



BEAUTY 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? _____

Are you in compliance with all City, County and/or State Ordinances? Yes No

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 Inhalation Devices: _____ UV Tanning Units: _____

BEAUTY SERVICES: Pick the best ONE for each technician	Number to be Insured
Beauticians: <i>Hair, Nails, Eyelash & Brow Enhancements, Sugaring, Waxing, Threading, Topical Makeup Application</i>	
Massage Therapist: <i>Massage, Body Wraps, Endermologie, Reiki</i>	
Aesthetician: <i>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</i>	
Advanced Aesthetician: If Yes, Provide Name & Check all that Apply	
<input type="checkbox"/> Medical Grade Peels <input type="checkbox"/> Ultrasound <input type="checkbox"/> LED/Microcurrent <input type="checkbox"/> Aesthetic Radio Frequency <input type="checkbox"/> Dermaplaning <input type="checkbox"/> Wart Removal <input type="checkbox"/> Skin Tag Removal <input type="checkbox"/> Cryo Spot Treatments <input type="checkbox"/> Body Contouring/Cellulite Reduction <input type="checkbox"/> Needling under 1.0mm deep <input type="checkbox"/> Needling over 1.0mm deep	
Name of Device used for Body Contouring Services: _____	
Total Number of Operators:	

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

Decorative Tattooing/Body Piercing: _____ Pigment Removal: _____ 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 & If less than 1 year experience, provide certificates of training for all procedures

Have you had formal instruction in the application of Permanent Cosmetics: Yes No

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

Training Dates

Name of School

Number of Hours Trained

Have you had formal instruction in the application of Microblading: Yes No

How many years of experience do you have with Microblading? _____

Training Dates

Name of School

Number of Hours Trained

Have you had formal instruction in the process of Pigment Removal: Yes No

How many years of experience do you have with Pigment Removal? _____

Training Dates

Name of School

Number of Hours Trained

Indicate what procedure (s) technician will perform: *Indicates Additional Premium May Apply

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Lips/Liners | <input type="checkbox"/> Eyebrows | <input type="checkbox"/> Eyeliners |
| <input type="checkbox"/> Beauty Marks | <input type="checkbox"/> Nipple Areola | <input type="checkbox"/> Cheek Blush* |
| <input type="checkbox"/> Scar Camouflage* | <input type="checkbox"/> Bald Spot Repigmentation* | <input type="checkbox"/> Microblading |
| <input type="checkbox"/> Pigment Removal* (Specify Product): _____ | | |

TOTAL NUMBER OF PROCEDURES IN THE LAST 12 MONTHS: _____

INFORMATION ABOUT YOUR PROFESSION

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

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 work? Yes No

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

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 Microblading, 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? _____

BEAUTY 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

S&H Underwriters, Inc.

Send To:
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Quotes@sh-underwriters.com