PLEASE PRINT CLEARLY–COMPLETE ALL QUESTIONS

1. Salon:

TRADE OR CORPORATE NAME OF SALON

DO YOU OPERATE AS . . .
☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORP.

SALON ADDRESS (NUMBER, STREET, CITY OR TOWN, COUNTY, STATE & ZIP CODE)

HOW LONG ARE YOU IN BUSINESS AT THIS ADDRESS?

SALON LOCATION	EST. ANNUAL GROSS SALES	FLOOR NUMBER	APPROX. AREA SQ. FT.	NO. OF STATIONS
☐ STORE ☐ DEPT. STORE ☐ OFFICE BLDG. ☐ HOTEL ☐ YOUR HOME				

NAME & ADDRESS OF ANY OTHER SALON(S) THAT YOU OPERATE

DO YOU RENT SPACE, BOOTHS OR CHAIRS . . .

☐ TO OTHERS? IF SO, NO. RENTED ➤ ☐ FROM OTHERS? IF SO, SALON NAME ➤

2. Owner(s) or Officers:

Names	Title (If Corporation) And/Or Duties	Licensed Oper. (Yes/No)	Active Oper. (Yes/No)	Full or Part Time	No. of Years Experience	Home Address & Phone Number

3. Personnel Data (For Each Employee and Lessee, Complete This Information):

NAMES OF EMPLOYEES AND LESSEES (IF LESSEE, PLEASE CHECK HERE) ——→		FULL OR PART TIME	IF PART TIME: NO. OF DAYS PER WEEK	LICENSED OPER. (YES/NO)	NO. OF YEARS EXPERIENCE	APPROX. WEEKLY INCOME (EXCLUDE TIPS)	SERVICES RENDERED (YES/NO) PERM. WAVES	HAIR DYEING	MANI-CURE	HAIR CUTTING

4. Claim History

YEAR OF CLAIM	NATURE OF INJURIES	EQUIPMENT INVOLVED	IF 'PENDING', GIVE DETAILS IF 'SETTLED', STATE AMOUNT.

5. Services Do You Perform Any of the Following:

YES	NO	
☐	☐	A) Electrolysis or Hair Removal by Electronic Tweezer
☐	☐	B) Chiropody or Podiatry
☐	☐	C) Wart or Mole Removal
☐	☐	D) Reducing, Slenderizing or Exercising Services
☐	☐	E) Tanning Services
☐	☐	F) Skin Treatments or Facials
☐	☐	G) Electric or Steam Baths or Sauna
☐	☐	H) Hair Implants or Transplants
☐	☐	I) Hair Weaving
☐	☐	J) Ear Piercing
☐	☐	K) Body massage other than face or neck.
☐	☐	L) Do you offer Services or Treatments that are not generally engaged in by Beauty Salons? Describe in full.

IF YOU ANSWER 'YES' TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS INCLUDING DESCRIPTIVE LITERATURE, NAMES OF PRODUCTS USED, THE PROCEDURES FOLLOWED AND THE ESTIMATED ANNUAL GROSS RECEIPTS. IF NECESSARY, USE SEPARATE SHEET.

6. Products LIST ALL PRODUCTS USED FOR THE FOLLOWING SERVICES:

PERMANENT HAIR WAVING	NAME OR TYPE OF SYSTEM	PRICE SCALE	APPROX. NO. PER YR.
HAIR DYEING AND SHAMPOO TINTING	PRODUCT USED		
HAIR STRAIGHTENING	PRODUCT USED		APPROX. NO. PER YR.
COSMETICS (SOLD FOR HOME USE)	NAMES OF PRODUCTS		APPROX. ANNUAL SALES $
EYE BROW AND EYE LASH COLORING	PRODUCT USED		
DYE STAIN REMOVING	PRODUCT USED		

LIST ANY PRODUCTS REPACKAGED, REBOTTLED, MANUFACTURED BY YOU OR LABELLED IN YOUR NAME

(Yes)	(No)		(Yes)	(No)	
☐	☐	IS THE 24 HOUR PREDISPOSITION TEST GIVEN TO PATRONS WHOSE HAIR HAS NOT BEEN PREVIOUSLY TINTED OR DYED?	☐	☐	DOES THE OWNER OR MANAGER SUPERVISE ALL PERMANENT WAVING OR HAIR DYEING?
☐	☐	ARE RECORDS (NAMES, ADDRESSES, DATES, PRODUCTS USED AND NAME OF OPERATOR) KEPT OF PATRONS RECEIVING PERMANENT WAVES AND HAIR DYES?			WHAT VOLUME OF PEROXIDE DO YOU USE ON PATRONS?

7. Coverages

IF YOU NOW CARRY BEAUTY SHOP MALPRACTICE LIABILITY INSURANCE, PLEASE GIVE... NAME OF INSURANCE COMPANY	RATE	COST PER YEAR	EXPIRATION DATE

IF ANY INSURANCE COMPANY HAS CANCELLED OR REFUSED TO RENEW SIMILAR INSURANCE POLICY IN THE PAST YEAR, GIVE NAME OF COMPANY AND FULL DETAILS

LIMITS OF LIABILITY ☐ $25,000/25,000 or ☐ Increased Limits of $	DO YOU WISH TO INCLUDE PREMISES LIABILITY COVERAGE? ☐ YES ☐ NO	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 $100

THIS REQUEST IS FOR A COST-FREE, PREMIUM QUOTATION ONLY. IN SIGNING, I UNDERSTAND I AM NOT OBLIGATED TO PURCHASE THIS INSURANCE.

SIGNATURE	DATE	TITLE OF OFFICER, IF CORPORATION
NAME OF AGENT OR BROKER		LICENSE NUMBER

ADDRESS

Supplemental Questionnaire

(Please complete and submit along with Application)

5. Services (continued)

IF YOU ANSWERED "YES" TO ANY OF THE SERVICES DESCRIBED IN QUESTION #5 ON THE APPLICATION, PLEASE PROVIDE:

D) Reducing, Slenderizing or Exercising Services, please provide estimated gross annual receipts: _____

_____

F) Skin Treatments or Facials, please provide manufacturer's name and type of skin care machine(s): _____

_____

Estimated gross annual receipts: _____

G) Electric or Steam Baths or Sauna (SEND BROCHURE), please provide estimated gross annual receipts: _____

_____

J) Ear Piercing, please provide manufacturer's name of gun used: _____

_____

K) Body Massage other than face or neck, please provide estimated gross annual receipts: _____

_____

If you desire Premises Liability Coverage, please provide estimated gross annual sales for entire business: _____

_____