



21 Maple Avenue • PO Box 9175 • Bay Shore, NY 11706-9175
 Call Toll Free (800) 645-5820 • in NY (631) 666-5050
 Fax: (631) 666-7646 • www.hairdressersagency.com

NOTE: All Questions Must Be Answered
PROFESSIONAL LIABILITY / GENERAL LIABILITY APPLICATION
 (Please type or print clearly)

SECTION I:

1. Requesting coverage for: Beauty/Nail Salon Beauty Spa Barber Shop Beauty School
2. Are you: An Owner A Lessee of Booth Space/Chair Renter/Independent Contractor
3. Trade Name Or Corporate Name: _____
COMPLETE NAME AS IT SHOULD APPEAR ON THE POLICY, INCLUDING INC., CORP., LTD., ETC.)
4. Business Address: _____
NO. STREET (indicate floor number) CITY COUNTY STATE ZIP
5. Name: _____ Title: _____
6. Are you an Active Operator? Yes No If Yes, complete Section III.
7. Residential Address: _____
NO. STREET CITY COUNTY STATE ZIP
8. Business Phone: _____ Home Phone: _____ Fax No.: _____
9. Email Address: _____ Website: _____
10. How did you hear of us? Web surfing Ad in which publication: _____ Other:
11. Limit of liability desired: \$1,000,000 \$2,000,000
12. Would you prefer a policy at a reduced rate under which for each claim you would be liable for:
 No Deductible The First \$250 The First \$500
13. Do you wish to include premises liability coverage? Yes No
14. Estimated Annual Gross Sales (for entire business): \$ _____
15. Years in business at this address: _____ Number of Stations: _____
16. Operate as: Corporation Partnership Individual Other:
17. Business located in: Store School Office Building Hotel Your Home
 Homes of Clients Assisted Living/Nursing Home (*provide full name*)
 Other:
18. Name and address of additional locations: _____
19. Do you rent booths/chairs to others? Yes No If so, number rented: _____
 Do you rent booths/chairs from others? Yes No Salon Name: _____
20. If you operate on premises of others, do you desire that their interest be included as additional insured? Yes No
 Name and address: _____

SECTION II: BUSINESS DATA (for each Active Owner, ALSO complete the **PERSONNEL DATA** section)

List additional owner(s), partner(s):

Name and Title (if corporation)	Active Operator (Y/N)	Duties	Home Address	Telephone

SECTION III: PERSONNEL DATA

Give following details For Each Active Owner, Employee and Lessee of Booth Space/Independent Contractor

Name	Owner, Employee or Lessee/ Indep.	Years Experience	# Days Per Week	Weekly Income (excluding tips)	Licensed (Y/N)	Services Rendered (Y/N)							
						Hair Cutting	Perm Waves	Hair Dyeing	Shampoo Only	Nails	Waxing	Skin Care	Massage Therapist
				\$									
				\$									
				\$									
				\$									
				\$									
				\$									
				\$									
				\$									

SECTION IV: For owners of a BEAUTY SCHOOL, please ALSO complete the following

- Number of years in business: _____ Estimated Annual Tuition and Clinic Receipts: _____
 Number of instructors: _____ Estimated number of students graduated each year: _____
- Is it your practice to have students work on each other? Yes No
 If so, do students sign a release? Yes No If yes, **attach a copy.**
- Is work done on the public? Yes No If so, what arrangements are made as to reduced prices, release etc.
- Do you operate a Beauty Salon? Yes No If so, at what location: _____
- Do you now carry insurance covering claims for injuries to students and public? Yes No
 If yes, name of company? _____ Rate: \$ _____ Premium: \$ _____

* BE SURE TO ATTACH A COPY OF THE FOLLOWING:

A Release Signed by Students, a Release Signed by the Public and a Sample of a Student Registration Form.

SECTION V: SERVICES

Do you perform any of the following:

	Brand/Product Manufacturer's Name and Procedures Followed	Estimated Gross Annual Receipts
<input type="checkbox"/> Electric or Steam Bath <i>(send brochure)</i>		\$
<input type="checkbox"/> Saunas <i>(send brochure)</i>		\$
<input type="checkbox"/> Body Massage <i>(other than face or neck)</i> Also list any machines used		\$
<input type="checkbox"/> Bodywrapping		\$
<input type="checkbox"/> Reducing, Slenderizing or Exercising Services Also list any machines used		\$
<input type="checkbox"/> Reflexology		\$
<input type="checkbox"/> Other:		\$
<input type="checkbox"/> Spray Tanning:		\$
<input type="checkbox"/> Tanning Beds		
<input type="checkbox"/> Electrolysis <i>(also fill out ELECTROLOGIST Application)</i>		
<input type="checkbox"/> Electronic Tweezer <i>(also fill out ELECTROLOGIST Application)</i>		
<input type="checkbox"/> Chiropody or Podiatry		
<input type="checkbox"/> Hair Removal by Waxing or a Depilatory Product		
<input type="checkbox"/> Laser Hair Removal		
<input type="checkbox"/> Hair Implants or Transplants		
<input type="checkbox"/> Hair Straightening		
<input type="checkbox"/> Hair Weaving		
<input type="checkbox"/> Ear Piercing <i>(provide type of method)</i>		
<input type="checkbox"/> Wart or Mole Removal		

Skin Treatments or Facials	Manufacturer's Name & Model of Machines
Do You Use: <input type="checkbox"/> Microdermabrasion machine <i>(send brochure)</i>	
Do You Use: <input type="checkbox"/> Facial Steamer <i>(provide name)</i>	
Do You Use: <input type="checkbox"/> Any other skin care machines	
Total Receipts for all Skin Care Services <i>(including totals from skin care machines)</i>	\$

SECTION VI: PRODUCTS (THIS SECTION MUST BE COMPLETED IN FULL)

List all products used for the following services or enter NONE:

	Product Name/Type of System (or fill in "NONE")	Price Scale	Approx # per Year	Approx. Annual Sales
Cosmetics (sold for home use)				\$
Permanent Hair Waving				
Hair Dyeing & Shampoo Tinting				
Eye Brow & Eye Lash Coloring				
Skin Care Products				

SECTION VII

- List any products repackaged, rebottled, manufactured by you or relabeled in any way, give details:
- Is the 24-hour predisposition test given to patrons whose hair has not been previously tinted or dyed? Yes No
- Does the owner or manager supervise all permanent waving or hair dyeing? Yes No
- Are records (names, addresses, dates, products used and name of operator) kept of patrons receiving permanent waves and Hair dyes? Yes No
- What volume of peroxide do you use on patrons?

SECTION VIII: COVERAGE

Has any insurance company cancelled or refused to renew similar insurance policy in the past year? Yes No

If yes, give name of company and full details:

SECTION IX: CLAIM HISTORY

Give following details as to claims made by patrons in the past three years for injuries or infections (IF NONE, SO STATE):

Claim Date	Nature of Injuries	Equipment Involved	If Pending, give details	Settlement Amount
				\$
				\$
				\$
				\$
				\$

NOTE: THIS APPLICATION MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN OR CEO OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE. This request is for a cost-free, premium quotation only. In signing, I understand I am not obligated to purchase this insurance.

APPLICANT'S SIGNATURE

TITLE OF OFFICER, IF CORPORATION

DATE

BROKER'S NAME/ COMPANY

BROKER'S LICENSE

ADDRESS

CITY

STATE

ZIP

TELEPHONE