



## BEAUTY/BARBER SHOP LIABILITY APPLICATION

Applicant's Name: \_\_\_\_\_  
 \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Location Address: \_\_\_\_\_  
 \_\_\_\_\_

Agency Name: \_\_\_\_\_  
 Agent No.: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 Phone No.: \_\_\_\_\_

**PROPOSED EFFECTIVE DATE:** From \_\_\_\_\_ To \_\_\_\_\_ 12:01 A.M., Standard Time at the address of the Applicant

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE" (N/A)

**Applicant is:**

- a.  Individual     Corporation     Partnership     Joint Venture  
 Limited Liability Company     Other (Specify): \_\_\_\_\_
- b.  Owner     Employed Operator     Independent Contractor

**Website Address:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_ **Phone No.:** \_\_\_\_\_

**Inspection Contact:** \_\_\_\_\_ **Phone No.:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**1. Name of business (D/B/A):** \_\_\_\_\_

- 2. Business is:**     Barber Shop     Beauty Parlor     Day Spa     Dental Spa  
 Massage Parlor     Medical (Medi) Spa     Tanning Salon

**3. How long has applicant been in business?**.....\_\_\_\_\_ years

**4. Number of operators:** .....

Full-time hair: \_\_\_\_\_ Part-time hair (less than twenty [20] hours per week): \_\_\_\_\_  
 Aestheticians: \_\_\_\_\_ Masseuses: \_\_\_\_\_ Nail Technicians: \_\_\_\_\_

**5. Are all operators licensed?**.....  Yes  No

**6. Total gross sales:** .....\$ \_\_\_\_\_

**Limits of Liability and Deductible Requested:**

General Aggregate (other than Products/Completed Operations)		\$
Products & Completed Operations Aggregate		\$
Personal & Advertising Injury (any one person or organization)		\$
Each Occurrence		\$
Damage to Premises Rented to You (any one premises)		\$
Medical Expense (any one person)		\$
Errors & Omissions Coverage (included up to General Liability Limits)	Each Claim Aggregate	\$ \$
Sexual and/or Physical Abuse Coverage		<input type="checkbox"/> \$50,000/\$100,000 (included) <input type="checkbox"/> \$100,000/\$300,000
Other Coverages, Restrictions and/or Endorsements:		\$
Deductible		\$

**7. Number of:**

Barber Shop chairs:	Saunas:	Tanning booths:
Hot tubs/spas:	Swimming pools:	Tanning spray on booths:
Hydromassage beds:	Tanning beds:	Toning beds:

**8. Are any of the following exposures included in the applicant's operation?**

<input type="checkbox"/> Acne scar treatment	<input type="checkbox"/> False lashes	<input type="checkbox"/> Plastic surgery
<input type="checkbox"/> Beauty schools/classes	<input type="checkbox"/> Fat Reducing Procedures	<input type="checkbox"/> Podiatry detoxification
<input type="checkbox"/> Body piercing (other than ear piercing)	<input type="checkbox"/> Intense pulsed light (IPL)	<input type="checkbox"/> Prenatal massage
<input type="checkbox"/> Body wraps	<input type="checkbox"/> Hair implants	<input type="checkbox"/> Removal of tattoo, port wine or birthmark
<input type="checkbox"/> Botox or other cosmetic injections	<input type="checkbox"/> Laser hair removal; receipts: \$ _____	<input type="checkbox"/> Tattoos
<input type="checkbox"/> Chemical peels: Type: _____ Receipts: \$ _____	<input type="checkbox"/> Lice removal	<input type="checkbox"/> Teeth whitening
<input type="checkbox"/> Chiropody	<input type="checkbox"/> Makeovers/Facials	<input type="checkbox"/> Vein treatments
<input type="checkbox"/> Colon hydrotherapy	<input type="checkbox"/> Manicures/Pedicures	<input type="checkbox"/> Wig application
<input type="checkbox"/> Ear candling	<input type="checkbox"/> Mesotherapy treatment	<input type="checkbox"/> Waxing—hot/cold
<input type="checkbox"/> Ear piercing	<input type="checkbox"/> Microdermabrasion; receipts: \$ _____	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Electrolysis	<input type="checkbox"/> Micro-needle therapy	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Face lifting	<input type="checkbox"/> Nail sculpting	
	<input type="checkbox"/> Permanent cosmetics; receipts: \$ _____	

**9. For Tanning Beds, Booths and Spray-on Booths:**

- Goggles provided?.....  Yes  No
- Are all timers operated by an attendant? .....  Yes  No
- Are tanning units Underwriters Laboratory approved? .....  Yes  No

- Are all tanning units manufactured in the United States?.....  Yes  No
- Are all tanning units disinfected after each use?.....  Yes  No
- Do signs prohibit use of tanning units during pregnancy or if on medication?.....  Yes  No
- Are customers advised to remove contact lenses?.....  Yes  No
- Are waivers signed by each customer? .....  Yes  No
- If customer is under the legal age, is the parent required to also sign waiver? .....  Yes  No

10. Does applicant manufacture or sell any food, beverage, supplement or vitamin under their own label?.....  Yes  No

11. Does applicant manufacture, mix, blend or repackage products sold for use on or off premises (other than any food, beverage, supplement or vitamin)?.....  Yes  No  
 If yes, advise receipts and explain: \_\_\_\_\_

12. Are any operations performed away from the applicant's premises? .....  Yes  No  
 If yes, explain: \_\_\_\_\_

13. Has any operator had a previous claim or pending allegations for alleged malpractice, error or mistake?.....  Yes  No  
 If yes, explain: \_\_\_\_\_

14. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies?.....  Yes  No  
 If yes, describe: \_\_\_\_\_

15. During the past three years, has any company canceled, declined or refused similar insurance to the applicant? (Not applicable in Missouri) .....  Yes  No  
 If yes, explain: \_\_\_\_\_

16. Does applicant have other business ventures for which coverage is not requested?.....  Yes  No  
 If yes, explain and advise where insured: \_\_\_\_\_

17. Additional Insured Information:

Name	Address	Interest

18. Prior Carrier Information:

Year			
Carrier			
Policy No.			
Coverage			
Occurrence or Claims Made			
Total Premium	\$	\$	\$

**19. Loss History:**

Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior three years. <input type="checkbox"/> Check if no losses last three years.				
Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA.)

**FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON):** Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON):** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**APPLICANT'S STATEMENT:**

I have read the above application and I declare that to the best of my knowledge and belief all of the foregoing statements are true, and that these statements are offered as an inducement to us to issue the policy for which I am applying. (Kansas: This does not constitute a warranty.)

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CO-APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRODUCER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

AGENT NAME: \_\_\_\_\_ AGENT LICENSE NUMBER: \_\_\_\_\_  
(Applicable to Florida Agents Only)

IOWA LICENSED AGENT: \_\_\_\_\_  
(Applicable in Iowa Only)

**IMPORTANT NOTICE**

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.