



# 3-B Program Questionnaire

(To be Attached to ACORD Application)

Named Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Please Note:** An Operator is considered full-time if they work 20 hours or more per week; whereas, part time is considered less than 20 hours per week. You must use the highest classification applicable.

	EMPLOYEE'S NAME	INDEPENDENT CONTRACTOR'S NAME	OWNER/ OPERATOR	BEAUTICIAN/BARBER NAIL TECHNICIAN		ELECTROLOGIST		MESSAGE THERAPIST	
			YES/NO	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

**QUESTIONS:**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Are all operators licensed?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How long has the insured been in business? _____  |                          |                          |
| 3. Do you employ students?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you perform: <b>(Please note: all activities listed below are not acceptable, and thus coverage is not provided)</b> |                          |                          |
| Wart or Mole Removal   | <input type="checkbox"/> | <input type="checkbox"/> |
| Podiatry / Chiropody   | <input type="checkbox"/> | <input type="checkbox"/> |
| Permanent Cosmetic application   | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical training programs, diet advice or body building   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is the 24-hr predisposition test given to patrons whose hair has not been previously tinted or dyed?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Describe any services or treatments rendered in your shop not generally engaged in by beauty shops.<br>_____            |                          |                          |
| 7. Do you engage in any off site activities?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you manufacture, repackage or relabel any products?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are premises Equipped with Hot Tubs, Saunas, Steambaths?<br>If so, how many: _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| 10. Do you engage in Health and Exercise Activities (including body wrapping)?<br>If yes, is operation less than 20% of total sales. (operations in excess of 20% not eligible for Businessowners Policy)                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you rent to Independent Contractors / Booth Renters?<br>Indicate the number of full and part time operators that rent from you. _____<br>Please provide the name, occupation and liability carrier. _____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you an Independent Contractor / Booth Renter?   | <input type="checkbox"/> | <input type="checkbox"/> |

**Tanning/Toning Operation:**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| 13. What percentage of U.V.B. radiation do your beds produce? _____  |                          |                          |
| 14. Are records kept on each customer for each visit and exposure time?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are all customers furnished information regarding bed and rays used?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are customers furnished goggles when using the tanning bed?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are all beds disinfected after each use?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are all tanning bed controls operated by the insured, not the customer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are customers limited to a maximum of 30 minutes per session?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Is there at least one currently tagged fire extinguisher on the premises?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are these beds UL listed?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Who is the manufacturer of these beds? _____   |                          |                          |
| 23. Do you use coin or slot tanning beds? _____  |                          |                          |
| 24. Are these beds owned or leased? _____  |                          |                          |
| 25. Does each customer sign a waiver of liability prior to using these beds?<br>Attach a copy of the waiver to this application. | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Number of Tanning Beds _____ Number of Toning Beds _____   |                          |                          |

**Massage Operation:**

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| 27. Are the insured and any therapists working with or for the insured members of the American Massage Therapy Association? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Has the insured ever been sued for malpractice?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Does the insured keep thorough records on all clients?  | <input type="checkbox"/> | <input type="checkbox"/> |

**Electrolysis Operation:**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| 30. Is all wiring and electrical equipment inspected frequently?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Does the insured travel to clients' homes or to hospitals to perform electrolysis? | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby declare to the best of my knowledge and belief that all of the foregoing statements are complete and true and that these statements are offered as an inducement to the company to issue the policy for which I am applying. It is understood and agreed that the completion of this questionnaire does not bind the insurance company.

Producer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_