BEAUTY SALON APPLICATION

1.1 Applicant Name:_____ Phone:_____

Business Name:_____ Website:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Business Address:_____ County:_____

Business operated as: ☐ Corporation ☐ Parternship ☐ 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

Category	Number to be Insured
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 ☐ **Yes** ☐ **No** *(Maximum Glycolic 40%)*	_____
8. Electrology	_____
9. Other: (Describe) _____	_____
TOTAL NUMBER OF OPERATORS	_____

2.1 Have you been trained in massage? ☐ Yes ☐ No
2.2 Do you offer hot stone massage? ☐ Yes ☐ No
2.3 Have you been trained in microdermabrasion? ☐ Yes ☐ No
2.4 Do you use a consent form for microdermabrasion? ☐ Yes ☐ No (If yes, attach copy)
2.5 Do you have Saunas/Steam Rooms ☐ Yes ☐ No If yes, # to Insure:_____
Soaking Pools ☐ Yes ☐ No If yes, # to Insure:_____
Showers? ☐ Yes ☐ No If yes, # to Insure:_____
2.6 Do you want coverage for sexual abuse? ☐ Yes ☐ No

(If yes choose limit) ☐ $50,000 Aggregate/$25,000 Claim
☐ $100,000 Aggregate/$50,000 Claim
☐ $200,000 Aggreagte/$100,000 Claim

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

Category	Number to Insure	Category	Number to Insure
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**

☐ **1 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_____ ☐ Yes ☐ No

BEAUTICIANS NUMBER_____ ☐ Yes ☐ No

BROW/LASH ENHANCEMENT NUMBER_____ ☐ Yes ☐ No

FACIALS NUMBER_____ ☐ Yes ☐ No

Include Peels? ☐ Yes ☐ No

List products & percentage of acids if including peels: _____

MICRODERMABRASION NUMBER_____ ☐ Yes ☐ No

LED/MICROCURRENT NUMBER_____ ☐ Yes ☐ No

WAX REMOVAL NUMBER_____ ☐ Yes ☐ No

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

BODY WRAPS NUMBER_____ ☐ Yes ☐ No
List the type of wraps you use:_____

MASSAGE NUMBER_____ CERTIFIED?_____ ☐ Yes ☐ No

ELECTROLOGY NUMBER_____ ☐ Yes ☐ No

EAR PIERCING NUMBER_____ ☐ Yes ☐ No

Indicate gross receipts from Ear Piercing:_____

AIRBRUSH TANNING UNITS_____ ☐ Yes ☐ No

PRODUCTS Gross Receipts:_____ ☐ Yes ☐ No

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

PERM. MAKEUP NUMBER_____ ☐ Yes ☐ No

TEACHING NUMBER_____ ☐ Yes ☐ No

CAMOUFLAGE NUMBER_____ ☐ Yes ☐ No

PIGMENT REMOVAL /LIGHTENING ☐ **SALINE** ☐ **REJUVI** ☐ **ELIMININK**

NEEDLING / MCA NUMBER_____ ☐ Yes ☐ No
MCA = Multitrepanic Collagen Actuation

BODY TATTOO **NUMBER**_____ ☐ Yes ☐ No

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

UV TANNING – UNITS UNITS_____ ☐ Yes ☐ No

If including tanning, complete the tanning bed supplement application

BODY PIERCING NUMBER_____ ☐ Yes ☐ No

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