BODY ART / SALON & SPA 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: _____ Sq. Ft._____

Your Business Address (2): _____

City: _____ State: _____ Zip code: _____ County: _____ Sq. Ft._____

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

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

Is your business part of a franchise? ☐ Yes ☐ No If Yes, which one? _____

Do you have any operations separate from the salon / spa? ☐ Yes ☐ No If Yes, describe: _____

Are you in compliance with all city, county, state ordinances? ☐ Yes ☐ No

Are you in compliance with CDC / Health Department guidelines? ☐ Yes ☐ No

Do you obtain written consent for any client photos you post online? ☐ Yes ☐ No ☐ N/A

SECTION I: GENERAL LIABILITY

If this Section does not apply, Check Here ☐

Do you need General Liability? ☐ Yes ☐ No If No, what Company insures your General Liability coverage? _____

If Yes, answer the below:

a. Are you required to name any other person or entity as an Additional Insured on your Policy? ☐ Yes ☐ No

If Yes, please provide Name and Address: _____

_____ Business Location #: _____

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

Do you need Products Liability for take home products you sell? ☐ Yes ☐ No Gross receipts: _____

Do you sell non - beauty related products? ☐ Yes ☐ No If Yes, describe: _____

Do you sell any CBD / Hemp Products? ☐ Yes ☐ No Gross receipts: _____

Do you private label products for sale? ☐ Yes ☐ No

a. If Yes, provide gross receipts for private label products ONLY: _____

b. Describe products being sold: _____

c. Are the ingredients / component parts purchased from the US? ☐ Yes ☐ No

If No, where are they purchased? _____

d. Any new products being introduced in the next 12 months? ☐ Yes ☐ No If Yes, explain: _____

e. Any foreign sales? ☐ Yes ☐ No If Yes, what percentage to what countries? _____

f. Do you have a written recall plan in place? ☐ Yes ☐ No

g. Are your products tested for contaminants, potency, etc.? ☐ Yes ☐ No If No, explain: _____

h. Do you have written instructions with the products or inherent hazards and warnings against misuse? ☐ Yes ☐ No

Do you have any of the following units? If Yes, indicate number of units for each:

☐ Wet Saunas / Steam Rooms: _____ ☐ Soaking Pools / Tubs: _____ ☐ Showers: _____

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SECTION II: TEACHING OF ANY SERVICE(S) ON APPLICATION

If this Section does not apply, Check Here ☐

Are you teaching or training any services? ☐ Yes ☐ No

If Yes, answer each of the below:

a. Are all students that are being taught 18 years of age or older? ☐ Yes ☐ No

b. How many students will be trained in the next 12 months? _____

c. Maximum number of students who will be attending each class? _____

d. How many hands-on procedures will each student perform for each service being taught? Describe (per service): _____

_____

e. Do you use a model release form for all individuals that students work on? ☐ Yes ☐ No

☐ I am submitting my own forms ☐ I will use PPIB approved forms

f. Do you guarantee Job Placement / Employability? ☐ Yes ☐ No

g. Provide name of each teacher:

Name: _____ Name: _____

Name: _____ Name: _____

SECTION III: COSMETOLOGY, AESTHETICS & WELLNESS SERVICES

If this Section does not apply, Check Here ☐

Schedule of Services	**# of People Performing**
Total Number of Technicians at Facility:	
Barber Services: *Hair and Related Services*	
Cosmetologist: *Hair Dressing, Manicures / Pedicures and Related Services, Topical Makeup, Eyelash Extensions / Tinting, Eyebrow Tinting, Eyebrow and Facial Hair Threading, Waxing, Sugaring*	
Massage Therapist: *Massage, Body Wraps, Endermologie, Reiki, Wet / Dry Cupping (No Heat / Fire)*	
Basic Aesthetics: *Facials including Aesthetic level Peels up to 40% Glycolic Acids, Airbrush / Spray Tanning, Electrology, Microdermabrasion, Needling / Collagen Induction Therapy under 1.0mm deep with Class I device, Dermaplaning, LED Services, Microcurrent, and Piercing for Earlobe and Outer Rim of Cartilage Only*	
Natural Wellness Services: *Chakra Healing, Non-Cryo Compression Therapy, Yoga / Pilates Instruction, One-on-one Personal Training, Guided Meditation, Energy Healing, Hypnosis*	
Advanced Aesthetics: *Aesthetic Plasma Services, LED Teeth Whitening, Skin Tag Removal, Wart Removal, Treatment of Age / Sunspots, Clogged Pores, Milia and Whiteheads, Smoothening & Tightening of the Skin, and / or Reduction of Minor Skin Imperfections using a Class I Non-Invasive Ultrasound, Aesthetic Radiofrequency, High Frequency, Cryopen / Cryoclear, Cryo Spot Treatments, and / or "Aesthetic Plasma Device"*	
Additional Aesthetic Options	
☐ Ear Candling ☐ Medical Peels ☐ Vajazzling ☐ Vajacials / Penacials ☐ Simple Nostril Piercing ☐ Henna Tattoos ☐ Airbrush Tattoo ☐ Temporary Sticker Tattoos ☐ Tooth Jewels ☐ Body Jewels (excluding Vajazzling) ☐ Face and / or Body Painting ☐ Non-Needle, Non-Prescription Spring Pressure Treatments ☐ Microneedling over 2.0mm Deep	
Do you teach any of the above services? ☐ Yes ☐ No	

Aesthetic Devices

Indicate Number of Units for each:

Infrared Sauna / Pod #: _____ Foot Detox Unit #: _____ Oxygen inhalation Device #: _____

Vaginal Steam Bath #: _____ UV Tanning Units #: _____

For UV Tanning Salon units, I confirm: (1) Lighting will NOT exceed 10% UVB in each unit; (2) Maximum tanning exposure in each unit will NOT exceed 30 minutes per session per 24-hour period; (3) All clients will wear goggles; (4) Tanning controls will ONLY be set by a Staff Member; (5) Tanning beds will be tested daily to ensure switches and timers operate properly; (6) Client information and history cards will be kept on each client according to state requirements; and (7) Drug reaction list and the FDA Warning Sign are posted as required by law.

Signature of Applicant: _____ **Date:** _____

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SECTION IV: BODY CONTOURING / CELLULITE REDUCTION

If this Section does not apply, Check Here ☐

	Name of Technician to be Insured	Years of Experience	Do they teach any of these services?
1.			☐ Yes ☐ No
2.			☐ Yes ☐ No
3.			☐ Yes ☐ No

If Less than 18 months of experience, provide training detail for each technician specific to these services.

1.	
2.	
3.	

If not trained, will you confirm that you will not use the machine until properly trained and provide certificates of training to our office? ☐ Yes ☐ No

Are you in compliance with all rules regarding authorization to use this Class I or IIa device? ☐ Yes ☐ No

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Name(s) of Device(s) being used: _____

Type of Device/Method being used? *(Mark ALL that apply)*

☐ Radio Frequency ☐ Ultrasound ☐ Cold Laser ☐ Cryo / Freezing

☐ Other: _____

SECTION V: PERMANENT COSMETIC SERVICES

If this Section does not apply, Check Here ☐

DEFINITIONS:

Permanent Cosmetics / Pigment Removal: *Ombré, microshading eyeliner, eyebrows, microblading, lips, lipliner, nipple areola, beauty marks, pigment removal using commercially prepared saline or acid-based solutions*

Microblading: *Eyebrows only*

Advanced Services: *Scar Camouflage, Bald Spot Repigmentation, Cheek Blush*

	Name of Technician to be Insured	Years of Experience	Permanent Cosmetics/ Pigment Removal	Micro-blading	Advanced Services	Do you teach any of these services?
1.			☐	☐	☐	☐ Yes ☐ No
2.			☐	☐	☐	☐ Yes ☐ No
3.			☐	☐	☐	☐ Yes ☐ No

If Less than 18 months of experience, provide training detail for each technician specific to these services.

1.	
2.	
3.	

Pick which service (s) you will be performing:

Advanced Services *(additional premium & training required):* ☐ Scar Camouflage ☐ Bald Spot Repigmentation ☐ Cheek Blush

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 and schedule a follow-up appointment after each procedure? ☐ Yes ☐ No

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

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

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SECTION VI: COLON HYDROTHERAPY

If this Section does not apply, Check Here ☐

	Name of Technician to be Insured	Years of Experience	Do they teach any of these services?
1.			☐ Yes ☐ No
2.			☐ Yes ☐ No
3.			☐ Yes ☐ No

If Less than 18 months of experience, provide training detail for each technician specific to these services.

1.	
2.	
3.	

Do you provide probiotic supplements following the procedure? ☐ Yes ☐ No

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

Do you understand that work cannot be provided on individuals under the age of 15? ☐ Yes ☐ No

For 15 to 17 year-old clients, do you require a physician prescription and parent / guardian permission prior to service? ☐ Yes ☐ No ☐ N/A

Do you have everyone sign a Consent Form and complete a Medical History Form? ☐ Yes ☐ No

SECTION VII: DECORATIVE TATTOO & / OR BODY PIERCING

If this Section does not apply, Check Here ☐

Do all artists have formal training and / or have completed an apprenticeship in Tattooing and / or Body Piercing? ☐ Yes ☐ No

For minors, do you require a parent / guardian written permission prior to service? ☐ Yes ☐ No ☐ N/A

Do you use a Consent Form and After Care Form on every client? ☐ Yes ☐ No

☐ I am submitting my own consent forms ☐ I will use PPIB approved consent forms

Is all your equipment either a) pre-sterile, one-time use OR b) heat sterilized prior to use? ☐ Yes ☐ No

Do you offer tooth jewels? ☐ Yes ☐ No

Indicate number of Technicians		**# to be Insured**
All Tattoo/Body Piercers must have at least 1 year experience or be working under an apprenticeship for coverage to apply *List each person ONLY once*	Tattoo Artist(s) Only:	
	Body Piercer(s) Only:	
	Both (Tattoo Artist and Body Piercer):	
	Total Number of Artists:	

If you have 7 or less Technicians, please indicate name and service (s) performed:

1.	☐ Tattoo ☐ Body Piercer ☐ Both
2.	☐ Tattoo ☐ Body Piercer ☐ Both
3.	☐ Tattoo ☐ Body Piercer ☐ Both
4.	☐ Tattoo ☐ Body Piercer ☐ Both
5.	☐ Tattoo ☐ Body Piercer ☐ Both
6.	☐ Tattoo ☐ Body Piercer ☐ Both
7.	☐ Tattoo ☐ Body Piercer ☐ Both

Piercers under 1 Year Experience are limited to the following: Eyebrow, Earlobe, Outer Rim Ear cartilage, Lower Lip-Sides and Center, Nostrils – Thin or Hyaline Cartilage Only, Navel, Nipples.

Limitations to work on Minors:
MINOR PIERCING: Ear, Nose, Lips, Tongue (midline only) & Eyebrow piercing on minors age 13 years or over with written parental consent (ear lobes children age 3 months or older) – if state law specifies an older age, you must follow state law.
MINOR TATTOOING: In states where legal age 16 or over with written parent consent.

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Equipment and Procedures – Piercing

Are all your jewelry and needles either a.) pre-sterile, one time use or b.) heat sterilized prior to use? ☐ Yes ☐ No

Is all jewelry you use made within US guidelines and/or meets EU/UK standards? ☐ Yes ☐ No

For new piercings, do you use jewelry specifically made for that purpose? ☐ Yes ☐ No

Equipment and Procedures – Tattooing

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

Do you EVER re-use needles? ☐ Yes ☐ No

SECTION VIII: OTHER SERVICES *additional premium and application will apply*

If this Section does not apply, Check Here ☐

Do you provide any of the following? If so, indicate the number of people performing.

Injectables? ☐ Yes ☐ No Number of Technicians: _____

Laser / Intense Pulse Light? ☐ Yes ☐ No Number of Technicians: _____

☐ Services not listed above:

SECTION IX: SUPERVISING PHYSICIAN / MEDICAL DIRECTOR

If this Section does not apply, Check Here ☐

Are you required to have oversight to any of the above services by a Supervising Physician / Medical Director? ☐ Yes ☐ No

If Yes, provide name(s) and designations of supervising staff:

Name:	Medical Designation:
Name:	Medical Designation:

SECTION X: OPTIONAL COVERAGES

If this Section does not apply, Check Here ☐

Do you need the following coverage? ☐ Non-Owned Auto ☐ Hired Auto ☐ Both

If so, answer questions 1-8:

1. Do you currently have a commercial auto policy? ☐ Yes ☐ No
2. Do you have a contractual requirement to carry Hired Auto? ☐ Yes ☐ No
3. Under which circumstances do the employees use their personal vehicles? _____
4. Approximate combined number of Non-Owned Auto trips annually? ☐ Under 10 ☐ 11-50 ☐ 50+
5. Approximate combine number of Hired Auto trips annually? ☐ Under 10 ☐ 11-50 ☐ 50+
6. Do you require your employees to carry their own insurance, with at least state minimum requirements, and obtain proof of insurance before you authorize them to use their own auto on company business? **If No, coverage will be excluded.** ☐ Yes ☐ No
7. Do you obtain Motor Vehicle Records of employees before you authorize them to use their own auto on company business? **If No, coverage will be excluded**. ☐ Yes ☐ No
8. Does anyone driving for this company have a DUI / DWI or Reckless Driving Violation on their Motor Vehicle Record? **If Yes, coverage will be excluded**. ☐ Yes ☐ No

Do you want Defense Outside the Limit? ☐ Yes ☐ No Limit requested: _____

Do you want coverage for Sexual Abuse at $25K / $50K limits? ☐ Yes ☐ No Other limit requested: _____

Do you want coverage for Cyber Liability? ☐ Yes ☐ No If Yes, Indicate Limit: ☐ $250K ☐ $500K

If Yes, does the business have a company-wide privacy policy for keeping customers information secure? ☐ Yes ☐ No

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SECTION XI: PROPERTY *(Complete this section for EACH location)* If this Section does not apply, Check Here ☐

Location #: _____ Address: _____

Year Built: _____ Construction Type: _____ Number of stories: _____

If building is over 15 years old, what year were the following upgraded? **(*) information required**

*Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____

*Roofing Material (Tile, Metal, Wood Shingles, etc.): _____ *Are there sprinklers inside your unit? ☐ Yes ☐ No

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

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

Name and address of Loss Payee: _____

Coverage Desired:

Contents: $: _____

Flash: $: _____

Tenant Improvements: $: _____

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

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

Outside Sign $: _____

Optional Coverages:

Do you want coverage for Property of Independent Contractors? ☐ Yes ☐ No

Do you want coverage for Equipment Breakdown? ☐ Yes ☐ No

Do you want coverage for Contingent Business Income? ☐ Yes ☐ No $10K limit (Off Premise Power Outage)

Location #: _____ Address: _____

Year Built: _____ Construction Type: _____ Number of stories: _____

If building is over 15 years old, what year were the following upgraded? **(*) information required**

*Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____

*Roofing Material (Tile, Metal, Wood Shingles, etc.): _____ *Are there sprinklers inside your unit? ☐ Yes ☐ No

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

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

Name and address of Loss Payee: _____

Coverage Desired:

Contents: $: _____

Flash: $: _____

Tenant Improvements: $: _____

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

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

Outside Sign: $: _____

Optional Coverages:

Do you want coverage for Property of Independent Contractors? ☐ Yes ☐ No

Do you want coverage for Equipment Breakdown? ☐ Yes ☐ No

Do you want coverage for Contingent Business Income? ☐ Yes ☐ No $10K limit (Off Premise Power Outage)

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SECTION XII: 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: _____

Do you have any past Professional, General Liability, Cyber and/ or Property Claims, whether or not insured? ☐ Yes ☐ No

If Yes, describe:

Do you have knowledge of an event, circumstance, or occurrence (other than listed above) prior to the effective date of the proposed policy that may result in a claim or incident? ☐ Yes ☐ No

If Yes, describe:

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 the company, 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 liability policy applied for will apply only to CLAIMS FIRST MADE and REPORTED 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 PRIOR OF BINDING (60 DAYS FOR RENEWALS).
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

POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), 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, as amended:** The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an 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, 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. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2027, the date on which the TRIA Program is scheduled to terminate, or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT 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. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 80% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A USD100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS USD100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED USD100 BILLION, YOUR COVERAGE MAY BE REDUCED.

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.

☐	(ACCEPT) I hereby elect to purchase coverage for acts of terrorism for a prospective premium of USD……
☐	(DECLINE) I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

_____ _____
Policyholder/Applicant's Signature Carrier

_____ _____
Print Name Policy Number

_____
Date