

SALON APPLICATION

Applicant Name: _____ Phone Number: _____

Business Name: _____

Email Address: _____ Website: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Business Address (1): _____

City: _____ State: _____ Zip code: _____

County: _____ Square Footage: _____

Business Address (2): _____

City: _____ State: _____ Zip code: _____

County: _____ Square Footage: _____

Business operated as: Corporation LLC LLP Partnership Individual Independent Contractor

How long in business? _____ Annual gross receipts from all operations? _____

Are you in compliance with all city, county, state ordinances? Yes No

Do you need General Liability? Yes No If no, what Company insures your General Liability coverage? _____

Are you required to name any other person or entity as an Additional Insured on your Policy? Yes No

a. If Yes, Please provide Name and Address: _____

b. What is the interest of the Additional Insured? Landlord City or Government Agency Lessor Franchisor
 Other: _____

c. Does the additional Insured require the following: Primary/ Non Contributory Wording Waiver of Subrogation

Products Liability needed for take home products sold by you Yes No Gross receipts (excluding private label): _____

Do you sell non - beauty related products? Yes No If Yes, Describe: _____

Do you private label products for sale? Yes No *If Yes, requires separate application*

Indicate number in your facility:

Saunas/Steam Rooms: _____ Soaking Pools: _____ Showers: _____ UV Tanning Units: _____

<u>Schedule of Services</u>	<u>Number to be Insured</u>
Manicurist: <i>Nails and Related Services</i>	
Beauticians and/or Barbers: <i>Hair, Eyebrow Tinting</i>	
Cosmetologist: <i>Topical Makeup, Eyelash & Eyebrow Extensions/Tinting, Threading, Waxing, Sugaring (includes Hair & Nails)</i>	
Massage Therapist: <i>Massage, Body Wraps, Endermologie, Reiki</i>	
Aesthetician: <i>If Yes, Mark ALL that apply</i>	
<input type="checkbox"/> Facials <input type="checkbox"/> Aesthetic Grade Peels <input type="checkbox"/> Spray Tanning <input type="checkbox"/> Needling/Collagen Induction Therapy <input type="checkbox"/> Electrology <input type="checkbox"/> Microdermabrasion <input type="checkbox"/> LED/Microcurrent <input type="checkbox"/> Medical Grade Peels	
Total Number of Operators:	

If you provide any of the following, please indicate how many operators – *will require separate application*

Decorative Tattooing: _____ Body Piercing: _____ Yoga/Personal Trainers: _____

Laser/Intense Pulse Light: _____ Permanent Makeup: _____ Medical Radio Frequency: _____

Other not listed on application: _____

Other Coverages: *additional premium may apply*

Do you want coverage for Non-Owned Or Hired Auto? Yes No *If Yes, Separate Supplement Required*

Do you want coverage for Sexual Abuse Yes No *If Yes, indicate limits desired*

\$25,000 Per Occ./ \$50,000 Agg \$50,000 Per Occ./ \$100,000 Agg. \$100,000 Per Occ./ \$200,000 Agg.

SALON APPLICATION

Property Section: Complete for EACH location **Check Here if not Desired**

Age of Building: _____ Construction: _____ Number of stories: _____

If building is over 20 years old, when were the following upgraded? **(*) information required**

*Roof: _____ *Plumbing: _____ *Wiring: _____ Sprinklers: Yes No

*Is there a Central Station Burglar Alarm: Yes No If Yes, advise Alarm Provider: _____

*If Yes, is the aforementioned alarm inside your unit and in your control? Yes No

Other Occupancies in building? (describe): _____

Adjoining Occupancies: Left: _____ Right: _____

Approximate distance from fire station: _____ Distance from fire hydrant: _____

Do you sell or use jewelry? Yes No If Yes, Jewelry Value (\$): _____

Name and address of Loss Payee: _____

Coverage Desired:

Contents: \$: _____

Tenant Improvements: \$: _____

Building: \$: _____ Do you own the Building? Yes No

Business Interruption: \$: _____ Amount per month: _____

Sign: \$: _____

History: *Note – ALL questions must be answered. Failure to disclose claims history could invalidate coverage*

Do you Currently have Insurance coverage Yes No

<i>Insurer</i>	<i>Policy #</i>	<i>Liability Limits</i>	<i>Premium</i>	<i>Exp. Date</i>
_____	_____	_____	_____	_____

If Claims Made, most Recent Retroactive Date: _____

List any Professional, General Liability or Property Claims history below, whether or not insured **If None, Check Here**

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 an result of said event, circumstance or occurrence? If Yes, Describe Event Yes No

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. 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
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DATE SIGNED	REQUESTED EFFECTIVE DATE	LIABILITY LIMIT REQUESTED
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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 AN ADDITIONAL PREMIUM

I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT AN ADDITIONAL PREMIUM