

AGENCY: _____
CONTACT NAME: _____
EMAIL _____
PHONE _____
ADDRESS _____
CITY _____

BEAUTY/BARBER/NAIL/TANNING APPLICATION

NAMED INSURED _____
MAILING ADDRESS _____ CITY _____
COUNTY _____ STATE _____ ZIP _____
LOCATION ADDRESS _____ CITY _____
COUNTY _____ STATE _____ ZIP _____
LEGAL ENTITY INDIVIDUAL PARTNERSHIP CORPORATION OTHER _____
EFFECTIVE DATE _____ EMAIL ADDRESS (MANDATORY) _____

1. TYPE OF OPERATION: BARBER SHOP BEAUTY SALON NAIL SALON TANNING SALON

2. DO YOU PERFORM ANY OF THE FOLLOWING:
 REMOVAL OF WARTS OR MOLES BODY MASSAGE (OTHER THAN FACE, SCALP OR HAND)
 EAR PIERCING STEAM BATHS OR SAUNAS
 NAIL SERVICES PERMANENT MAKE-UP APPLICATION

3. NUMBER OF YEARS IN BUSINESS? _____

4. PROVIDE THE NUMBER OF THE FOLLOWING PERSONNEL

PARTNERS, OWNERS, OFFICERS	FULL-TIME STAFF	PART TIME	OTHER: EXPLAIN

5. PROVIDE DETAILS OF LICENSING OR CERTIFICATION NEEDED FOR THIS OPERATION _____

6. DAYS AND HOURS OF OPERATION: _____

7. ANNUAL GROSS RECEIPTS _____ PRIOR YEARS RECEIPTS _____

8. DURING THE PAST (3) YEARS, HAVE ANY CLAIMS BEEN PRESENTED TO YOUR CURRENT OR PRIOR INSURANCE CARRIER? IF YES, PROVIDE FULL DETAILS: _____

9. IS THIS OPERATION LOCATED IN ONE OF THE FOLLOWING: (CHECK ONE)
 BEAUTY SALON BARBER SHOP HOTEL/MOTEL HEALTH/FITNESS CLUB OTHER _____

10. ARE YOU THE SOLE OCCUPANT OF THE SPACE? YES NO IF NOT, SQUARE FOOTAGE _____

11. IS ADDITIONAL INSURED REQUIRED? IF SO, PLEASE PROVIDE ALL INFORMATION:
 NAME/ADDRESS/INTEREST: _____

12. GENERAL LIABILITY

LIMITS OF INSURANCE REQUESTED:

GENERAL AGGREGATE LIMIT (OTHER THAN PRODUCTS – COMPLETED OPERATIONS) \$ _____
 PRODUCTS COMPLETED OPERATIONS AGGREGATE LIMIT \$ _____
 PERSONAL AND ADVERTISING INJURY LIMIT \$ _____
 EACH OCCURENCE LIMIT \$ _____
 DAMAGE TO PREMISES RENTED \$ _____
 MEDICAL EXPENSE LIMIT \$ _____
 *PROFESSIONAL LIABILITY ENDORSEMENT INCLUDED - NO CHARGE

13. PROPERTY

CAUSE OF LOSS BASIC BROAD SPECIAL

CONSTRUCTION _____ PROTECTION CLASS _____ SQUARE FEET _____ BUILDING AGE _____

COVERAGE DESIRED	LIMIT	RC/ACV	CO-INS/INDEMNITY	DEDUCTIBLE (MIN \$500)
BUILDING				
BUSINESS PROPERTY				
BUSINESS INCOME				

LOSS PAYEE: _____

MORTGAGEE: _____

14. TANNING SALON INFORMATION (IF APPLICABLE)

- a. ULTRAVIOLET LAMPS CURRENTLY INSTALLED YES NO
- b. PERCENTAGE OF UVA BULBS _____% PERCENTAGE OF UVB BULBS _____%
- c. NUMBER OF BEDS _____ NUMBER OF FACIAL TANNERS _____
- d. UL APPROVED YES NO
- e. ARE PROTECTIVE COVERS OVER THE UV LAMP TO PREVENT ACCIDENTAL BURNS YES NO
- f. ALL TIMERS TESTED DAILY YES NO
- g. ARE TIMERS CONTROLLED BY EMPLOYEES YES NO
- h. CAN PATRONS SET TIMERS YES NO
- i. ARE CUTOFF SWITCHES AVAILABLE FOR CUSTOMERS TO USE IN AN EMERGENCY YES NO
- j. ARE GOGGLES REQUIRED AND PROVIDED FOR ALL USERS YES NO
- k. ARE THERE SIGNS INSIDE AND OUTSIDE OF BOOTHS INSTRUCTING ON USE OF GOGGLES YES NO
- l. ARE BOOTHS COIN OPERATED YES NO
- m. ARE BEDS/BOOTHS THOROUGHLY DISINFECTED AFTER EACH USE YES NO
- n. DO MINORS NEED SIGNED PARENTAL CONSENT TO USE FACILITY YES NO
- o. HAVE ALL EMPLOYEES RECEIVED TRAINING IN USE OF TIMERS YES NO
- p. ARE PATRONS REQUIRED TO SIGN A WAIVER OR RELEASE PRIOR TO USING YES NO
- q. IS THE FOLLOWING WORDING HANGING IN A VISABLE AREA TO PATRONS YES NO

F.D.A Requirement – Danger – Ultraviolet Radiation. Follow All Instructions. As With Natural Sunlight, Overexposure May Cause Premature Aging Of The Skin And Skin Cancer. Medications Or Cosmetics Applied To The Skin May Increase Your Sensitivity To Ultraviolet Light. Consult Your Physician Before Entering Booth, If Taking Medication Or If You believe Yourself Especially Sensitive To Sunlight

15. **BEAUTY SALON/BARBER SHOP INFORMATION** (IF APPLICABLE)

- a. DO YOU CATER SPECIFICALLY TO THE ELDERLY, HANDICAPPED OR CHILDREN YES NO
 - b. HOW LONG DO YOU RETAIN RECORDS (NAME, ADDRESS & DATE OF SERVICE) OF PERSONS RECEIVING PERMANENT WAVES OR HAIR DYES _____
 - c. DO YOU HAVE RETAIL SALE OF ITEMS OTHER THAN HAIR CARE AND NAIL CARE PRODUCTS YES NO
 - d. APPROXIMATELY WHAT PERCENTAGE OF YOUR TOTAL RECEIPTS IS GENERATED DOWN FROM RETAIL SALES OF PRODUCTS _____%
 - e. ARE ALL COMBS, BRUSHES AND HAIR CUTTING IMPLEMENTS STERILIZED BEFORE AND AFTER USE YES NO
 - f. HOW FREQUENTLY DO YOU CHANGE THE GERMICIDAL SOLUTION _____
-

16. **EAR PIERCING INFORMATION** (IF APPLICABLE)

- a. WHAT HIRING REQUIREMENTS APPLY TO EMPLOYEES WHO PERFORM EAR PIERCING _____

- b. PLEASE DESCRIBE METHOD(S) OF EAR PIERCING YOU USE _____

- c. DO YOU OR WILL YOU AGREE TO PERFORM PIERCING OF ANY BODY PARTS OTHER THAN EARS YES NO
- d. WHAT PROCEDURES/PROCESSES ARE USED TO STERILIZE TABLES, TOOLS AND EQUIPMENT _____

- e. HOW FREQUENTLY ARE TABLES, TOOLS, AND EQUIPMENT STERILIZED _____

17. **COMMENTS:**

I HEREBY DECLARE TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT ALL THE FOREGOING STATEMENTS ARE COMPLETE AND TRUE, AND THAT THESE STATEMENTS ARE OFFERED AS AN INDUCEMENT TO THE COMPANY TO ISSUE A POLICY FOR WHICH I AM APPLYING. IT IS UNDERSTOOD AND AGREED THAT COMPLETION OF THIS QUESTIONNAIRE DOES NOT BIND THE COMPANY.

Signature of Applicant

Date

Signature of Agent