

CLICK HERE TO SUBMIT

CLICK HERE TO PRINT AND FAX TO 415-475-4303

PERMANENT COLOR LIABILITY INSURANCE APPLICATION

PART I. GENERAL INFORMATION

- 1.1 Your Name: _____ Phone: _____
Your Business Name: _____ Email address: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Business Address #1: _____
Business Address #2: _____ Add premises liability?
(There is an additional charge if premises liability is needed for more than one location.)
- Are you a broker? If yes, provide the following:
- | <i>Agency Name</i> | <i>Contact Name</i> | <i>Agency Address</i> | <i>Agency Email</i> | <i>Agency Phone</i> |
|--------------------|---------------------|-----------------------|---------------------|---------------------|
| | | | | |
- 1.2 Working as: Sole Proprietorship Partnership Corporation Employee
- 1.3 Type of business (where equipment is located): Salon Clinic Independent, multiple locations, Number _____
Other, describe _____
- 1.4 Are you in compliance with all city, county and/or state ordinances?
Business License No. _____ (Attach copy)
- 1.5 How long in business applying permanent color? _____
- 1.6 Have you had formal instruction in the application of permanent color: Yes No
If Yes, attach all certificates of training. If no, attach description of training and experience.
- 1.7 How many procedures have you performed in the past 12 months for the following:
Eyeliner _____ Eyebrows _____ Lipliner _____ Lips _____ Cheek blush _____ Skin Repigmentation/Camouflage _____
Decorative Tattooing _____ Other, explain: _____

PART II. INFORMATION ABOUT YOUR PROFESSION

- 2.1 Do you use a medical history/client information form on everyone? Yes No
If yes, attach a copy.
- 2.2 Do you use a hold harmless or informed consent form? Yes No
If yes, attach a copy
- 2.3 Do you take before and after photos of cover-ups and cosmetic work? Yes No
- 2.4 Do you schedule a follow-up appointment after the procedures? Yes No
If yes, when? _____
- 2.5 Do you advertise other than a listing in the local telephone directory? Yes No
If yes, attach a copy of all promotional materials.

PART III. EQUIPMENT AND PROCEDURES

- 3.1 Are all pigments you use from US manufacturers? Yes No
If no, please provide a copy of the FDA stamp from the importer.
- 3.2 Do you ever re-use needles? Yes No
- 3.3 Is all your equipment pre-sterile, one-time use? Yes No
If no, indicate your method of sterilization: _____
- 3.4 Is all your equipment in proper running order? Yes No
- 3.5 Do you wear gloves with each procedure? Yes No
- 3.6 Do have hot and cold running water on site? Yes No
- 3.7 Do you dispose of your pigments after each client? Yes No
- 3.8 Provide the following information on all machines/devices:
- | | |
|--------------------|---------------------|
| MANUFACTURER _____ | PURCHASE DATE _____ |
| MANUFACTURER _____ | PURCHASE DATE _____ |
- 3.9 What anesthetics, if any, do you use? _____

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 permanent makeup, beauty, tattooing 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

How did you hear about us? _____

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

ADDITIONAL INSURED: Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.
NAME: _____
ADDRESS: _____
Relationship to your business (Landlord, lienholder): _____

SCHEDULE OF SERVICES

Indicate which services you provide, the number of operators and if we are to insure them. Independent contractors are not covered unless coverage is specifically extended to them.

		INSURE WITH US?	
		Yes	No
MANICURISTS	NUMBER_____	Yes	No
BEAUTICIANS	NUMBER_____	Yes	No
BROW/LASH ENHANCEMENT	NUMBER_____	Yes	No
FACIALS	NUMBER_____	Yes	No
Include Peels?	Yes No		
List products & percentage of acids if including peels: _____			
MICRODERMABRASION	NUMBER_____	Yes	No
LED/MICROCURRENT	NUMBER_____	Yes	No
WAX REMOVAL	NUMBER_____	Yes	No
Are all the facialists doing wax removal as well?	Yes No		
BODY WRAPS	NUMBER_____	Yes	No
List the type of wraps you use: _____			
MASSAGE	NUMBER_____ CERTIFIED?_____	Yes	No
ELECTROLOGY	NUMBER_____	Yes	No
EAR PIERCING	NUMBER_____	Yes	No
Indicate gross receipts from Ear Piercing: _____			
AIRBRUSH TANNING	UNITS_____	Yes	No
PRODUCTS	Gross Receipts: _____	Yes	No
Are Products Privately Labeled by you?	Yes No If yes a separate application is required.		
PERM. MAKEUP	NUMBER_____	Yes	No
TEACHING	NUMBER_____	Yes	No
CAMOUFLAGE	NUMBER_____	Yes	No
PIGMENT REMOVAL /LIGHTENING	SALINE REJUVI ELIMININK		
NEEDLING / MCA	NUMBER_____	Yes	No
MCA = Multitrepanic Collagen Actuation			
BODY TATTOO	NUMBER_____	Yes	No
<u>FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED</u>			
UV TANNING – UNITS	UNITS_____	Yes	No
If including tanning, complete the tanning bed supplement application			
BODY PIERCING	NUMBER_____	Yes	No

LIABILITY LIMIT REQUESTED: _____ NUMBER OF OPERATORS: _____

IMPORTANT: SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. Coverage becomes effective only when accepted by the insurance company.

APPLICANT

TODAY'S DATE