SALON/PERMANENT MAKEUP APPLICATION

Applicant Name: _____ Phone Number: _____

Business Name: _____

Email Address: _____ Website: _____

Your Mailing Address: _____

City: _____ State: _____ Zip code: _____

Your Business Address (1):_____

City: _____ State: _____ Zip code: _____

County: _____ Square Footage: _____

Your Business Address (2): _____

City: _____ State: _____ Zip code: _____

County: _____ Square Footage: _____

Business operated as: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Individual ☐ Independent Contractor

How long have you been in business? _____ Annual gross receipts from all operations? _____

Are you in compliance with all city, county, 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 sell non - beauty related products? ☐ Yes ☐ No If Yes, Describe: _____

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 _____

Schedule of Services	**# of People Performing**
Total Number of People at Facility:	
Manicurist: *Nails and Related Services*	
Beauticians and/or Barbers: *Hair, Eyebrow Tinting*	
Cosmetologist: *Topical Makeup, Eyelash & Eyebrow Extensions/Tinting, Threading, Waxing, Sugaring (includes Hair & Nails)*	
Massage Therapist: *Massage, Body Wraps, Endermologie, Reiki*	
Aesthetician: ***If Yes, Mark ALL that apply***	
☐ Spray Tanning ☐ Electrology ☐ Medical Peels ☐ Facials/Aesthetic Grade Peels	
☐ Ear Candling ☐ Microdermabrasion ☐ Dermaplaning ☐ Aesthetic Radio Frequency	
☐ Ultrasound ☐ LED/Microcurrent ☐ Wart Removal ☐ Microneedling under 1.0 Deep	
☐ Skin Tag Removal ☐ Cryo Spot Treatment ☐ Ear Piercing ☐ Microneedling over 1.0 Deep	
☐ Body Contouring/Cellulite Reduction and Name of Device Used:	

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Permanent Makeup Section: Complete for **EACH** technician **Check Here If not NEEDED** ☐

Name of Technician to be covered: _____ Years of Experience: _____

Pick which service (s) you will be performing:

☐ Permanent Makeup: *eyeliner, eyebrows, microblading, lips, lipliner, nipple areola* ☐ Microblading: *Eyebrows Only*

☐ Pigment Removal (Not including touch ups) Specify Product: _____

Advanced Services *(Additional Premium & Training Required):* ☐ Scar Camouflage ☐ Bald Spot Repigmentation ☐ Cheek Blush

Total number of procedures done including at school: _____

Training:

Total Number of Hours of In Person:	*Total Number of Hours of Online:*	*Name of School*	*Date(s) Attended*
_____	_____	_____	_____

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 work? ☐ Yes ☐ No

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

Are all pigments/removal products you use from US or Canada manufacturers and/or EU standards? ☐ Yes ☐ No

Do you EVER reuse needles? ☐ Yes ☐ No

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

Property Section: Complete for **EACH** Location **Check Here if not NEEDED** ☐

Age of Building: _____ Construction: _____ Number of stories: _____

If building is over 20 years old, when were the following upgraded? **(*) information required**

*Roof: _____ *Plumbing: _____ *Wiring: _____ Sprinklers: ☐ Yes ☐ No

*Is there a Central Station Burglar Alarm: ☐ Yes ☐ No Is the alarm inside your unit and in your control? ☐ Yes ☐ No

Other Occupancies in building? (describe): _____

Adjoining Occupancies: Left:_____ Right: _____

Approximate distance from fire station: _____ Distance from fire hydrant: _____

Do you sell or use jewelry? ☐ Yes ☐ No If Yes, Jewelry Value ($): _____

Name and address of Loss Payee: _____

Coverage Desired:

Contents: $:_____

Tenant Improvements: $: _____

Building: $: _____ Do you own the Building? ☐ Yes ☐ No

Business Interruption: Amt Per Month: $: _____ Months to be covered: _____

Sign: $: _____

Optional Coverages

Do you want coverage for Contingent Business Income?	☐ Yes ☐ No	$10K limit (Off Premise, Power Outage)
Do you want coverage for the Coverage Extension	☐ Yes ☐ No	$15K Total: Equipment Breakdown, Accounts Receivable, Valuable Papers
Do you want coverage for Spoilage?	☐ Yes ☐ No	Temperature change on perishable items

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Other Coverages: *additional premium and application will apply*

Do you provide any of the following? If so, please indication number of people performing

Decorative Tattooing/Body Piercing:	☐ Yes ☐ No	Number of Technicians: _____
Yoga/Personal Trainer:	☐ Yes ☐ No	Number of Technicians: _____
Laser/Intense Pulse Light:	☐ Yes ☐ No	Number of Technicians: _____

☐ Services not listed above: _____

_____

Do you want coverage for Non-Owned Or Hired Auto?	☐ Yes ☐ No	*If Yes, Separate Supplement Required*
Do you want coverage for Sexual Abuse at $25K/$50K limits?	☐ Yes ☐ No	Other limit requested: _____
Do you want coverage for Cyber Protection at $50K limits?	☐ Yes ☐ No	

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, General Liability or Property 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. I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

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

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**