Allen Financial Insurance Group

Beauty Application

Applicant's Name(including firm names and DBAs)		
Mailing Address		County
City	State	Zip Code
Business Location Address		County
City	State	Zip Code
Applicant is: ☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ Other		Year Business Started
Business Phone	Cell Phone	FAX
Contact Name	Website	
Email	Federal Employer Identification Number	
Description of Business		
Desired Limits of Liability ☐ ☐ ☐ ☐ ☐ $1,000,000 ☐ Other _____		
Would you like to purchase Terrorism Coverage?	Yes ☐ No	
How many years in the industry?	Requested Effective Date	

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Services	Number of Operators	Years of Experience
Manicurists		
Beautician		
Wax Removal		
Eyelash Extensions and Enhancements		
Body Wraps		
Massages		
Electrology		
Ear Piercing		
Tanning- Number of beds ____		
Facials, NO PEELS		
Facials with Peels and/or Microdermabrasion		
Dermaplaning		
MCA Needling		
Permanent Cosmetics (Including Full Lips)		
Camouflage *4 years of experience required*		
Cheek Blush *4 years of experience required*		
Nipple Areola		
Pigment Removal (limited to skin types I-IV) ☐ Saline ☐ Rejuvi ☐ Tattoo Vanish ☐ Eliminink		
Decorative Tattooing		
Temporary Tattooing and/or Henna		
Body Piercing- Less than 1 Year		
Body Piercing including minors with written parental consent.		
Photofacial and Skin Rejuvenation (IPL)		
Veins		
Age/Sun Spots		
Rosacea		
Nonablative Wrinkle Reduction		
Acne Treatment		
Cellulite Treatment		

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LED/ Laser Services	Number of Operators	Years of Experience
Photofacial and Skin Rejuvenation		
Veins		
Age and Sun Spots		
Rosacea		
Nonablative Wrinkle Reduction		
Acne Treatment		
Laser/IPL Hair Removal (Skin types I-IV only)		
Laser/ IPL Hair Removal (Skin types V-VI only)		
If Yes, and Laser Hair Removal Operator is not an M.D., please provide the name and address of your Supervisory Medical Professional:		
Laser Tattoo Removal		
If Yes, and Laser Tattoo Removal Operator is not an M.D., please provide the name and address of your Supervisory Medical Professional:		
Laser Hair Stimulation		
Sclerotherapy		
Dermal Fillers		
Off-Label Botox ($50,000 max. limit- foreheads and crows feet only.)		
If Yes, and Botox Operator is not an M.D., please provide the name and address of your Supervisory Medical Professional:		
Medical Strength Peels ($100,000 max. limit) Skin Types V-VI excluded		
If Yes, and Medical Strength Peels Operator is not an M.D., please provide the name and address of your Supervisory Medical Professional:		

PLEASE NOTE: Coverage is excluded for any services that require the cuse of equipment higher than the FDA approved class II or Equipment more than 20 Joules/CM Squared or Infrared Light. This applies to the above services.

Do you offer any services NOT listed? **If Yes,** please provide details:

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Operations	Yes	No	N/A
Do all operators understand the Fitzpatrick Scale?			
Does your facility require all operators to be trailed "in accordance with all FDA regulations and state laws for every service provided"?			
Does your facility keep proof (i.e. training certificates) of training for all operators in accordance with all FDA regulations and state laws for every service provided?			
Does your facility require every client to sign a consent and release form?			
Do you provide all clients with written aftercare instructions?			
Do you take client "before and after" photos of all cover-up and cosmetic work?			
Do you schedule follow-up appointments?			
Do you perform work on minors (anyone under 18)?			
Do you require a signed parental consent form for all minors?			
Do you keep a copy of all signed client forms and photos on file for a minimum of one year?			
Does your business have a valid CPR certificate posted?			
Do your operators follow Health Department Center for Disease Control sanitation guidelines?			
Are new gloves worn for every procedure?			
Do you ever re-use needles?			
Do you dispose of pigments after each procedure?			
Does all jewelry meet the standards of the Association of Professional Piercers?			
Do you use piercing guns for any area other than earlobes?			
Are all apprentice operators supervised by an experienced operator?			
Are all students supervised by a Trainer/Teacher?			
Are all products, equipment, and devices sterilized before every procedure?			
Other	**Yes**	**No**	**N/A**
Apprentice Coverage (less than one year) Please list services:			
Teaching/Training(any services) Please list services:			
Student Coverage- Number of Students Per Class____, Please list services:			

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Artist and Operator Information

Name	Years of Experience	Does this operator perform work on minors? ☐ Yes ☐ No
☐ Owner ☐ Employee ☐ M.D. ☐ Independent Contractor ☐ Apprentice		

Name	Years of Experience	Does this operator perform work on minors? ☐ Yes ☐ No
☐ Owner ☐ Employee ☐ M.D. ☐ Independent Contractor ☐ Apprentice		

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Name	Years of Experience	Does this operator perform work on minors? ☐ Yes ☐ No
☐ Owner ☐ Employee ☐ M.D. ☐ Independent Contractor ☐ Apprentice		

If one of the above is an M.D. (i.e. physician, dentist, ect.) please indicate if they are

☐ Supervising ☐ Practicing

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Property

Complete this section for building, equipment or office contents coverage if needed.

Property Address	
Do you ☐ Own ☐ Lease ☐ Rent Age of Building _____	Building Square footage _____ Square footage you occupy _____
Year of Upgrades to Roof _____ Plumbing _____ Electrical _____	Number of stories _____
Type of Construction: ☐ Frame ☐ Joisted Masonry/Brick ☐ Steel/Metal ☐ Other _____	
Type of Roof: ☐ Slate ☐ Metal ☐ Asphalt Shingles ☐ Built up Tar ☐ Rubber Membrane ☐ Other _____	
Alarm System: ☐ None ☐ Monitored System ☐ Un-Monitored System ☐ Dead Bolt ☐ Smoke Alarm	
Is property within than 150 miles of Sea Coast? ☐ Yes ☐ No **If yes**, How many miles from Sea Coast?_____	
Distance from Fire Dept. _____ Distance From hydrant _____	Is building sprinklered? ☐ Yes ☐ No
Building Replacement Value $_____ (If building coverage is needed)	Business Income & Extra Expense $_____
Business Personal Property $_____	Replacement Cost: ☐ Yes ☐ No
Building Sign Coverage $_____	Kind of sign: ☐ Neon ☐ Wood ☐ Metal ☐ Other
Property of Others $_____	Replacement Cost: ☐ Yes ☐ No
Building Glass Coverage $_____	

Please attach copies of:

- All business licenses
- Membership Certificates of any professional association you or any operators are members of that promotes safety techniques and provides continuing professional education for its members
- Copies of training certificates for operators
- Consent and aftercare forms
- Parental consent form (if you perform work on minors)
- Evidence of medical malpractice insurance (if there is an M.D. to be insured)

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Additional Insured Landlord

Name			
Mailing Address	City	State	Zip Code
Phone Number	Email		
Name			
Mailing Address	City	State	Zip Code
Phone Number	Email		

Prior Insurance

Do you currently have insurance coverage? ☐ Yes ☐ No **If yes**, please provide the following:	
Insurer	Policy Number
Liability Limits	Premium
Expiration Date	Retroactive Date

Have you had any policies or coverage cancelled, declined, or non-renewed in the past 3 years other than a carrier withdrawing from a class of business? **If yes**, please describe: _____

_____

Do you own any other properties or business operations under this legal entity? ☐ Yes ☐ No

Have any operations been sold, acquired or discontinued in the past 5 years? ☐ Yes ☐ No

Any bankruptcies, tax, or credit liens in the past 5 years? **If yes,** please describe: _____

_____

Are you aware of any event, incident, or occurrence that may arise in a claim? ☐ Yes ☐ No
If yes, please describe:

_____

_____

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PLEASE ATTACH 3 YEAR LOSS HISTORY FOR ALL COVERAGES REQUESTED. Provide detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid, and a description of the claim or allegation.

I UNDERSTAND AND AGREE THERE IS NO COVERAGE FOR THE FOLLOWING: Any equipment and/or product not approved or deemed unsafe by Federal Food & Drug Administration (FDA) Medical Peels for Skin Types V and VI.

The undersigned represents and warrants that all statements and answers to the questions are true, complete, and accurate and that there has been no suppression or misstatement of fact. The undersigned agrees that any policy issued will rely on the truth of the statements. If the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify Allen Financial Insurance Group of such changes and Allen Financial Insurance Group may withdraw or modify any outstanding quotations and/or agreements to bind insurance. **I understand and agree this application as well as all supplements attached hereto will be made part of any policy issued, and such policy will be issued in reliance upon the representation made herein.**

Applicants Name: _____ Title: _____

Applicant Signature: _____ Date:_____

Coverage becomes effective only when accepted by the insurance company, signing this form does not bind coverage.

Allen Financial Insurance Group / AFIG Entertainment / The Equestrian Group

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