OPERATOR/SALON APPLICATION

Applicant Name: _____ Phone Number: _____
Business Name: _____
Email Address: _____ Website: _____
Mailing Address: _____
City: _____ State: _____ Zip code: _____
Business Address (1): _____
City: _____ State: _____ Zip code: _____
Type of Facility: _____ Square Footage: _____
Business Address (2): _____
City: _____ State: _____ Zip code: _____
Type of Facility: _____ Square Footage: _____

Business operated as: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Individual ☐ Independent Contractor

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

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

Indicate number in your facility:

Saunas/Steam Rooms: _____ Soaking Pools: _____ Showers: _____

Foot Detox Units: _____ Oxygen Devices: _____ UV Tanning Units:_____

BEAUTY SERVICES: Pick the best ONE for each technician	**Number to be Insured**
Beauticians: *Hair, Nails, Eyelash & Brow Enhancements, Sugaring, Waxing, Threading, Topical Makeup Application*	
Massage Therapist: *Massage, Body Wraps, Endermologie, Reiki*	
Aesthetician: *All Beautician services AND Facials, Aesthetic Peels, Body Wraps, Massage, Electrology, Microdermabrasion, Ear Piercing, Ear Candling, Airbrush Tanning, Aesthetic Body Treatments, Needling/Collagen Induction Therapy*	
Advanced Aesthetician: If Yes, Provide Name & Check all that Apply _____ ☐ Medical Grade Peels ☐ Ultrasound ☐ LED/Microcurrent ☐ Aesthetic Radio Frequency ☐ Dermaplaning ☐ Wart Removal ☐ Skin Tag Removal ☐ Cryo Spot Treatments	
Total Number of Operators:	

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

Decorative Tattooing: _____ Body Piercing: _____ Yoga/Personal Trainers: _____
Laser/Intense Pulse Light: _____ Permanent Makeup:_____ Medical Radio Frequency: _____
Other not listed on application: _____
_____
_____
_____

OPERATOR/SALON APPLICATION

Other Coverages:

Do you want coverage for Property ☐ Yes ☐ No If Yes, requires separate application

Do you want coverage for Cyber Liability ☐ Yes ☐ No If Yes, $50,000 limit available

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.

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

Do you Currently have Insurance coverage ☐ Yes ☐ No

Insurer	***Policy #***	***Liability Limits***	***Premium***	***Exp. Date***

If Claims Made, most Recent Retroactive Date: _____

List any Professional or General Liability 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.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE 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 is not 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.

By signing below, I confirm on behalf of all technicians covered under this policy:

1. Technicians are licensed as necessary for all services being provided.
2. Technicians do not use any product that contains more than 2% formaldehyde.
3. I understand that no service or individual is covered unless listed and a premium paid.
4. That all technicians have been trained for the service they are performing or on the device they are using.
5. I understand that no coverage is provided under this policy for invasive or surgical procedures unless specifically listed

_____ _____

APPLICANT SIGNATURE TITLE

_____ _____ _____

DATE SIGNED REQUESTED EFFECTIVE DATE LIABILITY LIMIT REQUESTED

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**

Business Owners Application

1.1 Applicant Name:_____ Phone:_____

Business Name:_____ Website:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Business Address:_____

County: _____ Square Footage of Business_____

Business operated as: ☐ Corporation ☐Partnership ☐Individual ☐Independent Contractor ☐LLC

1.2 Business operated as salon?_____ If not, other:_____

1.3 How long in business?_____Do all professionals have licenses? _____

PROPERTY SECTION **MUST INSURE FOR AT LEAST 80% OF THE REPLACEMENT COST**

2.1 Age of building:_____ Construction:_____ Number of stories:_____

2.2 If building is over 20 years old, when were the following upgraded? **(*) Information is Required**
*Roof:_____*Plumbing:_____*Wiring:_____Sprinklers:_____

2.3 *Is there a Central Station Burglar Alarm? **Yes** ☐ **No** ☐ If yes, advise alarm provider:_____

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

2.4 Other Occupancies in building? (Describe)_____

2.5 Adjoining Occupancies: LEFT:_____ RIGHT:_____

2.6 Approximate distance from fire station:_____Distance from fire hydrant:_____

2.7 Do you sell items not directly related to beauty or skincare? **Yes** ☐ **No** ☐ Inventory Value ($):_____
If yes, describe:_____

2.8 Do you sell or use jewelry? **Yes** ☐ **No** ☐ If yes, Jewelry Value: $_____

2.9 Name & address of loss payee:_____

COVERAGES DESIRED

A. CONTENTS - Total Limit Needed: $_____

Does any of this property belong to employees or independent contractors that work under your business name? Yes ☐ No ☐

B. TENANT IMPROVEMENTS - Limit Needed: $_____

C. BUILDING - Limit Needed: $_____

Do you own the building? Yes ☐ No ☐

If yes, are there any tenants besides your business? Please explain:_____

If no, do you have a Triple Net Lease? Yes ☐ No ☐

D. BUSINESS INTERRUPTION INSURANCE - Amount per Month Needed: $_____

For how many months? _____

E. SIGN - Limit Needed: $_____

OPTIONAL COVERAGES (Additional Premium Will Apply)

☐ **Contingent Business Income** (Utility Business Interruption) ☐ **Spoilage** (Temperature change on perishable items)

☐ **Coverage Extension** ($15,000 Blanket Total for: equipment breakdown, accounts receivable, valuable papers)

HISTORY

3.1 List all property claims in the past 5 years, whether or not insured:_____

_____

3.2 Current property insurance carrier, policy number:_____

COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

_____ _____

APPLICANT SIGNATURE DATE

POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, **as defined in Section 102(1) of the Act, as amended:** The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2020, the date on which the TRIA Program is scheduled to terminate, or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 AND 80% BEGINNING ON JANUARY 1, 2020; OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A USD100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS USD100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED USD100 BILLION, YOUR COVERAGE MAY BE REDUCED.

THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

☐	I hereby elect to purchase coverage for acts of terrorism for a prospective premium of USD……
☐	I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

_____
Policyholder/Applicant's Signature

On behalf of certain underwriters at Lloyd's

_____
Print Name

_____
Policy Number

_____
Date

LMA9104

12 January 2015