

CALIFORNIA BARBER & BEAUTY INDEPENDENT CONTRACTOR PROGRAM APPLICATION Insurance Package Policy

SECTION I – GENERAL INFORMATION

PLEASE COMPLETE EVERY ITEM OR INDICATE N/A

1. Name of Applicants: _____ d/b/a: _____	Proposed Effective Date: _____
2. Mailing Address: _____ (Street) _____ (City) (State) (Zip Code) Establishment Name: _____ Location Address: _____ (Street) _____ (City) (State) (Zip Code)	
3. Phone Number: _____ Alternate Phone Number: _____	
4. Web Site Address: _____ Email Address: _____	
5. Business Type: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Corporation <input type="checkbox"/> Other: _____	
6. How many years in business under the above name? _____	
7. Have you operated or traded under any other business name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide explain: _____	
8. List any professional associations of which you are a member: _____	
9. Do you attend business related trade shows? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many per year: _____	
10. Are you required to name any other person or entity as an additional insured on your policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide name, address and interest: _____	

SECTION II – PROFESSIONAL SERVICES PLEASE COMPLETE EVERY ITEM OR INDICATE N/A

1. Professional Designation: <input type="checkbox"/> Barber <input type="checkbox"/> Cosmetologist <input type="checkbox"/> Manicurist <input type="checkbox"/> Electrologist <input type="checkbox"/> Esthetician <input type="checkbox"/> Massage Therapist	
2. Are you licensed per state guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. What are your estimated gross annual receipts? \$ _____ What percentage of the above is from product sales? _____ % What percentage of the above is from Barber/Beauty Services? _____ %	
4. Do you sell products or provide any services that are not normal or customary to the beauty industry? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____	
Do you provide any of the following services:	
5. Ear Piercing <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the estimated number per year? _____	
6. Waxing, Skin Peels, and Body Wraps <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the estimated number of weekly treatments scheduled? _____	
7. Electrolysis <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the Electrolysis Supplemental Application	
8. Microdermabrasion <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the Microdermabrasion Supplemental Application	
9. Tanning – Full, Body, Facial, Spray <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the Tanning Supplemental Application	

- 10. Chiroprody or Podiatry Yes No
 - 11. Face lifting, removal of warts, moles or growths Yes No
 - 12. Body Piercing (other than ear) Yes No
 - 13. Permanent Makeup Yes No
 - 14. Wigs, Hair Implanting, Hair Transplanting Yes No
 - 15. Saunas or Steam Baths Yes No
 - 16. Laser hair removal Yes No
 - 17. Eyelash & Eye Brow Tinting Yes No
 - 18. Weight Control Services or Nutritional Counseling Yes No
 - 19. Do you provide any other services not described above? Yes No
- If yes, please describe: _____

SECTION III – TOOLS AND EQUIPMENT COVERAGE PLEASE COMPLETE EVERY ITEM OR INDICATE N/A

Limit of Insurance: \$ _____ Please describe any item valued over \$2,500: _____

SECTION IV – PRIOR INSURANCE AND CLAIMS INFORMATION PLEASE COMPLETE EVERY ITEM OR INDICATE N/A

1. Please provide prior insurance information.

Insurance Company	Policy Period	Limits of Liability	Premium	Occurrence or Claims Made

2. Have you, or any other person for whom coverage is being requested, had any liability applications denied, policies cancelled, or policies not renewed in the past three (3) years? Yes No
 If yes, please provide complete details: _____

3. Have you, or any other person for whom coverage is being requested, had a license or certification ever been investigated, limited, revoked, suspended, cancelled or voluntarily surrendered by, or to, any state or federal licensing board or regulatory agency? Yes No
 If yes, please provide complete details: _____

4. Have you, or any other person for whom coverage is being requested, had any claims in the past five years? Yes No
 If yes, please complete the following in detail. If needed, attach another sheet with the details.

Date of Claim	Description of Claim	Open/Closed	Amount Paid or Reserved

5. Are you, or any other person for whom coverage is being requested, aware of any circumstances which may result in a claim? Yes No
 If yes, please provide full details: _____

Applicants Warranty:
 Applicant warrants that all operations meet the requirements as published under Article 12: Health and Safety of the California State Board of Barbering and Cosmetology Code of Regulations.

 Applicant's Name (Please Print) Title

 Applicant's Signature Date

 Submitting Producer Date

IMPORTANT: THIS IS NOT A BINDER OR OFFER OF COVERAGE