

OPERATOR/SALON APPLICATION

Applicant Name: _____ Phone: _____
Business Name: _____
Email Address: _____ Website: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Business Address #1: _____
City: _____ State: _____ Zip Code: _____
Type of Facility: _____ Square Footage: _____
Business Address #2: _____
City: _____ State: _____ Zip Code: _____
Type of Facility: _____ Square Footage: _____

Business operated as: Corporation LLC LLP Partnership Individual Independent Contractor
How long in business? _____ Annual gross receipts from all operations? _____
Products liability needed for take home products sold by you? Yes No Gross receipts (excluding private label) _____
Do you private label products for sale? Yes No *If yes, this requires a separate application for coverage.*
Landlord, Lessor, Entity to be _____
named as Additional Insured: _____
Do you need General Liability? Yes No If no, what Company insures your General Liability coverage?: _____

Do you have:

Saunas/Steam Rooms? Yes No Number _____

Soaking Pools? Yes No Number _____

Showers? Yes No Number _____

<u>BEAUTY SERVICES</u>	<u>Category – Pick the best ONE for each technician</u>	<u>Number to be Insured</u>
Beauticians		_____
Massage Therapist		_____
Aesthetician		_____
Advanced Aesthetician		_____

TOTAL NUMBER OF OPERATORS _____

DEFINITIONS

- * **BEAUTICIANS:** Hair, Nails, Eyelash & Brow Enhancements, Sugaring, Waxing, Threading, Topical Makeup Application
- * **MASSAGE THERAPIST:** Massage, Body Wraps, Endermologie
- * **AESTHETICIANS:** All Beautician services AND Facials, Aesthetic Peels, Body Wraps, Massage, Electrology, Microdermabrasion, Ear Piercing, Airbrush Tanning, Aesthetic Body Treatments, Needling/Collagen Induction Therapy

In addition to the above, if anyone is performing the following please indicate:

Advanced Aesthetician Procedures: Medical Grade Peels LED/Microcurrent Non-invasive Ultrasound
 Aesthetic Radio Frequency Dermaplaning Ear Candling Skin Tag Removal Wart Removal

Please provide Names of Advanced Aestheticians: _____

OTHER COVERAGES

Do you want coverage for Sexual Abuse? Yes No
Limit Desired: \$25,000 Per Occ/\$50,000 Agg \$50,000 Per Occ/\$100,000 Agg \$100,000 Per Occ/\$200,000 Agg

Do you want to include \$50,000 Indemnity Coverage for Communicable Disease? Yes No

If you provide any of the following, please indicate below. These services may require separate applications to provide coverage.

UV Tanning Units # _____ Foot Detox Units # _____ Decorative Tattooing # _____ Body Piercing # _____
Teaching # _____ Laser/Intense Pulsed Light # _____ Permanent Makeup # _____ Medical Radiofrequency # _____

Are there ANY other services or operations not listed on this application that are present in your facility? Yes No

If yes, please describe: _____

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HISTORY

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

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: _____

List liability claims history arising from any body piercing, tattoo, permanent makeup 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*

Do you have knowledge of an event, circumstance or occurrence (other than listed above) prior to the effective date of the proposed policy, or are you aware that a claim may be brought as a result of said event, circumstance or occurrence?

_____ Yes _____ No. If yes, describe details of the event:

ATTESTATION

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 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 is not 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.

By signing below, I confirm on behalf of all technicians covered under this policy:

1. Technicians are licensed as necessary for all services being provided.
2. Technicians do not use any product that contains more than 2% formaldehyde.
3. I understand that no service or individual is covered unless listed and a premium paid.
4. That all technicians have been trained for the service they are performing or on the device they are using.

APPLICANT SIGNATURE

TITLE

DATE SIGNED

REQUESTED EFFECTIVE DATE

LIABILITY LIMIT REQUESTED

Can we email you your policy (usually within 2-3 weeks) Yes No _____ @ _____

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