

Application for Member Insurance Coverage Healthy Look Professionals, Inc.



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Rich Hill, MO 64779

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Salon/Spa Application Checklist

1. Have you signed this application at the bottom of Section 6? Unsigned applications cannot be processed.
2. You must accept or reject, sign and date the "Notice of Terrorism Insurance Coverage" Form and return to us.
3. No coverage can be effective before we receive payment. You must attach your annual payment in full, or provide credit card information. If you want to use an installment plan, you must pay the "down payment" by check or credit card. You will receive a coupon book for the installments.
4. You must return the "Quote Sheet" mailed to you. Designate the payment option that you desire on the quote sheet..
5. If your building or contents is financed by a bank or leasing company, we will need the name and address of these if they are to be named as loss payee. If your landlord requires proof of insurance or to be named as an additional insured under your policy, we will need this information also.

Coverage is not effective until the application is approved and payment or payment arrangements received.

Section I General Information

Applicant(s)/Contact(s): _____

Business Name: _____

If Incorporated: I. What is your business name? _____

II. Attach a list of acceptable contacts, if necessary.

Form of legal organization is: Proprietorship Partnership Corporation LLC

Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (_____) _____ Fax: (_____) _____

Business Physical Address:

City: _____ State: _____ Zip: _____ County: _____

Email Address: _____

If you have more than one location that we are covering under this application, list their addresses below:

<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>
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What date is coverage to be effective? EFFECTIVE: _____

I would like insurance for (Check one): Liability Insurance Only Liability and Property

Section 2**Liability Insurance**

Limit of Liability Insurance: Check one limit for Premises and Professional liability.

Premises, Products, Personal Injury, & Professional Liability limits per occurrence

\$300,000

\$500,000

\$1,000,000

\$2,000,000

The General Annual Aggregate (total of all claims annually) is equal to the single "Occurrence" (per claim) limit. You may elect to double the aggregate limit to be increased to twice the "Occurrence" limit. The charge for this feature is 5% applied to the liability premium.

Double the annual aggregate limit? Yes No

Section 3**Covered Operations**

This application allows for up to 3 locations. Please list the **total number** of professional operators including booth renters/independent operators **at each location** accordingly. If you perform services that we are not covering, including your booth renters or independent contractors, please do not list them here. If issued, this policy will cover only those operations for which a premium is charged or designated as "Included" in the schedule of insured hazards.

Operation	Number @ Location #1	Number @ Location #2	Number @ Location #3	Totals for all
Aerobic Instructors (on-site only)				
Air Brush Tanning (# of units)				
Cosmetologist I (covers: any hair and/or any nail services)				
Cosmetologist II (covers: hair, nails, cosmetic facials, & facial waxing)				
Dietary or Nutritional Supplements (describe: _____)				
Ear Piercing (no body piercing)				
Esthetician I (skin care, waxing/sugaring, body wrap, endothermology, aromatherapy, muscle electrostimulation & lymphatic drainage)				
Esthetician II (the above plus electrolysis, microdermabrasion & infrared body wraps)				
Esthetician II—Chemical Peels (the above plus chemical peels under 30% acidity)				
Facial Tanning Units (separate from tanning units)				
Hydrotherapy/Aquamassage/Whirlpool/Sauna/Vichy shower (circle any that apply)				
LED Light Therapy (certification required)				
Massage Therapist or Massage Bed (circle one and enter # of each)(pregnancy and infant massage excluded)				
Nutritional Counselors (those who recommend and set-up diets)				
Oxygen Bar (# of generators)				
Permanent Make-up (special limits/rates apply)				
Passive Exercise Equipment (free weights excluded)				
Personal Trainer (on-site only)				
Pulse Light Therapy (certification required)				
Spray Tanning Booths/Tanning Beds/Stand-up Booths (total of all together)				
Other (please describe):				
Other (please describe):				

Are you doing any other type of business not listed above? Yes No

If so, please describe: _____

Are you or anyone else doing any type of business on this premises that we are not covering? (Including booth renters/independent contractors) _____

In order to bind, you must provide proof of any other insurance company covering any operation that you conduct on your premises that we are not covering.

Section 4 Additional Insured

If your landlord, bank, or leasing company requires evidence of insurance, please provide full address, phone, and/or faxing information here. If no certificate is required, please put "none". **Please circle whether they are loss payee, additional insured or both.**

1. Name: _____ Additional Insured Loss Payee Both

Mailing Address: _____

2. Name: _____ Additional Insured Loss Payee Both

Mailing Address: _____

3. Name: _____ Additional Insured Loss Payee Both

Mailing Address: _____

Section 5 Business Safety Questionnaire

This information must be filled out fully and accurately. Any information on this application supersedes any information given on a phone quote. Please answer all that apply to your particular business.

1. Please provide the name of your current insurance carrier. If none, state "none". _____

2. Have any liability claims been made against you or paid in the past 5 years? Yes No

If "Yes", give details: _____

3. How many years in management do you have in the salon/day spa business? ____ If "none", please give any previous involvement in either business. _____

4. If you are a member of a safety group, please provide the name of that group:

5. Does your equipment comply with and are you aware of all requirements of Federal and State regulatory agencies? Yes No

6. Do independent contractors or booth renters conduct operations on your premises? Yes No

7. Are the work areas where acrylics are used well ventilated? Yes No N/A

8. Are all employees instructed in first aid to potential eye contamination by chemicals? Yes No

9. Are all body contact supplies sanitized after each use? Yes No

10. Are toxic chemicals stored away from the access of customers? Yes No

11. Do you provide on site child care for customers or employees? Yes No (This is not a covered hazard)

12. If your clients operate any exercise equipment, are they instructed and monitored? Yes No

13. Is your business located in a private residence? Yes No

If so, is there a separate entrance? Yes No

14. Do you manufacture or repackage any product? Yes No

15. Is any product manufactured and distributed under your private label? Yes No

If so, please describe the product and attach proof of manufacturer coverage: _____

16. Do you use and save as a permanent record, a hazard disclosure and personal injury disclaimer or waiver for each customer for all services performed? Yes No

Section 6

Insurance on Building and/or Contents You Own or Lease

Please indicate amount of building or contents coverage needed for each location.
If you do not wish for us to cover any of your property, please skip to the signature at the bottom.

Property Type	Amount Covered Location #1	Amount Covered Location #2	Amount Covered Location #3
Buildings You Own If you own your building, do you want us to insure it? Yes <input type="checkbox"/> No <input type="checkbox"/>	\$	\$	\$
Mandatory information for either building or contents coverage: Construction Type Examples: wood, brick, block, steel Building Type Examples: free standing, strip mall, enclosed mall, residence	Construction type: _____ Building type: _____ Approximate Age: _____ Sprinkler <input type="checkbox"/> Burglar Alarm <input type="checkbox"/>	Construction type: _____ Building type: _____ Approximate Age: _____ Sprinkler <input type="checkbox"/> Burglar Alarm <input type="checkbox"/>	Construction type: _____ Building type: _____ Approximate Age: _____ Sprinkler <input type="checkbox"/> Burglar Alarm <input type="checkbox"/>
Business Personal Property (Contents) (Replacement cost on equipment, inventory, fixtures and your building improvements) - 90% co-insurance	\$	\$	\$
Loss of Business Income Amount is 25% of Business Personal Property The maximum amount you may recover in any 30 day period is 1/3 of this amount. Maximum recovery period of 90 days.	\$	\$	\$
Outdoor Signs Amount is 10% of Business Personal Property	\$	\$	\$
Money & Securities	\$5,000	\$	\$
Employee Dishonesty	\$1,000	\$	\$
Electronic Data Processing	\$5,000	\$	\$
Glass	\$2,500	\$	\$

Policy comes with a \$500 property deductible. please indicate here if you desire a: \$1,000 \$1,500 \$2,500

- Any other business or residential occupants in this building? Yes No Describe: _____
- How many stories is the building that you own or rent at each location? _____
- Describe your local fire service: Full time Volunteer
- Have you had any property losses in the past three years? Details: _____
- Wiring Improvements? Yes No Year? _____ Which Locations? _____
- Roofing Improvements? Yes No Year? _____ Which Locations? _____
- Plumbing Improvements? Yes No Year? _____ Which Locations? _____
- Heating Improvements? Yes No Year? _____ Which Locations? _____
- Other Improvements? Yes No Year? _____ Which Locations? _____

I acknowledge that any insurance provided as a result of acceptance of this application will be provided by an insurance company eligible to provide insurance on a "Surplus Lines" basis in my State and in the domicile State of the Master Policy. Surplus Lines insurers are not covered by any State sponsored guaranty fund. I desire to become eligible to procure insurance through Healthy Look Professionals, Inc. (HLP). If I have elected to pay my insurance premium by installment, I appoint Insurtec, Inc., agent of HLP, as attorney-in-fact to cancel my policy if I fail to pay any scheduled installment or late charge. Coverage is not effective until the application is approved and payment or payment arrangements received. I warrant that all statements I have made on this application are true to the best of my knowledge.

Your Business Name: _____ Date: _____

Your Signature: **X** _____

If written, this policy does not provide coverage for worker's compensation.

Resent Entire Form

**POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM INSURANCE COVERAGE**

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, effective November 26, 2002, 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: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States – to be an act of terrorism; to be a violent 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 acting on behalf of any foreign person or foreign interest, 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.

YOU SHOULD KNOW THAT ANY 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. UNDER THE FORMULA, THE UNITED STATES PAYS 90% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER PROVIDING THE COVERAGE. 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.

SELECTION OR REJECTION OF TERRORISM INSURANCE COVERAGE

YOU HAVE THE RIGHT UNDER THE ACT TO SELECT OR REJECT THIS TERRORISM COVERAGE. YOU MAY SELECT THIS COVER BY AGREEING TO AND PAYING THE ADDITIONAL PREMIUM NOTED BELOW. YOU MAY ALSO CHOOSE TO DECLINE THIS COVER, IN WHICH EVENT, YOU WILL NOT BE CHARGED FOR THE PREMIUM NOTED ABOVE, AND WE WILL ATTACH A TERRORISM EXCLUSION ENDORSEMENT TO YOUR POLICY. IF YOU DECLINE THIS COVERAGE, YOU WILL NOT BE COVERED FOR LOSSES ARISING FROM TERRORIST ACTS AS DEFINED IN THE ACT.

<input type="checkbox"/>	I hereby elect to purchase coverage for certified Acts of terrorism for a premium of \$
<input type="checkbox"/>	I hereby elect NOT to purchase coverage for certified Acts of terrorism and understand that I will have no coverage for losses arising from any certified acts of terrorism.

Policyholder/Applicant's Signature

Insurer

Print Name

Policy Number

Date