

BEAUTY SALON APPLICATION

- 1.1 Applicant Name: _____ Phone: _____
 Business Name: _____ Website: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Business Address: _____ County: _____
 Business operated as: Corporation Partnership Individual Independent Contractor
- 1.2 How long in business? _____ Square Feet: _____
- 1.3 Do you have operations not listed on the schedule? ___ If yes, provide details: _____
 Do you have insurance for these operations? _____ Name of insurance company: _____
- 1.4 Products liability needed? _____ Gross receipts (excluding private label): _____
 Do you private-label products for sale? _____ (No coverage is provided for private label products)
- 1.5 Have you ever experienced a liability claim arising from any professional activity whether or not insured?
 Yes No (If yes provide details on separate sheet)
- 1.6 Do you use any products in your facility that contains 2% or more of formaldehyde? Yes No
 If yes provide details on products being used: _____

SCHEDULE OF SERVICES

<u>Category</u>	<u>Number to be Insured</u>
1. Beautician/Barber (Hair & Nails) Include Names of Individuals	_____
2. Waxing	_____
3. Body Wrap	_____
4. Massage	_____
5. Eyelash & Brow Enhancements	_____
6. Topical Makeup Application	_____
7. Facials, Peels? Include Microdermabrasion <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Maximum Glycolic 40%)</i>	_____
8. Electrology	_____
9. Other: (Describe) _____	_____

TOTAL NUMBER OF OPERATORS

- | | | | | | |
|---|--------------------------|-------------------------------------|--------------------------|----|----------------------------|
| 2.1 Have you been trained in massage? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | |
| 2.2 Do you offer hot stone massage? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | |
| 2.3 Have you been trained in microdermabrasion? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | |
| 2.4 Do you use a consent form for microdermabrasion? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | (If yes, attach copy) |
| 2.5 Do you have Saunas/Steam Rooms | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | If yes, # to Insure: _____ |
| | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | If yes, # to Insure: _____ |
| | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | If yes, # to Insure: _____ |
| 2.6 Do you want coverage for sexual abuse?
(If yes choose limit) | <input type="checkbox"/> | \$50,000 Aggregate/\$25,000 Claim | | | |
| | <input type="checkbox"/> | \$100,000 Aggregate/\$50,000 Claim | | | |
| | <input type="checkbox"/> | \$200,000 Aggregate/\$100,000 Claim | | | |

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

<u>Category</u>	<u>Number to Insure</u>	<u>Category</u>	<u>Number to Insure</u>
1. UV Tanning Units	_____	4. Laser/IPL/LED Units	_____
2. Permanent Makeup	_____	5. Airbrush Tanning Units	_____
3. Needling/MCA	_____	6. Body Tattoo/Piercing	_____

PART IV. HISTORY

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

4.1 Do you currently have insurance coverage? ___ Yes ___ No If yes, indicate the following:
Insurer Policy # Liability Limits Premium Exp. Date

If claims made, most recent retroactive date: _____

4.2 List liability claims history arising from any tanning, permanent makeup, beauty, health or other professional activity, whether or not insured: If none, state so _____
YR/Claim Nature of injuries Equip. Involved Details, if Pending Amt. if settled

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 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, describe details of the event:

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

APPLICANT SIGNATURE TITLE

DATE REQUESTED EFFECTIVE DATE LIABILITY LIMIT REQUESTED

One box below must be checked:

- I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM
- I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

ADDITIONAL INSURED: @ \$30 Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.
NAME: _____
ADDRESS: _____
Relationship to your business (Landlord, lienholder): _____

SCHEDULE OF SERVICES

Indicate which services you provide, the number of operators and if we are to insure them. **Independent contractors are not covered unless coverage is specifically extended to them.**

INSURE WITH US?

MANICURISTS	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
BEAUTICIANS	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
BROW/LASH ENHANCEMENT	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
FACIALS	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Include Peels? Yes No

List products & percentage of acids if including peels: _____

MICRODERMABRASION	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
LED/MICROCURRENT	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
WAX REMOVAL	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are all the facialists doing wax removal as well? Yes No

BODY WRAPS	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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List the type of wraps you use: _____

MASSAGE	NUMBER _____	CERTIFIED? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
ELECTROLOGY	NUMBER _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
EAR PIERCING	NUMBER _____		<input type="checkbox"/> Yes <input type="checkbox"/> No

Indicate gross receipts from Ear Piercing: _____

AIRBRUSH TANNING	UNITS _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
PRODUCTS	Gross Receipts: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are Products Privately Labeled by you? Yes No If yes a separate application is required.

PERM. MAKEUP	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
TEACHING	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
CAMOUFLAGE	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

PIGMENT REMOVAL /LIGHTENING SALINE REJUVI ELIMININK

NEEDLING / MCA	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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MCA = Multitrepanic Collagen Actuation

BODY TATTOO	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

UV TANNING – UNITS	UNITS _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If including tanning, complete the tanning bed supplement application

BODY PIERCING	NUMBER _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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LIABILITY LIMIT REQUESTED: _____ NUMBER OF OPERATORS: _____

IMPORTANT: SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. Coverage becomes effective only when accepted by the insurance company.

APPLICANT

TODAY'S DATE