

Professional
Program
Insurance
Brokerage

www.tattoo-ins.com &
www.medispa-ins.com

Dear Sir or Madame:

Thank you for your interest in our insurance program for the Beauty Industry. Enclosed is the information on our program you have requested.

To order coverage, please send the following items:

1. Completed, signed application
2. The full payment if the premium is under \$500,
or 25% plus fees to finance if it is over \$500.
Note the minimum premium is \$500 + taxes and \$200 broker fee.

If you are doing permanent makeup or you have lasers or light devices of any type, we will need to send you a separate application and pricing outline. Also we have a separate Medispa Program.

Thank you for your response.

Sincerely,

Susan Preston
Professional Program Insurance Brokerage

BEAUTY SALON/OPERATOR APPLICATION

- 1.1 Applicant Name: _____ Phone: _____
 Business Name: _____ email: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Business Address: _____
- 1.2 Business operated as: Corporation Partnership 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

<u>Category</u>	<u>Number to be Insured</u>
1. Aesthetician Multiple Services	_____
2. Aesthetician Including Microdermabrasion	_____
3. Aesthetician Single Service List Service: _____	_____
4. Beautician/Nail Technician	_____
5. Electrology (Excluding All Other Services)	_____
6. Massage (Excluding All Other Services)	_____
7. Other: (Describe) _____	_____
TOTAL NUMBER OF OPERATORS _____	
(Must add up to the numbers in column)	

Definitions – PLEASE CIRCLE ALL SERVICES YOU ARE PROVIDING

- * AESTHETICIAN: Facials, Peels, Waxing, Eyelash & Brow Enhancements, Body Wraps, Hair, Nails, Massage, Electrology
 * BEAUTICIANS: Hair, Nails, Eyelash & Brow Enhancements

- 2.1 Have you been trained in microdermabrasion? Yes No
 2.2 Do you use a consent form for microdermabrasion? Yes No (If yes, attach copy)
 2.3 Have you been trained in massage? Yes No
 2.4 Do you have Sauna's, Soaking Pools, Steam Rooms, or Showers? Yes No If yes, # to Insure: _____

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

<u>Category</u>	<u>Number to Insure</u>	<u>Category</u>	<u>Number to Insure</u>
1. Tanning Units UV & Airbrush	_____	5. Laser/IPL	_____
2. Permanent Makeup	_____	6. LED Unit(s)	_____
3. Needling/MCA	_____	7. Ear Piercing	_____
4. Pigment Removal/Lightening	_____	8. 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
- 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): _____

LED/MICROCURRENT SUPPLEMENT

- 1.1 Applicant name: _____ Phone: _____
Business name: _____
- 1.2 Are you in compliance with all FDA & state laws as to use of LED & Microcurrent devices? _____
- 1.3 Do you have everyone sign a consent form? _____ We must receive a copy of the form(s) you use.
- 1.4 Do you use a medical history form on everyone? _____ If so, provide a copy
- 1.5 Do you provide goggles for all LED & Microcurrent work on faces? _____

OPERATOR INFORMATION

- 2.1 OPERATOR TO BE NAMED: _____
- 2.2 Licenses you hold & license numbers: _____
- 2.3 How long have you been working with LEDs? _____ With Microcurrents? _____
- 2.4 What specific LED/Microcurrent equipment do you want to insure? _____

2.5 List all training in LED & Microcurrent equipment: _____

2.6 What services do you offer with the LED & Microcurrent: _____

2.7 What type of services, not listed above, do you offer? _____

2.8 List all claims history whether or note insured: If none, state so _____.

YR/Claim	Nature of injuries	Equip. Involved	Details, if Pending	Amt. if settled
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2.9 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 the details of the event:

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 COMPANY

APPLICANT

TODAY'S DATE