

**APPLICATION - BEAUTY PARLORS/BARBER SHOPS**

**GENERAL INFORMATION**

1. First Named Insured \_\_\_\_\_  
(The first Named Insured is responsible for premium payment, cancellation, and changes - refer to policy wording.)
2. Other Insured(s) \_\_\_\_\_
3. Mailing Address \_\_\_\_\_  

Street	City	County	State	ZIP Code
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4. Location of Premises:  Same as mailing address  
 Other \_\_\_\_\_
5. Effective Date Desired \_\_\_\_\_ Term Desired \_\_\_\_\_

6. 

PRIOR INSURANCE CARRIER AND LOSS HISTORY FOR THE PAST THREE YEARS					
Year	Carrier/Policy Number/Premium	Coverage	# of Losses	Amount	Description of Losses <small>(Use separate sheet if necessary)</small>

7. Missouri Applicants: **DO NOT** answer this question.  
 Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?  
 No  Yes - If so, give name of company, date, and reason. \_\_\_\_\_
8. Years in Business \_\_\_\_\_ Years of Experience \_\_\_\_\_
9. Describe prior experience \_\_\_\_\_
10. Applicant is:  Individual  Partnership  Corporation  LLC  Other \_\_\_\_\_
11. Operating in:  Home  Hospital  Beauty Salon  Shopping Center  
 Tanning Salon  Nursing Home  Other \_\_\_\_\_
12. Interest of Named Insured in premises:  Owner  General Lessee  Tenant  Other \_\_\_\_\_
13. Part occupied by Named Insured:  Entire  Portion (\_\_\_\_%)  None (Lessor's Risk Only)
14. Does applicant operate any other business from or on these premises?  Yes  No  
 If yes, describe. \_\_\_\_\_

15. 

COVERAGES / LIMITS DESIRED	
<input type="checkbox"/> Premises-Operations	\$ _____ Each Occurrence Limit
	\$ _____ General Aggregate
<input type="checkbox"/> Products-Completed Operations	\$ _____ Aggregate
<input type="checkbox"/> Personal and Advertising Injury	\$ _____ Limit
<input type="checkbox"/> Damage to Premises Rented to You	\$ _____ Limit
<input type="checkbox"/> Medical Payments	\$ _____ Limit
<input type="checkbox"/> Contractual Liability (No Separate Limit)	
<input type="checkbox"/> Professional Liability	\$ _____ Each Occurrence Limit
	\$ _____ Aggregate

16. Does applicant:      Sell private-label, repackaged or foreign-made products?       Yes  No  
    Manufacture, mix, blend, bottle or label any products?       Yes  No

**PERSONNEL DATA**

17. Complete for each employee and lessee. (Attach additional sheet if necessary.)

Name	Full or Part Time	# of Days per Week	Licensed Operator?	# Years Experience	Approximate Weekly Income
			Y N		
			Y N		
			Y N		
			Y N		

18. Have you or any of your employees had licensing violations?       Yes  No

19. Indicate total number for each category:

Beauty Parlor/Shop Chairs		Tanning Beds/Booths	
Beauticians/Barbers - Full Time		Manicurists	
Beauticians/Barbers - Part-time		Beauty School Teachers	

**SERVICES**

20. Indicate those you perform and the percentage of total receipts devoted:

	Performed		% of Total Receipts		Performed		% of Total Receipts
	YES	NO			YES	NO	
Permanent waves	<input type="checkbox"/>	<input type="checkbox"/>		Steam bath	<input type="checkbox"/>	<input type="checkbox"/>	
Hair cuts	<input type="checkbox"/>	<input type="checkbox"/>		Hair implants/transplants	<input type="checkbox"/>	<input type="checkbox"/>	
Hair dyeing	<input type="checkbox"/>	<input type="checkbox"/>		Hair weaving	<input type="checkbox"/>	<input type="checkbox"/>	
Manicures	<input type="checkbox"/>	<input type="checkbox"/>		Ear piercing	<input type="checkbox"/>	<input type="checkbox"/>	
Nail sculpturing/attachments	<input type="checkbox"/>	<input type="checkbox"/>		Permanent make-up (e.g. eyeliner)	<input type="checkbox"/>	<input type="checkbox"/>	
Waxing (hot or cold)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Electrolysis/hair removal	<input type="checkbox"/>	<input type="checkbox"/>		Tanning beds/booths	<input type="checkbox"/>	<input type="checkbox"/>	
Chiropody	<input type="checkbox"/>	<input type="checkbox"/>		Body wraps	<input type="checkbox"/>	<input type="checkbox"/>	
Wart or mole removal	<input type="checkbox"/>	<input type="checkbox"/>		Demonstrations for groups or sponsors	<input type="checkbox"/>	<input type="checkbox"/>	
Reducing, slenderizing or exercising service	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Skin treatments or facials	<input type="checkbox"/>	<input type="checkbox"/>		Other – explain	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Comments/Remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment.

Signature of Applicant \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Signature of Producing Agent \_\_\_\_\_ Date \_\_\_\_\_

Agent Name and Address \_\_\_\_\_