASER//IPL/RF APPLICATION**

1 Please advise if you provide the following laser/IPL operations:

Laser  Yes  No                      RF ( )Yes ( ) No                      Pulse Light  Yes  No

2 Please provide all operators who provide **Laser/Light/RF** treatment and their experience:

NAME PERSON PROVIDING LASER/IPL TREATMENTS	YEARS OF EDUCATION	YEARS EXPERIENCE/ QUALIFICATION	ANY PRIOR CLAIMS MADE AGAINST EACH INDIVIDUAL PLEASE GIVE DETAILS

3 Please circle what skin types you provide services on:

As per the Fitzpatrick Scale:                      1                      2                      3                      4                      5                      6

- 4 Do you complete a patch test at least 24 hours prior to laser hair removal operations?                       Yes  No
- 5 Do you wear surgical gloves when providing laser services to clients?                       Yes  No
- 6 Does your client wear protective eyewear during laser services?                       Yes  No
- 7 Do you keep copies of all client service records for a minimal 7 years?                       Yes  No
- 8 Is a waiver signed, dated and kept on record for 7 years?                       Yes  No
- 9 Do you explain to the client what steps to take prior to any laser treatment                       Yes  No
- 10 Do you explain to the client what steps to take after any laser treatment?                       Yes  No
- 11 Are Laser/IPL/RF machines used to for hair removal?                       Yes  No
- Spider Vein Treatments?                       Yes  No
- Acne                       Yes  No
- Any ablative/Invasive treatments?                      ( )Yes ( ) No
- List all other treatments \_\_\_\_\_

12 What is the minimum age of clients \_\_\_\_\_yrs

13 Complete this section for all laser/IPL/RF systems (attach an additional page if necessary)

MAKE	MODEL & SERIAL NUMBER	AGE	LIST PRICE NEW INCLUDING ATTACHMENTS/HANDPIECES
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$

14 Have all operators listed had training on the above laser/IPL/RF machine(s) and is the equipment being used in accordance with the manufacturers specifications ( ) YES ( ) NO

15 Is your laser machine leased or financed? If yes, from whom? Provide Company name and full address \_\_\_\_\_

16 How often do you calibrate your machines? \_\_\_\_\_

17 Please list all locations, methods of transporting equipment and frequency of all off-site treatments:

\_\_\_\_\_

\_\_\_\_\_

18 Do you lease or rent your machine to other individuals / businesses? ( ) YES ( ) NO

If yes to whom and how often (attach list if needed) \_\_\_\_\_

If the machine is left overnight do all locations have a monitored alarm system? ( ) YES ( ) NO

Any person who knowingly and with intent to defraud any insurance company or another person, files and application containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects this person to criminal and civil penalties.

Date \_\_\_\_\_

Signature \_\_\_\_\_

**MASSAGE THERAPY:**

- 1 What type(s) of Massage do you perform? \_\_\_\_\_
  - 2 Do you offer Hot Stone massage ( ) Yes ( ) No
  - 3 Number of years of experience? \_\_\_\_\_ years
  - 4 Are you a RMT? [ ] Yes [ ] No
  - 5 Do you collect and discuss the client's health information? [ ] Yes [ ] No
  - 6 Is client's health information saved for at least 7 years? [ ] Yes [ ] No
  - 7 Is a waiver signed, dated and kept on record for at least 7 years? [ ] Yes [ ] No
  - 8 Have you ever had a claim made against you? [ ] Yes [ ] No
- If so, please advise: \_\_\_\_\_

**ELECTROLYSIS, ACID PEELS & MICRODERMABRASION:**

- 1 Do you use an autoclave to sterilize equipment? [ ] Yes [ ] No
  - 2 Does all staff wear surgical gloves when performing services? [ ] Yes [ ] No
  - 3 Do you use disposable tips for each new client? [ ] Yes [ ] No
  - 4 Do you provide peels over 30% Glycolic Acid [ ] Yes [ ] No
  - 5 Do you client sign a waiver? [ ] Yes [ ] No
  - 6 Do you collect and discuss the client's health information? [ ] Yes [ ] No
  - 7 The number of year's client's information is saved? \_\_\_\_\_ years
  - 8 Have you ever had a claim made against you? [ ] Yes [ ] No
- If so, please advise: \_\_\_\_\_
- 9 Please circle what skin types you provide services on:  
 As per the Fitzpatrick Scale:                      1        2        3        4        5        6
- 10 What is the minimum age of client's \_\_\_\_\_ yrs.

**PERMANENT MAKEUP**

- 1. Number of Staff that are providing this service \_\_\_\_\_
- 2. Estimated Receipts for Permanent Make-up \_\_\_\_\_
- 3. Years of experience for each individual \_\_\_\_\_
- 4. Education/Training: Where were you trained? \_\_\_\_\_. Do you have a Certificate for this service? \_\_\_\_\_ If yes, from who? \_\_\_\_\_
- 5. Do all clients sign a waiver/release form? \_\_\_\_\_
- 6. Do you perform a patch test for allergies? \_\_\_\_\_
- 7. Do you use disposable products only? \_\_\_\_\_
- 8. Describe sterilization procedure \_\_\_\_\_
- 9. Other than eyes and lips, do you perform services on any other areas of the body [ ] Yes [ ] No If yes, please specify \_\_\_\_\_
- 10. What type of dye do you use? \_\_\_\_\_ Where do you purchase it ? \_\_\_\_\_
- 11. Do you manufacturer or sell your own permanent makeup product to others \_\_\_\_\_

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Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**★ PLEASE ATTACH A SUPPLEMENTARY PAGE OUTLINING ALL OF YOUR STERILIZATION PROCEDURES AS WELL AS POLICIES IN PLACE TO PREVENT CROSS-CONTAMINATION**

**TANNING OPERATIONS****EQUIPMENT:**

	# of Units	Intensity	Manufacturer	Type of timer (digital, manual, etc.)	Where are timing controls located?
Beds	_____	_____	_____	_____	_____
Booths	_____	_____	_____	_____	_____
Facial Units	_____	_____	_____	_____	_____
Spray Booths -	# of Units _____	_____	_____	_____	_____
Air Brush -	# of Units _____	_____	_____	_____	_____

Total cost to replace all tanning beds / booths with new equipment: \$ \_\_\_\_\_

Average age of beds? \_\_\_\_\_ Do licensed electricians service the equipment?  Yes  No

How often inspected? \_\_\_\_\_ Are beds cleaned after every use?  Yes  No

Who changes the bulbs? \_\_\_\_\_

Do you have laundry facilities for towels?  Yes  No

If so, how often are exterior dryer vents cleaned? \_\_\_\_\_

**TANNING PROCEDURE:**

Are employees permitted to touch clients?  Yes  No

Are clients given tanning instruction?  Yes  No

Do you use Accelerators?  Yes  No

Unlimited Tanning offered?  Yes  No

If yes, what system is in place to prevent over exposure? \_\_\_\_\_

Average number of clients annually \_\_\_\_\_

Do you have all clients sign a waiver?  Yes  No

Are children left unattended?  Yes  No

Do you use Skin analysis/evaluation with clients?  Yes  No

Are staff trained and certified by Smart Tan  Yes  No

Are goggles supplied & REQUIRED to be used?  Yes  No

Min. age of clients \_\_\_\_\_

Do you keep a record of your clients tanning sessions?  Yes  No

If yes, how? \_\_\_\_\_

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**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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PRIVACY CLAUSE

Our brokerage and the insurance industry have a solid track record of respecting your right to privacy and safeguarding your personal information. As a result of federal legislation, we've further strengthened our privacy commitment by informing you of why and how we collect, use and disclose your personal information. You can be assured that we'll only handle your personal information in a manner that a reasonable person would consider appropriate in the circumstances.

The Client hereby acknowledges that by completing and returning the application to Sound Insurance Services Inc., you agreed to and consent to the collection, use and disclosure of such information, including any personal information, by Sound Insurance Services Inc. for the following purposes:

- Communicating with you
- Assessing your application for insurance
- Disclosing information to the Insurance Companies
- Negotiating, maintaining or renewing insurance on your behalf
- Providing claims assistance and service
- Advising you of other products or services
- Complying with regulations and legal authorities

***Please do not hesitate to contact our Privacy Officer should you have any questions.  
Our Privacy Officer may be contacted as follows:***

**JEYA YOGANANTHAM**

<b>Name of Organization:</b>	Sound Insurance Services Inc.
<b>Address:</b>	205 Lesmill Road, Toronto, ON M3B 2V1
<b>Telephone:</b>	416-756-3334
<b>Fax:</b>	416-756-1635
<b>Email:</b>	jeyay@soundinsurance.ca

For more information about our privacy policies or to obtain a copy of our privacy policy, please visit our website at [www.soundinsurance.ca](http://www.soundinsurance.ca).