



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

4. Location of Premises: Same as mailing address
 Other _____

5. Effective Date Desired _____ Term Desired _____

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
 Trust 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 _____

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"/>		Tanning beds/booths	<input type="checkbox"/>	<input type="checkbox"/>	
Electrolysis/hair removal	<input type="checkbox"/>	<input type="checkbox"/>		Body wraps	<input type="checkbox"/>	<input type="checkbox"/>	
Chiropody	<input type="checkbox"/>	<input type="checkbox"/>		Demonstrations for groups or sponsors	<input type="checkbox"/>	<input type="checkbox"/>	
Wart or mole removal	<input type="checkbox"/>	<input type="checkbox"/>					
Reducing, slenderizing or exercising service	<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 _____