

TANNING & BEAUTY SALON/OPERATOR APPLICATION

- 1.1 Applicant Name: _____ Phone: _____
 Business Name: _____ Website: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Business Address: _____
- 1.2 Business operated as: Corporation Partership Individual Independent Contractor
- 1.3 Business operated as salon? _____ If not, other: _____
- 1.4 How long in business? _____ Do all professionals have licenses? _____
- 1.5 Do you have operations not listed on the schedule? ___ If yes, provide details: _____
 Do you have insurance for these operations? _____ Name of insurance company: _____
- 1.6 Products liability needed? _____ Gross receipts (excluding private label): _____
 Do you private-label products for sale? _____ (No coverage is provided for private label products)

SCHEDULE OF SERVICES

Indicate which services you provide, number of operators who do the service and if we are to insure them.

				<u>INSURE?</u>
MANICURISTS	YES/NO	NUMBER _____		_____
BEAUTICIANS	YES/NO	NUMBER _____		_____
FACIALS	YES/NO	NUMBER _____		_____
List products you use and percentage of acids: _____				
Have you had training on the peels you are using? _____				
MICRODERMABRASION	YES/NO	NUMBER _____		_____
Have you been trained in microdermabrasion?			YES/NO	_____
Do you use a consent form for microdermabrasion?			YES/NO (If yes, attach copy)	_____
WAX REMOVAL	YES/NO	NUMBER _____		_____
Are all the facialists doing wax removal as well?			YES/NO	_____
BODY WRAPS	YES/NO	NUMBER _____		_____
List the type of wraps you use: _____				
MASSAGE	YES/NO	NUMBER _____		_____
Have you been trained in massage?			YES/NO (If yes, attach copy)	_____
ELECTROLOGY	YES/NO	NUMBER _____		_____
EAR PIERCING	YES/NO	NUMBER _____		_____
TANNING - AIRBRUSH	YES/NO	UNITS _____		_____
<u>FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED</u>				
TANNING - UNIT	YES/NO	UNITS _____		_____
PERMANENT MAKEUP	YES/NO	NUMBER _____		_____
NEEDLING / MCA (MCA= Multitrepannic Collagen Actualtion)	YES/NO	NUMBER _____		_____
LASER / INTENSE PULSED LIGHT	YES/NO	NUMBER _____		_____
LED UNIT(S)	YES/NO	NUMBER _____		_____
PIGMENT REMOVAL / LIGHTENING	YES/NO	NUMBER _____		_____
BODY TATTOO	YES/NO	NUMBER _____		_____
BODY PIERCING	YES/NO	NUMBER _____		_____
TOTAL NUMBER OF TECHNICIANS TO BE INSURED			NUMBER _____	

TANNING BED SUPPLEMENT APPLICATION

BUSINESS NAME: _____

Complete address where beds are located: _____

1. What type of lighting is used? UVA UVB
What is the percentage of UVB? _____
2. What is the maximum exposure time for tanning? _____
3. Are goggles worn by ALL CLIENTS? _____
4. Are timer controls set by user? _____ Salon Operator? _____ Tokens? _____
5. Are beds tested daily to ensure switches & timers are operating properly? _____
6. Number of beds: _____ Number of booths: _____
7. Manufacturer of each bed/booth: _____

8. Is U.L. label on each bed? _____
9. Does applicant restrict use to once every 24 hours? _____
10. Do you use customer history cards? _____ If yes, enclose a copy of your form.
How long are client records kept? _____ (must be a minimum of 3 years.)
11. Do you use a drug reaction list? _____ If yes, enclose a copy of your form.
12. Do you have the FDA Warning Sign posted as required by law: _____

I affirm all the above to be true:

Signed: _____ Date: _____

(Note signatures on application are only valid for 30 days, after 30 days all apps will need to be re-signed and dated)

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): _____