

Gentleman:

Thank you for your recent call regarding our beauty salon program. This program includes general liability as well as professional liability for your operators. Property coverage is also available which includes contents and business interruption. Upon receipt of your completed application we will issue our no obligation proposal. Thanks for considering our nationwide program.

Best regards,

Sandy Baldinger, CEO



**Program Insurance Specialists**

CORPORATE HEADQUARTERS:  
23805 Stuart Ranch Rd., Suite 110  
City Hall Building, Malibu, CA 90265  
BIS@Baldingerins.com  
800-877-2348 • 310-456-3368 (f)



**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)					
						Perm Waves	Hair Dyeing	Nails	Hair Cutting	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"/> 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		
<input type="checkbox"/> Tanning Services		

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	
<b>Total Receipts for all Skin Care Services <i>(including totals from skin care machines)</i></b>	<b>\$</b>

**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 \_\_\_\_\_