



Submission #

PO Box 440549 Kennesaw, GA 30160
Phone: (866) 671-0520
www.spachoiceins.com

Send Completed Application to: Fax: (678) 290-2200 or Email: news@thomcoins.com

The Following Items Are Required To Be Submitted With This Application:

- 1. Four Years of Loss Runs 2. Certificate of Insurance for all Medical Doctors on Staff
3. Copies Of Current Medical Licenses & Training Certificates for Medical Estheticians, Medical Doctors, & Nurse Practitioners
4. Copy of Sample Consent Forms Completed By Clients. 5. Copy of Sample After Care Forms.

BASIC INFORMATION:

Named Insured: DBA:
Loss Control Contact Name: Phone: Fax:
Website Address: Email Address:
Mailing Address:
Physical Address:

Type of Entity: Corporation Individual Partnership Joint Venture LLC

FEIN/Social Security Number:

Date business started under current ownership:

Proposed Effective Date:

Current Carrier & Limits of Liability: Retro Date:

Is this policy being non-renewed: Yes No Is the expiring policy written as Claims Made? Yes No

Is this a new venture? Yes No

Expiring Premium: Gross Annual Revenue/Sales \$

List all losses in the past 5 years whether or not insured(Attach additional sheet if necessary):

Table with 5 columns: Date of Claim, Description of Claim, Open/Closed, Paid \$, Reserve \$

LIABILITY LIMITS & COVERAGE (per occurrence limit/ aggregate limit):

General Liability Limit (choose one):

\$1,000,000 / \$2,000,000 \$500,000 / \$1,000,000 \$300,000 / \$600,000

Please choose a GL Deductible: \$0 \$250 \$500 \$1,000 \$1,500 \$2,000

Professional Liability Limit (choose one): Note: The limit chosen cannot exceed the GL per occurrence limit chosen above

N/A \$300,000 \$500,000 \$1,000,000

Please choose a PL Deductible: \$0 (N/A for MediSpa) \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$5,000

PL Retroactive Date:

Medical Payments Limit (Automatically included at \$5,000) Higher limit available: \$10,000

Damage to Premises Rented To You (Automatically included at \$300,000)

Higher Limits Available if required by lease (copy of lease required): \$500,000 \$750,000 \$1,000,000

Stop Gap Limit (Available in ND, OH, WA, WY only)(choose one): Annual Payroll

\$100,000 / \$500,000 / \$100,000 \$1,000,000 / \$1,000,000 / \$1,000,000

Employee Benefits Liability: Retroactive Date Number of employees per location

Limit (choose one) N/A \$500,000 / \$ 500,000 \$500,000 / \$1,000,000 \$1,000,000 / \$ 1,000,000

Abuse Liability Limit (automatically provided at \$100,000 per occurrence/ \$300,000 aggregate):

Higher Limits Available: \$500,000 / \$1,000,000 \$1,000,000 / \$2,000,000

Hired & Non-Owned Auto: Reject \$100,000 \$300,000 \$500,000 \$1,000,000

Submission # _____

DaySpa, MediSpa & Beauty Shop Application

(A Copy of this Page is Required for Each Additional Location)

GL COVERAGE: Location # _____ Annual Revenue: _____ Sq Feet: _____

Location Address: _____

Which best describes the operations at this location: DaySpa* MediSpa* Beauty Shop Barber Shop
 Combined DaySpa/Medispas* Resort Other _____

*Requires the completion of a supplemental application

Are any childcare services provided at this location? Yes No If yes, please complete the supplemental application.

Are any retail products sold at this location? Revenue _____

Exposure	How Many	Exposure	How Many	Exposure	How Many
<input type="checkbox"/> Hydrotherapy Tub		<input type="checkbox"/> Vichy Shower		<input type="checkbox"/> IPL Light Therapy	
<input type="checkbox"/> Steam Rooms		<input type="checkbox"/> Tanning Beds/Booths*		<input type="checkbox"/> Exercise Equipment	
<input type="checkbox"/> Saunas/Jacuzzis		<input type="checkbox"/> Toning Machines		<input type="checkbox"/> Office Space (sq ft)	
<input type="checkbox"/> Whirlpools		<input type="checkbox"/> Aqua Massage/Hydration Station		<input type="checkbox"/> Warehouse Space	
<input type="checkbox"/> Pools		<input type="checkbox"/> Oxygen Bar		<input type="checkbox"/> Misc Tanning	

Additional insureds are automatically included if required by contract. Only complete the below section if the additional insured is required to be named.

Name: _____ Additional Insured Loss Payee Both

Address: _____

Insured Type: Designated Person Franchiser Leaser of Equipment Landlord

Name: _____ Additional Insured Loss Payee Both

Address: _____

Insured Type: Designated Person Franchiser Leaser of Equipment Landlord

PL COVERAGE (Only complete if you are purchasing this coverage):

Service Providers	How Many (Employees & ICs)	Service Providers	How Many (Employees & ICs)
<input type="checkbox"/> Acupuncturists		<input type="checkbox"/> Massage Therapists	
<input type="checkbox"/> Barbers		<input type="checkbox"/> Medical Director (Oversight Only)	
<input type="checkbox"/> Barber Students		<input type="checkbox"/> Medical Doctor (Performs Procedures)	
<input type="checkbox"/> Beauty School Students		<input type="checkbox"/> Nail Technicians	
<input type="checkbox"/> Licensed Body Wrap Technician		<input type="checkbox"/> Nurses	
<input type="checkbox"/> Unlicensed Body Wrap Technicians		<input type="checkbox"/> Permanent Makeup Operators*	
<input type="checkbox"/> Cosmetologists		<input type="checkbox"/> Physician Assistants	
<input type="checkbox"/> Ear Piercing Operators		<input type="checkbox"/> Shampoo Technicians	
<input type="checkbox"/> Electrologists		<input type="checkbox"/> Teeth Whitening Technicians	
<input type="checkbox"/> Medical Esthetician		<input type="checkbox"/> Paramedical Makeup Technician	
<input type="checkbox"/> Non Medical Esthetician		<input type="checkbox"/> Personal Trainer	
<input type="checkbox"/> Physical Therapists			

Do you provide airbrush tattoo application services? Yes No If so, do you use Henna Ink? Yes No

Do you provide permanent tattoo application services? Yes No

Are all operators/trainers licensed and/or certified in the jurisdiction where the services are provided? Yes No
 If you answered no, there is no coverage.

Submission # _____

DaySpa, MediSpa & Beauty Shop Application

(A Copy of this Page is Required for Each Additional Location)

PROPERTY LIMITS AND COVERAGE – (If applicable)

Property Deductible (choose one): \$250 \$500 \$1000 \$1,500 \$2,500 \$5,000

Location #: _____

Address: _____

Coverage Desired:

	Co-insurance	Limit of Ins
<input type="checkbox"/> Business Personal Property-Replacement Cost	<input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	
<input type="checkbox"/> Tenant Improvements & Betterments of your leased space-Replacement Cost	<input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	
<input type="checkbox"/> Building Coverage-Replacement Cost	<input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	
<input type="checkbox"/> Business Income - There is a 72 hour waiting period for TX, LA, MS, AL, FL, SC, NC & VA. A 24 hour waiting period applies to all other states.	<input type="checkbox"/> 1/3 Monthly Limit <input type="checkbox"/> 1/4 Monthly Limit <input type="checkbox"/> 1/6 Monthly Limit	
<input type="checkbox"/> Glass Coverage		

Tell Us About Your Building - REQUIRED FOR QUOTE - DO NOT LEAVE BLANK

Construction Type (choose one): Frame Joisted Masonry Masonry Non-Combustible
 Non-Combustible Semi-Fire Resistive Fire Resistive

Year Built: _____ Total Square Feet: _____ # of Stories: _____ Sprinklered: Yes No

Central Alarm System: Yes No

Year Updated: _____ Plumbing: _____ Heating: _____ Roof: _____ Electrical: _____

Business/exposure to your: Left: _____ Right: _____ Rear: _____

Mortgage Holder (If Needed):

Name: _____

Address: _____

City, State, Zip: _____

Loss Payee (If Needed):

Name: _____

Address: _____

City, State, Zip: _____

COVERAGE ENHANCEMENTS – The following property enhancements are included at no additional charge, however, higher limits are available by request for an additional premium.

Coverage	Limit Included	Optional Limits Available
Fire Department Service	\$5,000 Each Occurrence	<input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000
Money & Securities	\$10,000 Inside/ \$5,000 Outside	<input type="checkbox"/> \$15,000 Inside/ \$10,000 Outside
Forgery & Alteration	\$2,500 Each Occurrence	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
Outdoor Signs (not attached to bldg)	\$5,000 Each Occurrence	Can be increased in increments of \$100 (\$100,000 Maximum) Total Limit \$ _____
Employee Dishonesty	\$10,000 Each Occurrence	<input type="checkbox"/> \$15,000
Personal Effects & Property Of Others	\$5,000 Each Premises	<input type="checkbox"/> \$10,000
Valuable Papers & Records	\$5,000 On Premises/ \$2,500 Off Premises	Can be increased in increments of \$1,000 (\$250,000 Maximum) Total Limit \$ _____
Employees' Equipment	\$5,000 at each premises/ \$2,500 in transit	<input type="checkbox"/> \$10,000 On Premises/ \$5,000 in transit
Accounts Receivable	\$10,000 On Premises/ \$1,500 off Premises	<input type="checkbox"/> \$15,000 On Premises/ \$1,500 Off Premises
Electronic Data Processing	\$10,000 *(\$5,000 Deductible)	Can be increased in increments of \$1,000 (\$25,000 Maximum) Total Limit \$ _____ (<input type="checkbox"/> \$500 or <input type="checkbox"/> \$1,000 deductible options)
Equipment Breakdown Coverage	Total of Building, Business Personal Property Limits	None
Fine Arts Coverage	None	<input type="checkbox"/> \$25,000

RISK ASSESSMENT - Provide details to any "Yes" answers

	YES	NO
1. Do you have a formal safety program?		
2. Any policy or coverage declined, cancelled or non-renewed during the prior 3 years? N/A in Missouri.		
3. Have any crimes occurred or been attempted on your premises within the last 3 years?		
4. Have you had any bankruptcies?		

RISK MANAGEMENT

	YES	NO
1. Do you use customer history cards or use a computer software program to track client visits? If using a software program, please provide the name of the program.		
2. Are signed consent forms obtained for each service performed?		
3. Are Aftercare Instructions provided for each service performed?		
4. Do you obtain parental consent forms for minors?		
5. Are employees required to obtain a signed form prior to use of the equipment by minors?		
6. Do you manufacture, blend or formulate your own products? (lotions, etc.) **If you answer yes, there is no coverage - you must provide proof of other insurance coverage for your product manufacturing.**		
7. Are any products sold under the insured's name? **If you answer yes, there is no coverage - you must provide proof of other insurance coverage for your product manufacturing.**		
8. Do you use independent contractors?		
If yes: Do you require and maintain a copy of the independent contractor's insurance? And what limits are required?		
9. Do you do pre-employment screening such as background checks, drug testing, etc?		
10. Do you have a formal training program for new employees?		
11. Do you use any products that are not FDA Approved?		

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Date: _____
(Only applicable if using a producer)

Producer's License Number: _____ Exp. Date: _____

Submission #

DaySpa Supplement

(A copy of this Page is Required for Each Location)



Only Non-Surgical Treatments and those that use FDA approved products are eligible for this program.

Please advise which services are provided at this location and which licensed professional is providing the service (ex. Electrologist, Esthetician, etc.):

Service	Licensed Professional Providing Service
---------	---

Body Wraps _____

Type of Wraps _____

Chemical Peels _____

Solution Used and Concentration/Medical Strength _____

Cosmetology _____

Ear Piercing _____

Electrolysis _____

Facials _____

Manicures/Pedicures _____

Do you do fish pedicures? Yes No

Massage Therapy _____

Esthetics _____

Microdermabrasion _____

Do you go below the dermal layer? Yes No

Cellulite Treatments _____

Teeth Whitening _____

Product Used _____

LED Lights Used? Trays Used? At Home Kits Sold?

Waxing _____

Dermaplaning _____

Ear Candling _____

Mesotherapy _____

Prescription Drug Weight Loss _____

Other _____

Do any services provided at this location include the use of a laser? Yes No

(If Yes, a Medi-Spa supplement must be completed)



Only Non-Surgical Treatments and those that use FDA approved products are eligible for this program.

1. Do you administer injectable fillers? Yes No

Type of Filler: Artefill Botox Cosmetic Collagen Juvederm Restylane
 Lipodissolve Other _____

Who administers the injections? (Select all that apply):

Cosmetologist Electrologist Medical Esthetician Non Medical Esthetician
 Medical Doctor Physician Assistant Other _____

2. Do you perform IPL Treatments? Yes No

Select all treatments that are done with the IPL Laser: Acne Scars PhotoFacials
 PhotoRejuvenation Rosacea Other _____

Who administers the treatments? (Select all that apply):

Cosmetologist Electrologist Medical Esthetician Non Medical Esthetician
 Medical Doctor Nurse Physician Assistant Other _____

Do you perform hair removal with the use of IPL treatments? Yes No

Who administers the treatments? (Select all that apply):

Cosmetologist Electrologist Medical Esthetician Non Medical Esthetician
 Medical Doctor Nurse Physician Assistant Other _____

Do you perform tattoo removal with the use of IPL treatments? Yes No

Who administers the treatments? (Select all that apply):

Cosmetologist Electrologist Medical Esthetician Non Medical Esthetician
 Medical Doctor Nurse Physician Assistant Other _____

3. Do you provide Sclerotherapy? Yes No

What is the largest size vein you will treat? _____

4. Do you provide Chemical Peels? Yes No

What solution and concentration is used for the treatments? _____

5. Do you provide Microdermabrasion? Yes No

Who administers the treatments? (Select all that apply):

Cosmetologist Electrologist Medical Esthetician Non Medical Esthetician
 Medical Doctor Nurse Physician Assistant Other _____

6. Do you provide Thermage? Yes No

7. Do you provide Dermaplaning? Yes No

8. Do you provide Prescription Drug Weight Loss services? Yes No

9. Do you provide Acupuncture Services? Yes No

10. Do you provide Permanent Make Up Services? Yes No

11. Do you provide Botox parties? Yes No

12. Do you perform procedures requiring anesthesia or surgical excision? Yes No

13. Do you provide any other services not listed above? Yes No

If so, please describe:

14. Is your business certified by a medical organization? Yes No

If so, which one?

American Board of Dermatology American Board of Ophthalmology

American Board of Plastic Surgery American Board of Otolaryngology

American Board of Facial Plastic Reconstructive Surgery

Other _____

Tanning Supplement

(A copy of this Page is Required for Each Location)



Please advise the following:

1. How is tanning exposure time controlled?

User Operator Token

2. Is protective eye wear provided for customers? Yes No

Is it sanitized after each use? Yes No

3. Are the beds sanitized after each use? Yes No

4. Is the maximum exposure time for tanning within manufacturer guidelines? Yes No

5. Is a drug reaction list posted in your salon? Yes No

6. Are all beds UL listed? Yes No

7. Do you manufacture your own tanning beds? Yes No

8. Are customers required to read & sign an acknowledgement of the risks involved with the tanning exposure? Yes No

A COPY OF YOUR HOLD HARMLESS AGREEMENT IS REQUIRED WITH THE APPLICATION

Please advise the following:

1. How long has the permanent makeup operator been applying permanent color? _____

2. How many procedures have been performed in the past 12 months for the following:

Eyeliner _____ Eyebrows _____ Lipliner _____ Lips _____ Cheek Blush _____

Skin Repigmentation/Camouflage _____ Decorative Tattooing _____

3. Are all pigments used from US manufacturers? Yes No

4. Do you ever re-use needles? Yes No

5. Is all of your equipment pre-sterile, one-time use? Yes No

If no, indicate your method of sterilization: _____

6. Do all operators wear gloves with each procedure? Yes No

7. Do you dispose of your pigments after each client? Yes No

8. Do you take before and after photos? Yes No