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**P**rofessional  
**P**rogram  
**I**nsurance  
**B**rokerage

[www.tattoo-ins.com](http://www.tattoo-ins.com) or [www.medispa-ins.com](http://www.medispa-ins.com)

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**PRIVATE LABEL PRODUCTS INSURANCE PROGRAM**

**I. Applicant Information**

Applicant Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Name: \_\_\_\_\_ Website: \_\_\_\_\_

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: \_\_\_\_\_

**II. Location and Product Information**

2.1 Type of business

Salon/Spa/Aesthetic Clinic      Laser/Medi-Spa      Wholesale Distributor

Retail Supply Store      Other (describe) \_\_\_\_\_

2.2 Are all products purchased from a manufacturer or supplier within USA?      Yes      No

Estimated Annual Private Label Product sales: \$ \_\_\_\_\_

2.3 Do all manufacturers name you as an additional insured vendor?      Yes      No  
(If yes provide copies of certificates)

2.4 Describe all products sold by you under your own label.

2.5 List all suppliers of private label products

2.6 Do you sell products that you do **not** private label?      Yes      No

If yes provide gross receipts for all non private label products: \$ \_\_\_\_\_

2.7 Square footage of your location: \_\_\_\_\_

2.8 Do you exhibit at one or more trade shows per year?      Yes      No

2.9 Does your landlord need to be named as additional insured?      Yes      No

Does your landlord require a waiver of subrogation?      Yes      No

**PART III. HISTORY**

**NOTE:** All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

3.1 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: \_\_\_\_\_

3.2 List liability claims history arising from any product sales, general liability or other professional activity, whether or not insured: If none, state so \_\_\_\_\_  
*YR/Claim Nature of injuries Details, if Pending Amt. if settled*

3.3 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.

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 REQUESTED EFFECTIVE DATE LIABILITY LIMIT REQUESTED

ADDITIONAL INSURED: @ \$50 Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.  
NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
Relationship to your business (Landlord, lienholder): \_\_\_\_\_