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A DIVISION OF ALLEN FINANCIAL INSURANCE GROUP

Allen Financial Insurance Group Inc.
13880 N. Northsight Blvd. Building C #109
Scottsdale, AZ 85260
Phone: 800-874-9191 Fax: 602-992-8327

******TOP SECTION IS FOR INSURANCE AGENTS ONLY******

Agency/Brokerage Name: _____

Account Contact: _____

Phone Number: _____ Email: _____

BEAUTY SALON, DAY SPA, PMU SERVICES - APPLICANT INFORMATION

Applicant Name: _____ Phone Number: _____

Business Name: _____

Email Address: _____ Web Site: _____

Mailing Address: _____
Street City State Zip Code

Business Address (Loc #1) _____
Street City State Zip Code

Business Address (Loc #2) _____
Street City State Zip Code

Business Type: ☐ Corporation ☐ LLC ☐ Individual ☐ Partnership ☐ Independent Contractor ☐ Other: _____

Year Business Started: _____ # of Losses in the Past 5 Years: _____ Prior Insurance Company: _____

Do you currently have insurance coverage? If yes, complete below: ☐ Yes ☐ No

Expiration Date: _____ Policy Premium: _____ Claims Made Retro Date: _____

LIABILITY LIMITS/POLICY COVERAGES SECTION

☒ **Limits of Liability:**	☐ $100,000	☐ $200,000	☐ $300,000	☐ $500,000	☐ $1,000,000
☐ **Infectious Disease:**	☐ $25,000	☐ $50,000	☐ $100,000	☐ $250,000	
☐ **Assault & Battery:**	☐ $25,000	☐ $50,000	☐ $100,000		
☐ **Sexual Abuse:**	☐ $25,000	☐ $50,000	☐ $100,000		

☐ **I Elect to Purchase Optional Terrorism Coverage** ☐ **I Reject to Purchase Optional Terrorism Coverage**

Are you in compliance with all city, county, state ordinances and work in a licensed business? ☐ Yes ☐ No

Are you licensed by any state, county or municipality? (Send in copies of artist licenses) ☐ Yes ☐ No

Do you sell products other than the services you are providing? **Annual Sales from other products?** $ _____ ☐ Yes ☐ No

If Yes, please provide description of items sold **(i.e. Jewelry, Clothing, Aftercare Products etc….)**: _____ _____

_____ _____ _____ _____ _____

Do you manufacture, repackage, or re-label any products? If yes, please describe _____ ☐ Yes ☐ No

_____

If you are required to add any entity on as Additional Insured on your Policy, please list their info below:

☐ Landlord ☐ Property Management Co. ☐ Mortgage ☐ Loss Payee ☐ Waiver of Subrogation ☐ Primary Wording

Name: _____

Address: _____

SALON AND SPA SERVICES (CHECK ALL THAT APPLY) ☐ N/A

Technician Count: # Full Time _____ # Part Time: _____ Total # of Technicians (Full Time + Part Time): _____

 # Permanent Makeup/Microblading/Micro Scalp Pigmentation: _____ # Massage Therapists: _____ # Tanning Bed/Booth: _____

☐ Chemical Peels	☐ Cosmetic Micro-Needling	☐ Dermaplaning
☐ Electrology	☐ Eyebrow Threading	☐ Eyelash Extensions
☐ Facials	☐ Beautician/Barber Services	☐ Body Wraps (under 20% of annual sales)
☐ Makeup	☐ Massage	☐ Microdermabrasion
☐ Nails	☐ PMU Services Including Scalp & Microblading	☐ Salt Rooms
☐ Radio Frequency Skin Tightening	☐ Microcurrent Services	☐ Body Piercing
☐ Spray Tanning	☐ Teeth Whitening	☐ Waxing (Face & Body)
☐ Tanning Beds	☐ IPL (intense pulsed light) Therapy	☐ LED Light Therapy
Below Services Require Approval & Additional Supplemental Application		
☐ Acupuncture	☐ Ear stapling	☐ Plasma Fibroblasting
☐ Body wraps (over 20% of annual sales)	☐ Exercise activities (over 20% of annual sales)	☐ Laser hair removal
☐ Cellulite reduction	☐ Eyebrow Tinting	☐ Laser tattoo removal
☐ Colon hydrotherapy	☐ Eyelash Lifts or Tints	☐ Sensory deprivation chambers
☐ Cryotherapy	☐ Herbology	☐ Subcutaneous injections (e.g., Botox)
☐ Cupping	☐ Ear Candling	☐ CBD Treatments
☐ Ice Rooms	☐ Hyperbaric chambers or therapy	☐ Weight loss advice

List ***ANY*** services not listed above performed at your place of business: _____ _____

_____ _____ _____ _____ _____

Are any of the aesthetician's paramedical aestheticians; or do any operate under a physician's supervision or perform services based on medial referrals? ☐ Yes ☐ No

If you do body wraps or exercise activities, do more than 20% of annual sales come from these operations? ☐ Yes ☐ No

Do you perform facial chemical peels or microdermabrasion? ☐ Yes ☐ No

If yes, are customers required to wear eye protection? ☐ Yes ☐ No

Do you dispense or sell any herbal supplements or medications? ☐ Yes ☐ No

PROPERTY COVERAGE SECTION (IF NEEDED) ☐ N/A

Choose One: ☐ Rent or ☐ Own or ☐ Lease **Year of Construction:** _____ **Square footage you occupy:** _____ Sq. Ft.

Year of Most Recent Updates to the Building: Roof: _____ Plumbing: _____ Electrical: _____

Type of Construction: ☐ Frame/Wood ☐ Joisted Masonry/Brick ☐ Steel/Metal ☐ Stucco/Frame ☐ Other: _____

Type of Roof: ☐ Asphalt Shingles ☐ Built Up Tar ☐ Metal ☐ Tile ☐ Torch Down ☐ Rubber Membrane ☐ Other: _____

Alarm System: ☐ None ☐ Monitored System ☐ Un-Monitored System ☐ Dead Bolt Only ☐ Smoke Alarm ☐ Sprinkler System

Select Coverages and Corresponding Limits Desired:

☐ Business Personal Property **(BPP)**: Replacement Cost: $_____

☐ Business Income & Extra Expense: Annual Business Income: $_____

☐ Tenant Improvements & Betterments: Improvement Cost: $_____

☐ Property of Others **(including theft)**: Replacement Cost: $_____

☐ Tenant Building Glass Coverage: Cost to Replace Glass: $_____

☐ Outdoor Sign Coverage: Cost to Replace Sign: $_____ Type: ☐ Neon ☐ Wood ☐ Metal ☐ Mechanical

☐ Building Coverage **(Structure)**: Building Replacement Value: $_____
(If you own the building)

Distance to Seacoast? _____miles

Is distance to fire hydrant less than 1,000 feet? ☐ Yes ☐ No

If No, provide distance: _____ feet

Is distance to responding fire statement less than 5 miles? ☐ Yes ☐ No

If No, provide distance: _____ miles

PERMANENT MAKEUP (PMU) SECTION ☐ N/A

Complete this page for ***EACH*** technician performing any of the below services

Technician Name: _____ Technician Experience: Years _____ Months _____

Check ALL services rendered by technician: (Provide certificate of training for any of the below listed services for each technician)

☐ **Permanent Makeup:** *eyeliner, eyebrows, lips, lipliner, beauty marks* ☐ *eyeshadow, cheek blush* ☐ *nipple/areola* ☐ *scar camouflage*

☐ **Microblading**: *eyebrows only* ☐ **Scalp Micro Pigmentation** ☐ **Saline Pigment Removal**

Hours Training: _____ Name of School: _____ Dates Attended: Start _____ Completion _____

How long do you retain client records in years?	_____**Years**
Do you require every client to sign an information/consent form? **(Attach a Copy)**	☐ Yes ☐ No
Do you provide all clients with written aftercare instructions? **(Attach a Copy)**	☐ Yes ☐ No
Are all pigments from U.S. or Canada manufacturers and/or EU Standards?	☐ Yes ☐ No
Do you dispose of your used pigment's caps after each client?	☐ Yes ☐ No
Do you have written sterilization, sanitation and safety standards?	☐ Yes ☐ No
Do you take before and after photos of all work?	☐ Yes ☐ No
Do you have a contract with bio-waste disposal company?	☐ Yes ☐ No
Do you use Sharps waste container?	☐ Yes ☐ No
Do artists travel to client's location?	☐ Yes ☐ No
Do you ever ***RE-USE*** needles, blades or gloves?	☐ Yes ☐ No

ADDITIONAL COVERAGE SECTION

Are you interested in adding any of the following coverages?

- Excess Liability Coverage (In addition to the liability limits already selected on page 1) ☐ Yes ☐ No
  (If Yes, we may require an additional Excess Application to be Completed)
- Hired and Non-Owned Auto Liability Coverage ☐ Yes ☐ No

ANY ADDITIONAL INFORMATION

_____

_____

_____

I DECLARE THAT THE STATEMENTS MADE IN THIS SUPPLEMENTAL APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY AND ARE MADE PART OF ALL APPLICABLE APPLICATIONS FOR INSURANCE.
Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance, or the subject thereof may void any policy issued. I HAVE READ AND UNDERSTAND THE FRAUD WARNINGS CONTAINED IN ALL APPLICATIONS. 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.**

NOTE: THE APPLICATION MUST BE SIGNED BY AN ACTIVE OWNER, PARTNER OR EXECUTIVE OFFICER.

_____ _____ _____

Signature of Applicant Printed Name Date

If you are Mailing, E-Mailing or Faxing this application back to us, please use the contact information below:

Allen Financial Insurance Group Inc. 13880 N. Northsight Blvd. Building C #109 Scottsdale, AZ 85260
Email: Jay@EQGroup.com Phone: 800-874-9191 Fax: 602-992-8327 Website: www.EQGroup.com