



Spa and Salon Package Application

Please email or fax the attached application for a premium quotation

Contact: Donna L. Malkasian
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Covers a variety of services for aestheticians, electrologists, massage therapists, body piercers, micropigmentation technicians, tattoo artists plus more. Coverage available in all states.

APPLICANT INFORMATION

1. Name of Corporation or LLC (include "Inc", "Corp", "LLC", etc.): _____
 Name of business (your "dba" or "t/a" name): _____
 Name of business owners: _____

MAILING Address: _____
 City: _____ State: _____ Zip Code: _____ County: _____

LOCATION Address: _____
 City: _____ State: _____ Zip Code: _____ County: _____

For additional locations, please answer property information section, questions 1 through 14 on a separate page.

Phone: _____ Fax: _____
 Website: _____ Email Address: _____

2. FEIN (federal employer identification number) or social security number: _____
 3. Are there any businesses or business locations owned or operated that will not be specifically insured by this policy?
 Yes No *If yes, note that all coverage will be limited to the location listed in question 1 above.*
 4. Type of Ownership:
 Corporation Partnership or Joint Venture Sole Proprietorship (Individual)
 Limited Liability Corporation Other (describe) _____
 5. Total Annual Gross Receipts/Revenues? Current year (estimated) \$ _____ Previous Year \$ _____
 6. How long have you owned this business? _____
 7. Have there been any Property, General Liability or Products Liability losses, claims or suits within the last 3 years (even if not covered by insurance)? Yes No
 If yes, please attach a complete description of the loss including the date and nature of claim and amounts paid. Please also describe in detail what actions, if any, have you taken to prevent similar losses.
 8. Previous Insurance Carrier & Policy Number (Not required in Missouri): _____
 9. Will this policy need to cover any Loss Payees/Mortgagees/Additional Insureds? Yes No
 If yes, please list and describe each one below.

Location: _____
 Name: _____
 Address: _____
 Interest: _____

GENERAL LIABILITY INFORMATION

1. Do you:
 a. Repair or install equipment or machines? Yes No
 b. Rent equipment to others? Yes No
 c. Sell products under your own label? Yes No
 d. Sell products which you repackage, re-label, or re-manufacture? Yes No
 e. Do you manufacture or re-bottle any products at your business location? Yes No

2. Please indicate whether any of the following optional coverages (\$1,000,000) are desired:
- | | | |
|---|------------------------------|-----------------------------|
| a. Employee Benefits Liability | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Hired and Non-Owned Auto Liability | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Stop Gap Liability (ND, OH, WA, WV, and WY only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PROPERTY INFORMATION

Please answer these questions based on your primary location and building. If you have additional locations or buildings, please copy this section and answer the questions for your other property. Home based businesses should complete the following questions based on the business portion of the home.

- What is the desired Property Deductible? \$500 \$1,000 \$2,500 \$5,000
- Is the business within 1,000 feet of a fire hydrant? Yes No
- Is the business within 5 miles of a Fire Station? Yes No
- What is the 100% replacement value of the **business personal property** (including business contents, fine arts, value of all computer hardware and software and laptops)? \$ _____
- What is the construction of the building where the business is located?

<input type="checkbox"/> Frame (wood)	<input type="checkbox"/> Joisted masonry (brick)	<input type="checkbox"/> Non-combustible (steel)
<input type="checkbox"/> Masonry non-combustible (tilt-up concrete)	<input type="checkbox"/> Fire Resistive	

 If the construction of the building is not known, please provide details on the materials used for the roof, floors, and walls. _____
- What is the square footage of the space occupied by the business? _____
- How many stories in the building? _____
- What is the original year the building was built? _____
- What is the square footage of the entire building? _____
- If the building is over 10 years old, indicate the year each of the following was updated:

Electrical _____	Roofing _____	Plumbing _____	Heating _____
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- Please indicate the other types occupants in the same building (check all that apply):

Left:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
Behind:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
Above:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
Below:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
- Please indicate the types of occupants in neighboring buildings (check all that apply):

Left:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
Behind:	<input type="checkbox"/> None	<input type="checkbox"/> Office/Medical	<input type="checkbox"/> Retail	<input type="checkbox"/> Apartment	<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (describe): _____
- Does the building have an automatic sprinkler system covering 100% of the premises? Yes No
 Answering yes will give (in most cases) a substantial discount on property insurance.
 Do you understand that if you answer yes and receive a discount, there will be no coverage if you suffer a fire loss and the sprinkler system doesn't work? Yes No
- Do you own the building itself and/or do you need to insure the building itself? Yes No
 If yes, what is the 100% replacement value of the building? _____
- If you answered yes to question 14 above:

a. Is it a business condominium?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Are you renting/leasing the property under a triple net lease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Are you renting a portion of the building to others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

 If yes, what is your monthly rental income? _____

TOTAL BODY PACSM

New Hampshire Insurance Company, Administrative Office: 200 State Street, Boston MA 02109
 Professional Liability Insurance Application, Occurrence

I. GENERAL INFORMATION

- Name of Corporation or LLC (include "Inc", "Corp", "LLC", etc.): _____
 Name of business (your "dba" or "t/a" name): _____
 Name of business owners: _____
 MAILING Address: _____
 City: _____ State: _____ Zip Code: _____ County: _____
 Phone: _____ Fax: _____
 Website: _____ Email Address: _____
- List any professional associations in which the Applicant is a member: _____

II. INSURANCE INFORMATION

- 1 Limits of Liability: \$1,000,000 per occurrence / \$2,000,000 aggregate
 \$2,000,000 per occurrence / \$4,000,000 aggregate
 (this limit available for tattoo & body piercing only) \$500,000 per occurrence / \$500,000 aggregate
- 2 Professional Liability Deductibles: none \$1,000 (8% discount)
 \$2,500 (12% discount) \$5,000 (20% discount)
NOTE: Optional deductibles not available in all states.
NOTE: A minimum deductible of \$100 shall apply to micropigmentation and body piercing policies.
NOTE: A minimum deductible of \$250 shall apply to tattoo policies.
- 3 Do you desire Premises Liability (trip & fall) coverage? Yes No
 If yes, list all locations and square footage of each office: _____
-
- 4 Previous Insurance Carrier & Policy Number (Not required in Missouri): _____
- 5 Previous liability coverage written on: claims made occurrence form
 If claims made, attach copy of prior policy and provide retroactive date: _____
- 6 Has any previous carrier cancelled or not renewed a policy? (Not required in Missouri) Yes No
 If yes, provide details: _____
-
- 7 Should your landlord be named as an additional insured? Yes No
 If yes, provide name and mailing address: _____

III. PROFESSIONAL SERVICES INFORMATION

- 1 Please check the professional services that you perform and for which you desire coverage under the policy.
NOTE: Any professional service for which you do not provide such information will not be covered under the policy.
NOTE: Checking any professional service does not obligate us to insure it.
- | | |
|--|---|
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Facial & Skin Cleansing |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Hydrotherapy |
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Aromatherapy |
| <input type="checkbox"/> Manicure or Pedicure | <input type="checkbox"/> Endermology |
| <input type="checkbox"/> Body Wraps for weight/water reduction | <input type="checkbox"/> Body Wraps for other than weight/water reduction |
| <input type="checkbox"/> Hair Cutting / Styling / Coloring | <input type="checkbox"/> Body Massage |
| <input type="checkbox"/> Facial & Scalp Massage | <input type="checkbox"/> Cosmetics / Make-up application |
| <input type="checkbox"/> Personal trainers / Yoga Instructors | <input type="checkbox"/> Tanning Beds / Booths / Units |
| <input type="checkbox"/> Ear Piercing | <input type="checkbox"/> Micropigmentation |
| <input type="checkbox"/> Body Piercing (other than ear lobe) | <input type="checkbox"/> Tattoo |
| <input type="checkbox"/> Other services not listed above (describe): _____ | |
-
- 2 Please indicate the numbers of employees, independent contractors, and students performing the professional services shown above and for whom you desire coverage under the policy.
- | | Employee | Independent | Student |
|---|----------|---------------|---------|
| Tattoo | _____ | _____ | _____ |
| Micropigmentation | _____ | _____ | _____ |
| Micropigmentation Training | _____ | _____ | _____ |
| Body Piercing | _____ | _____ | _____ |
| Hair / Nails / Cosmetics | _____ | _____ | _____ |
| Personal Trainers / Yoga Instructors | _____ | _____ | _____ |
| Aestheticians | _____ | _____ | _____ |
| Massage Therapists | _____ | _____ | _____ |
| Electrologists | _____ | _____ | _____ |
| TOTAL number providing services | _____ | _____ | _____ |
| Tanning Beds / Booths / Units | | (# of units): | _____ |
| Hydrotherapy Tubs / Hydrotherapy Tables / Showers | | (# of units): | _____ |
| Exercise Equipment | | (# of units): | _____ |
- 3 Are all technicians licensed if required by law? Yes No
- 4 Are any employees or independent contractors medical doctors? Yes No
 If yes, do they provide treatments / services to customers? Yes No
 If yes, attach proof of medical malpractice insurance coverage for doctor(s).

- 5 If you have checked "Body Piercing," "Micropigmentation," or "Tattoo," please answer the following:
- A Do you always obtain a medical history for every client? Yes No
- B Do you always supply a patient / customer with aftercare information? Yes (if yes, attach copy) No
NOTE: Distribution of aftercare information is required by policy
- C Do you always obtain a signed consent or release form? Yes (if yes, attach copy) No
NOTE: Use of consent / release form is required by policy
- D Do you use piercing guns? Yes Earlobe Only No
- E Please describe your method of sterilization for your equipment (including needles) and both used and unused jewelry: _____
- F Do you pierce or tattoo minors? Yes No
 If yes, please describe your policy for piercing or tattooing minors: _____
- 6 List schools you attended or graduated from and describe any training received: _____

NOTE: Micropigmentation technicians must attach a copy of training certificate or diploma.

IV. LOSS INFORMATION AND WARRANTY

- 1 Have there been any claims reported in the last five years? Yes No
 If yes, attach a complete description including name of claimant, date of claim, nature of injury, and amounts paid.
- 2 Are there any pending claims against the applicant? Yes No
 If yes, attach a complete description including name of claimant, date of claim, and nature of injury.
- 3 Upon communication with all of your partners, employees, independent contractors, and students, are you aware of any act, error, or omission that might give rise to a claim(s) under the proposed policy? Yes No
 If yes, attach a complete description including name of claimant, date of claim, and nature of injury.
- 4 The applicant warrants that the statements set forth herein are true, and that if the information supplied on this application changes between the date of this application and the date on which coverage is bound, the applicant will immediately notify the insurance company of such changes. The signing of this application does not bind the insurance company to provide the requested coverage, but it is agreed that if a policy is issued, this application shall be the basis for the policy, and it will be attached to and made part of the policy.

V. SUPPLEMENTAL INFORMATION

- 1 Do you offer massage services to minors (under 18 years old)? Yes No n/a—No Massage
- 2 Do you obtain criminal background checks on all massage therapists? Yes No n/a—No Massage
- 3 Do you offer chemical/acid peel services? Yes No
 If yes, do you use.... Trichloroacetic acid (TCA) preparations with concentrations over 20%? Yes No
AHA preparations with concentrations over 30% with pH lower than 3.0? Yes No
Jessner's solution preparations with concentration over 14%? Yes No
Any medical-grade peels? Yes No
- 4 Do you offer sclerotherapy, telangiectasia, or any services to minimize the appearance of veins? Yes No
 If yes, describe services: _____
- 5 Do you offer any services intended to remove skin tags, warts, moles, or other growths? Yes No
 If yes, describe services: _____

FRAUD WARNINGS

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT

WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MINNESOTA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DECEIVE AND DEFRAUD, MAKES ANY MATERIAL ORAL OR WRITTEN MISREPRESENTATION OR WHO HELPS ANOTHER MAKE A FRAUDULENT MISREPRESENTATION TO AN INSURER, COMMITS A FRAUD AGAINST THE INSURER AND IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS: 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.

Signed: _____

Producer Name, Address and License Number: _____

Date: _____

Signature of Agent/Date: _____



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PREMIUM AND LOSS HISTORY INFORMATION

1. Name of Corporation or LLC (include "Inc", "Corp", "LLC", etc.): _____
 Name of business (your "dba" or "va" name): _____
 Name of business owners: _____

2. Years in business: _____

3. Have you carried any business insurance in the past three years? Yes No

If yes, provide the following information for all such policies:

Effective Dates	Insurance Carrier/Policy Number	Type of Coverage	Annual Premium
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Have there been any claims in the past three years (whether or not insured)? Yes No

If yes, provide the following information for all such claims:

Date of Claim	Type of Claim/Description	Amounts Paid
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF YOU ANSWERED YES TO QUESTION 3 ABOVE, PLEASE RETURN THIS PAGE WITH 3 YEARS LOSS RUNS FROM YOUR PRIOR INSURANCE CARRIER.

IF YOU ANSWERED NO TO QUESTIONS 3 AND 4 ABOVE, PLEASE SIGN BELOW AND RETURN.

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

We have not carried business insurance coverage during the past three years. There have been no claims (insured or otherwise) during the past three years. We are not aware of any circumstances during the past three years which may give rise to a claim.

Signed: _____

Date: _____