

# PERMANENT COLOR LIABILITY INSURANCE APPLICATION

## PART I. GENERAL INFORMATION

- 1.1 Your Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Your Business Name: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Website: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Business Address #1: \_\_\_\_\_  
Business Address #2: \_\_\_\_\_ Add premises liability? \_\_\_\_\_  
(There is an additional charge if premises liability is needed for more than one location.)
- 1.2 Your Business structure:  Corporation  LLC  Employee  Sole Proprietorship  Partnership
- 1.3 Type of business (where equipment is located):  Salon  Clinic  Independent, Number of locations \_\_\_\_\_  
 Other, describe \_\_\_\_\_
- 1.4 Are you in compliance with all city, county and/or state ordinances? \_\_\_\_\_  
Business License No. \_\_\_\_\_ (Attach copy)
- 1.5 How long in business applying permanent color? \_\_\_\_\_
- 1.6 Have you had formal instruction in the application of permanent color:  Yes  No  
If less than 2 years experience attach all certificates of training or attach description of training and experience.
- 1.7 How many procedures have you performed in the past 12 months for the following:
- |                  |       |                      |       |                                 |       |                       |       |
|------------------|-------|----------------------|-------|---------------------------------|-------|-----------------------|-------|
| Eyeliner:        | _____ | Lipliner             | _____ | Skin Repigmentation/Camouflage: | _____ | Cheek blush:          | _____ |
| Eyebrows:        | _____ | Lips:                | _____ | MCA / Needling:                 | _____ | Decorative Tattooing: | _____ |
| Pigment Removal: | _____ | Removal Method used? | _____ |                                 |       |                       |       |
- Other, explain: \_\_\_\_\_

## PART II. INFORMATION ABOUT YOUR PROFESSION

- 2.1 Do you use a medical history/client information form on everyone?  Yes  No  
If yes, attach a copy.
- 2.2 Do you use a hold harmless or informed consent form?  Yes  No  
If yes, attach a copy
- 2.3 Do you take before and after photos of all permanent cosmetic work?  Yes  No
- 2.4 Do you schedule a follow-up appointment after the procedures?  Yes  No  
If yes, when? \_\_\_\_\_

## PART III. EQUIPMENT AND PROCEDURES

- 3.1 Are all pigments you use from US manufacturers?  Yes  No  
If no, List Manufacturers: \_\_\_\_\_
- 3.2 Do you ever re-use needles?  Yes  No
- 3.3 Is all your equipment pre-sterile, one-time use?  Yes  No  
If no, indicate your method of sterilization: \_\_\_\_\_
- 3.4 Do you wear gloves with each procedure?  Yes  No
- 3.5 Do have hot and cold running water on site?  Yes  No
- 3.6 What anesthetics, if any, do you use? \_\_\_\_\_

**PART IV. HISTORY**

**NOTE:** All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

4.1 Do you currently have insurance coverage? \_\_\_Yes \_\_\_No If yes, indicate the following:

*Insurer Policy # Liability Limits Premium Exp. Date*

If claims made, most recent retroactive date: \_\_\_\_\_

4.2 List liability claims history arising from any body piercing, tattoo, permanent makeup or other professional activity, whether or not insured: If none, state so \_\_\_\_\_

*YR/Claim Nature of injuries Equip. Involved Details, if Pending Amt. if settled*

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or are you aware that a claim may be brought as a result of said event, circumstance or occurrence? \_\_\_\_\_Yes \_\_\_\_\_No. If yes, describe details of the event:

\_\_\_\_\_

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.

Furthermore, I understand that the 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 OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY**

\_\_\_\_\_  
APPLICANT SIGNATURE TITLE

\_\_\_\_\_  
DATE SIGNED REQUESTED EFFECTIVE DATE LIABILITY LIMIT REQUESTED

Can we email you your policy (usually within 2-3 weeks)  Yes  No \_\_\_\_\_@\_\_\_\_\_

One box below must be checked:

I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

ADDITIONAL INSURED: @ \$30 Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Relationship to your business (Landlord, lienholder): \_\_\_\_\_

# SCHEDULE OF SERVICES

Indicate which services you provide, the number of operators and if we are to insure them. Independent contractors are not covered unless coverage is specifically extended to them.

				<b>INSURE WITH US?</b>
MANICURISTS	YES/NO	NUMBER_____		_____
BEAUTICIANS	YES/NO	NUMBER_____		_____
FACIALS	YES/NO	NUMBER_____		_____
AESTHETIC PEELS	YES/NO	NUMBER_____		_____
MEDICAL PEELS	YES/NO	NUMBER_____		_____
MICRODERMABRASION	YES/NO	NUMBER_____		_____
WAX REMOVAL	YES/NO	NUMBER_____		_____
BODY WRAPS	YES/NO	NUMBER_____		_____
MASSAGE	YES/NO	NUMBER_____	CERTIFIED?_____	_____
ELECTROLOGY	YES/NO	NUMBER_____		_____
EAR PIERCING	YES/NO	NUMBER_____		_____
TANNING - AIRBRUSH	YES/NO	UNITS_____		_____
PRODUCTS (No coverage is provided for private label products)	YES/NO	Gross Receipts:_____		_____
CAMOUFLAGE	YES/NO	NUMBER_____		_____
<b>PIGMENT REMOVAL/LIGHTENING: CHECK ONE OF THE FOLLOWING</b>				
SALINE/TATT2AWAY/A+OCEAN/TATTOO VANISH			<input type="checkbox"/>	
REJUVI/ELIMININK			<input type="checkbox"/>	
NEEDLING / MCA <small>MCA = Multitrepanic Collagen Actuation</small>	YES/NO	NUMBER_____		_____
<i><u>FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED</u></i>				
PERM. MAKEUP	YES/NO	NUMBER_____		_____
TEACHING	YES/NO	NUMBER_____		_____
TANNING – UNITS	YES/NO	UNITS_____		_____
BODY PIERCING	YES/NO	NUMBER_____		_____
BODY TATTOO	YES/NO	NUMBER_____		_____
LASERS / INTENSE PULSED LIGHT DEVICES	YES/NO	NUMBER_____		_____
SAUNAS/STEAM ROOMS/SOAKING POOLS/SHOWERS	YES/NO	NUMBER OF UNITS		_____
OTHER:	_____			

LIABILITY LIMIT REQUESTED: \_\_\_\_\_ NUMBER OF OPERATORS: \_\_\_\_\_

**IMPORTANT: SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.**  
Coverage becomes effective only when accepted by the insurance company.

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
TODAY'S DATE