PERMANENT MAKEUP 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:	**0**

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: _____
_____

PERMANENT MAKEUP SUPPLEMENT

Name of Permanent Makeup Technician to be covered:_____

Complete for each technician

Are you in compliance with all city, county and/or state ordinances? ☐Yes ☐No

Have you had formal instruction in the application of permanent color: ☐Yes ☐No

Have you had formal instruction in the process of pigment removal: ☐Yes ☐No

How many years of experience do you have with Permanent Makeup? _____

If less than 1 year of experience, attach all certificates of training or attach description of training and experience

Indicate what procedure (s) you will perform:

PERMANENT COLOR OPTIONS **Indicates Additional Premium May Apply*

☐ Lips/Liners	☐ Eyebrows	☐ Eyeliners
☐ Beauty Marks	☐ Nipple Areola	☐ Cheek Blush*
☐ Scar Camouflage*	☐ Bald Spot Repigmentation*	☐ Microstroking

☐ Pigment Removal (Specify Product): _____

Total Number of Procedures in the last 12 months: _____

INFORMATION ABOUT YOUR PROFESSION

Do you have everyone sign a Consent form and complete a Medical History form? ☐Yes ☐No

☐ I am Submitting my own forms ☐ I will use PPIB approved forms

Do you take before and after photos of all permanent cosmetic work? ☐Yes ☐No

Do you schedule a follow up appointment after each procedure? ☐Yes ☐No

Is Yes, when: _____

EQUIPMENT AND PROCEDURES

Are all Pigments/ Removal Products you use from US or Canada manufacturers and/or EU Standards? ☐Yes ☐No

If No, list manufacturers: _____

Do you EVER reuse needles? ☐Yes ☐No

If you perform Microstroking, does your tool have a needle grouping? ☐Yes ☐No

If No, indicate method: _____

Is all your equipment pre-sterile, one time use? ☐Yes ☐No

If No, indicate your method of sterilization: _____

Do you wear gloves with each procedure? ☐Yes ☐No

Do you have Hot and Cold running water on site? ☐Yes ☐No

What anesthetics, if any, do you use? _____

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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**