BEAUTY SALON/OPERATOR APPLICATION

1.1	Applicant Name:		Phone	e:	
	Business Name:				
	Mailing Address:				
	Business Address:				
1.2	Business operated as: Corporati	on Partnershi	p Individual	Independ	dent Contractor
1.3	Business operated as salon?	If not, other	•		
1.4	How long in business?	Do	all professionals hav	ve licenses?	
1.5	Do you have operations not listed on	the schedule?	If yes, provide	details:	
	Do you have insurance for these opera	ations? Na	ne of insurance com	pany:	
1.6	Products liability needed? G	ross receipts (exclu	ding private label):_		
	Do you private-label products for sale	? No	coverage is provided f	or private label	products)
	SCH	EDULE OF	SERVICES	\$	
Cate	gory			Numbe	r to be Insured
1. Ae	sthetician Multiple Services				
2 40	sthetician Including Microdermabrasio			-	1 3
		n		•	-
	sthetician Single Service ist Service:				
				-	
4. Bea	utician/Nail Technician				
5. Elec	ctrology (Excluding All Other Services)				
6. Mas	ssage (Excluding All Other Services)				
7. Oth	er: (Describe)				
			IBER OF OPERAT	rors	1
Definit * AES	ions – CHECK ALL SERVICES YOU STHETICIAN: Facials	ARE PROVIDING Waxing	production	D 1	
	Peels	Body Wraps	Eyelash & Brov	v Enhancement	i.S
	Massage	Electrology	Nails		
* BEA	UTICIANS: Hair	Nails	Eyelash & Brow	Enhancement	S
2.1 Ha	ve you been trained in microdermabrasion	?	Yes No		
2.2 Do 2.3 Hay	you use a consent form for microdermabre you been trained in massage?	rasion?	Yes No	(If yes, attacl	ı copy)
		· ·			
<u>FO</u>	LLOWING SERVICES REQUIRE SE	PARATE APPLIC	ATIONS IF COVE	RAGE IS NEI	<u>EDED</u>
Categor		Insure	Category		Number to Insure
	ing Units UV & Airbrush		5. Laser/IPL		
	anent Makeup		6. LED Unit(s)		/
1	ing/MCA ent Removal/Lightening		7. Ear Piercing	lawal	
A. T. IZIII			8. Body Tattoo/P	iercing	

PART IV. HISTORY

Insurer	ently have ins Polic	surance coverage y #	ge? Ye. Liability Limits		If yes, indicate Premium	e the follow	ing: Exp. Date
If claims ma	ide, most rece	nt retroactive of	late:				
List liability	claims histor	v arising from	any permanent n	nakeup, beau	y, health or other	orofessional	activity, whether or not
insured:	If none,						97
YR/Claim	Nature (of injuries	Equip. Invo	lved	Details, if Pend	ing	Amt. if settled
proposed po	licy, or do you	u foresee that a	cumstance or occ claim may be brose details of the e	ought as a re	er than listed in 4.2 sult of said event,	above) pric	or to the effective date of the or occurrence?
that failure to pr reliance on this a I authorize a business includi or other informa but shall include	rovide a true and application and/or and consent to in a suthorization at tion bearing upon any other source	accurate response r denial of claims vestigations of inf to every person on the foregoing. I s of information d	to the foregoing quest under any policy issu formation bearing upon rentity, public or pri- understand and agree eemed relevant by the	stions may, at the ed. on moral charact vate, to release a e these investiga e Company as m	e option of the company er, professional reputat Il Lloyd's of London p tions shall not be confi ay be authorized by law	ion and fitness articipating sy ned to informat	y. I further understand and ag voiding of the insurance issued to engage in the activities of indicates, any documents, recotion submitted in this application.
period of covera	ge shown on the	certificate of insur he policy.	rance issued with the	policy or certifi	cate on the date the pol	icy is canceled	ne Company in writing within I or terminated, whichever con
I understand	this insurance is	being provided th	irough a surplus lines		ie insurer may not be s		e insurance laws and rules in a
			nce Insolvency Fund		ie insurer may not be s	doject to all til	e insurance laws and rules in
State and the risk THIS APPLICE BIND THE CO	is not protected b CATION MUS' OMPANY TO	by the State Insura T BE SIGNED	nce Insolvency Fund	WITHIN 30	DAYS OF BINDIN	G. SIGNII	NG THIS FORM DOES N
State and the risk THIS APPLICE BIND THE CO	is not protected b CATION MUS' OMPANY TO COMPANY	by the State Insura T BE SIGNED	nce Insolvency Fund. BY APPLICANT THE INSURANC	WITHIN 30	DAYS OF BINDIN	G. SIGNII	e insurance laws and rules in r
State and the risk THIS APPLICE BIND THE CO	CATION MUS' OMPANY TO COMPANY	T BE SIGNED COMPLETE T	nce Insolvency Fund. BY APPLICANT THE INSURANC	WITHIN 30 E. COVERA	DAYS OF BINDIN GE BECOMES EF	G. SIGNIT	NG THIS FORM DOES IN WHEN ACCEPTED BY
THIS APPLICE BIND THE COUNTY INSURANCE DAT	E is not protected by CATION MUS'OMPANY TO COMPANY	T BE SIGNED COMPLETE T APPLICANT SI	nce Insolvency Fund. BY APPLICANT THE INSURANC	WITHIN 30 E. COVERA	DAYS OF BINDIN GE BECOMES ER	G. SIGNIT	NG THIS FORM DOES IN WHEN ACCEPTED BY
DAT we email yo box below n	E is not protected by CATION MUSTOMPANY TO COMPANY E wayour policy must be check ECT TO PUI	T BE SIGNED COMPLETE TO REPLICANT SINGLE (Usually with seed:	BY APPLICANT THE INSURANCE GNATURE EQUESTED EFFE in 2-3 weeks) [RRORISM COVERED STATES [RRORISM COVERED S	ECTIVE DATE YES YERAGE AT	DAYS OF BINDIN GE BECOMES ER No	G. SIGNIT FECTIVE V	NG THIS FORM DOES IN WHEN ACCEPTED BY TITLE Y LIMIT REQUESTED EMIUM
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DAT we email yo box below n I ELI 1 DO	E ou your policy nust be check ECT TO PUR NOT ELEC	T BE SIGNED COMPLETE TO APPLICANT SITE OF COMPLETE TO PURCE TO PURCE \$30 Certificate	BY APPLICANT THE INSURANCE GNATURE EQUESTED EFFE in 2-3 weeks) RRORISM COV HASE TERROR HOlder (Landlo)	ECTIVE DATE YES VERAGE AT RISM COVE	DAYS OF BINDIN GE BECOMES EN No T A 10% ADDITI RAGE AT A 10%	G. SIGNIT FECTIVE V LIABILITY ONAL PRI	NG THIS FORM DOES IN WHEN ACCEPTED BY THE TITLE Y LIMIT REQUESTED EMIUM ONAL PREMIUM

BEAUTY SALON SUPPLEMENTAL APPLICATION

1.1	Applicant Name:		Dhana	ê
	Business Name:	50	rnone:	
1.2	How long in business	5?	Do all f - i - i - i	:
1.3	Do you have operation	ons not listed on the schedule?_		licenses?
	Do you have insurance	ce for these operations?		
1.6	Products liability need	ded?Gross receipt	_Name of insurance compa	ny:
	Do you private-label	products for sale?	s (excluding private label):_	-
1.7	Have you over	1 11 1 11	_ (No coverage is provided for	private label products)
	Yes No (If yes	enced a liability claim arising free provide details on separate she	om any professional activity et)	whether or not insured?
		SCHEDULE ()F SERVICES	\$23
Categ			of other services	Number to be I
a.	itician/Barber (Hair) I	nclude Names of Individuals		Number to be Insured
c		b d		
2. Waxi				
a.		b		-
c		d.		
3 Naile		*		
a		b		
с		d.	•	**
4. Body				
a.		b		
с		d.		
		essional liability required)		
	<u>Alabara da Para da Pa</u>	h .		
·		d.		
	& Brow Enhancemen			
		,		
· ——		d		
. Topical	Makeup Application			Ť.
	1000-00-00-01112 YOU	b		
-		d.		
Other: ((Describe)		-	
		*		
		TOTAL NUI	MBER OF OPERATORS	
			st add up to the numbers i	n column)
Does the	ou been trained in massa e massage technician hav	ge? ve separate insurance in force?	Yes No	es, attach copy)
		UIRE SEPARATE APPLICATIO		
tegory		Number to Insure	Category	
Canning l	Units UV & Airbrush	The state of the s	6. Laser/IPL/LED Unit	Number to Insure
ermanen Teedling/I	nt Makeup MCA		7. Facials, Peels Micro	derm
igment R	Removal/Lightening		8. Body Tattoo/Piercing	
	,		9. Electrology	-

QUICK QUOTE FORM - MEDI-SPA PROGRAM

1.1 Business Name:	
1.2 Phone: () - Fay	
1.3 Your name:	Email:
	HOW to say 1
in the many location.	ns do you work out an
	C.IIV.
1.5 How many landlords need proof of ins? Note we offer coverage only in most of ins?	
Note we offer coverage only in professional of	fices/medi-spas, medical facilities or salons
SCHEDULE OF SERVICES - C	Only Complete Services You Want Coverage For
LASER / IPL HAIR REMOVAL Name of Non Doctors	LASER/IPL PROFESSIONAL (L.
•	
2. 3.	- I Vac I Vac
	1
	2.
ame of Doctor Operators	4.
oporators	Name of Doctor Operators
	1
	2. 3.
	1
SCLEROTHERAPY e & Degree of Technician	MEDICAL CDARE
	MEDICAL GRADE PEELS Name of Technician
	1
	2. 3.
AESTHETIC FACIALS, PEELS de Microdermabrasion? Yes No de Wax Removal? Yes No	LASER LIPOLYSIS (List Name & Degree)
	2
	1. PERMANENT MAKEUP
	2.
OR SUPERVISIOR TO BE INSURED? 🗌 YES 🖺	
Microcurrent (no hair removal)	
Performing Service	OTHER: List Services & name of technicians:
EETH WHITENING of Units	
be quoted? \$100,000 \$300,000 \$500,000	·
= 001000	TAIOUU IIIVIEI MUUTAGGIAI VINI 60 1
L	oss of Income: Sign: Glass at \$2,500 Y / N

PERMANENT COLOR LIABILITY INSURANCE APPLICATION

1	Your Name:		Phone:
	Vour Rusiness Name		Email address.
	Mailing Address:	City:	State:Zip:
	Pusiness Address #1.		
	D	A	Add premises liability?
	(There is an additional charge if premises liabili	ty is needed for more than one location.)	
1.2	Working as: Sole Proprietorship Partners	hip Corporation	Employee
1.3	Type of business (where equipment is located): Sal	on Clinic Independe	ent, multiple locations, Number
	Other, describe	· · · · · · · · · · · · · · · · · · ·	
1.4	Are you in compliance with all city, county and/or state	ordinances?	
1.7	Business License No. (Attac	n copy)	
1.5	How long in business applying permanent color?		
1.6	Have you had formal instruction in the application of pe	ermanent color:	Yes No
	If Yes, attach all certificates of training. If no, attach de	escription of training and experie	ence.
1.7	How many procedures have you performed in the past 1	2 months for the following:	Building (Computing
	Eyeliner Eyebrows Lipliner Lips_	Cheek blush Skin	Repigmentation/Camounage
	Decorative Tattooing Other, explain:		
PAR	T II. INFORMATION ABOUT YOUR PRO	FESSION	
			Yes No
2.1	Do you use a medical history/client information form or	i everyone?	
	If yes, attach a copy. Do you use a hold harmless or informed consent form?		Yes No
2.2	If yes, attach a copy		
2.3	Do you take before and after photos of cover-ups and co	esmetic work?	Yes No
2.4	Do you schedule a follow-up appointment after the proc	edures?	☐ Yes ☐ No
	If yes, when?		
2.5	Do you advertise other than a listing in the local telepho	ne directory?	Yes No
	If yes, attach a copy of all promotional materials.		
			8 8
PAR	T III. EQUIPMENT AND PROCEDURES		
. 1	Are all pigments you use from US manufacturers?		Yes No
3.1	If no, please provide a copy of the FDA stamp from the	importer.	
3.2	Do you ever re-use needles?		Yes No
3.3	Is all your equipment pre-sterile, one-time use?		Yes No
	If no, indicate your method of sterilization:		
3.4	Is all your equipment in proper running order?	0	☐Yes ☐ No
3.5	Do you wear gloves with each procedure?		Yes No
3.6	Do have hot and cold running water on site?		Yes No
3.7	Do you dispose of your pigments after each client?		Yes No
3.8	Provide the following information on all machines/device	ces:	
A11500	MANUFACTURER	THE CITACH T	PATE
	MANUFACIURER		
	MANUFACTURER		ATE

	ently have insurance Poli	ee coverage? icy #	☐Yes ☐No Liability Limits	If yes, indicate the following: Premium	Exp. Date
If claims mad	le, most recent retr	oactive date:			
List liability on not insured:	claims history arisi If no	ng from any bo	dy piercing, tattoo, perm	anent makeup or other profession	nal activity, whethe
YR/Claim	Nature of in		uip. Involved	Details, if Pending	Amt. if settled
· ·	3 3 0 2 mg 3 0 m 101 62	vent, circumstar	nce or occurrence (other may be brought as a resu	than listed in 4.2 above) prior to tall of said event, circumstance or a	the effective date of
Yes	□ No. If y	es, describe de	tails of the event:	iit of said event, circumstance or	occurrence?
I understand a	nd agree this Application	on and any sunntan	nomes attack at 11	lied upon for issuance of any policy. I fu ption of the company, result in the voiding	
I authorize and	consent to investigation authorization to every	ons of information person or entity, p	bearing upon moral character, ublic or private, to release all I	professional reputation and fitness to eng Lloyd's of London participating syndicate	gage in the activities of
I authorize and usiness including r other information ut shall include an Furthermore, I	n bearing upon the fore y other sources of infor understand that the pol-	going. I understan	d and agree these investigation evant by the Company as may	Lloyd's of London participating syndicate	es, any documents, record description of this application
r other information ut shall include an Furthermore, I eriod of coverage erst or as otherwise I understand ti	n bearing upon the fore y other sources of infor understand that the pol- shown on the certificate provided by the policy. his insurance is being	going. I understan mation deemed rel icy applied for will e of insurance issue	d and agree these investigation evant by the Company as may apply only to CLAIMS FIRS and with the policy or certificate	as shall not be confined to information sulbe authorized by law. T MADE AND REPORTED to the Company on the date the policy is canceled or term	es, any documents, recomments, recommendation in this application in the pany in writing within the pany in writing within the pany in whichever commendated, whichever commendated, whichever commendated.
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I authorize and usiness including or other information at shall include an Furthermore, I eriod of coverage est or as otherwise I understand the in my state a HIS APPLICAT	n bearing upon the fore y other sources of infor understand that the pol- shown on the certificate provided by the policy, his insurance is being and the risk is not pro ITON MUST BE SI PANY TO COMPI	going. I understan mation deemed rel icy applied for will e of insurance issue g provided throu stected by the Sta GNED BY APP LETE THE INS	d and agree these investigation evant by the Company as may be apply only to CLAIMS FIRSted with the policy or certificate gh a surplus lines company te Insurance Insolvency FullCANT WITHIN 30 DASURANCE. COVERAGI	r and the insurer is not subject to all and. YS OF BINDING. SIGNING THE BECOMES EFFECTIVE WHEN	es, any documents, recommendated in this application of the pany in writing within the pany in writing within the insurance laws and the insurance laws and IS FORM DOES NOT ACCEPTED BY T
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Relationship to your business (Landlord, lienholder):_

SCHEDULE OF SERVICES

Indicate which services you provide, the contractors are not covered unless cover	e number of operators and if we are to insur	e them. Independent	
	· · · · · · · · · · · · · · · · · · ·	INSURE	
MANICURISTS	NUMBER	WITH US?	
BEAUTICIANS		☐Yes ☐ No	
BROW/LASH ENHANCEMENT	NUMBER	Yes No	
FACIALS	NUMBER	Yes No	
Include Peels? Yes No	NUMBER	Yes No	
List products & percentage of acids if include	ding pools.	· ·	
MICRODERMABRASION		N.	
LED/MICROCURRENT	NUMBER	Yes No	
WAX REMOVAL	NUMBER	Yes No	
Are all the facialists doing wax removal as w	NUMBER	Yes No	
BODY WRAPS			
List the type of wraps you use:	NUMBER	Yes No	
MASSAGE) TD () -		
ELECTROLOGY	NUMBER CERTIFIED?	Yes No	
EAR PIERCING	NUMBER	Yes No	
Indicate gross receipts from Ear Piercing:	NUMBER	Yes No	
AIRBRUSH TANNING	· Daniel		
PRODUCTS	UNITS	Yes No	
Are Products Privately Labeled by you? Yes	Gross Receipts:	Yes No	
PERM. MAKEUP	No If yes a separate application is require	ed.	
TEACHING	NUMBER	Yes No	
CAMOUFLAGE	NUMBER	Yes No	
PIGMENT DEMONAL TO THE	NUMBER	Yes No	
NEEDLING/MCA	ALINE REJUVI ELIMININK		
MCA = Multitrepanic Collagen Actuation	NUMBER	Yes No	
BODY TATTOO	NUMBER		
<u>FOLLOWING SERVICES REQUIRE S</u>	SEPARATE APPLICATIONS IF COVERAC	Yes No	
UV TANNING – UNITS	UNITS		
If including tanning, complete the tanning bed supplement ap	DDI ication	Yes No	
BODY PIERCING	NUMBER	Yes No	San
LIABILITY LIMIT REQUESTED:	NUMBER OF OPERA	ΓORS:	
IMPORTANT: SIGNING THIS FORM DOES NOT I Coverage becomes effective only when accepted by the	MAND THE STATE OF	HE INSURANCE.	
APPLICANT	TOP:	THE TO LOT	
CATA-030 (AC3) (AC3) (AC3)	TODA	Y'S DATE	

	Applicant Nome.	
	Rusiness Name:	Phone:
	Z HOMAGOS I MINO.	Website:
	Business Address:	City:State: 7in:
1.2	Business operated as: Corporation	
1.3	Business operated as salon?	independent Contractor
1.4	How long in business?	If not, other:
1.5	Do you have operations not listed on the sch	
	Do you have insurance for these operations?	
II. I	Location and Product Information	Name of insurance company:
2.1	Type of business	
	Salon/Spa/Aesthetic Clinic Laser/M	fedi-Spa Wholesale Distributor
		describe)
2.2	Are all products purchased from a manufactu	
	Estimated Annual Private Label Product sales	er or supplier within USA? Yes No
2.3	Do all manufacturers name you as an addition (If yes provide copies of certificates) Describe all products sold by you under your	
2.5	List all suppliers of private label products	
.6	Do you sell products that you do not private la	bel? Yes No
	If yes provide gross receipts for all non private	label products: \$
7	Square footage of your location:	
8	Do you exhibit at one or more trade shows per	163 110
9	Does your landlord need to be named as additio	nal insured? Yes No
	Does your landlord require a waiver of subrogat	

PART III. HISTORY

		ability Limits Premiu	in Exp. Dute
			e de la companya de l
If claims made.	most recent retroactive date	e:	
nsured:	If none, state so	y product sales, general liability	y or other professional activity, whether or not
YR/Claim			and forther
g 19 Claim	Nature of injuries	Details, if Pending	Amt. if settlea
o you have known	wledge of an event, circum	nstance or occurrence (other than	an listed in 4.2 above) prior to the effective date of said event, circumstance or occurrence?
			uit of said event, circumstance or occurrence?
	INO. If yes, describe d	letails of the event:	
	10		
inderstand and agr	a this Application and any sure la		
at failure to provide	a true and accurate response to the	ne foregoing questions may, at the optic	oon for issuance of any policy. I further understand and agon of the company, result in the voiding of the insurance issu
at failure to provide reliance on this app	e a true and accurate response to the plication and/or denial of claims ur	ne foregoing questions may, at the option ander any policy issued.	on of the company, result in the voiding of the insurance issu
reliance on this appute the consensation of th	a true and accurate response to the oblication and/or denial of claims urent to investigations of information at thorization to every person or entithorization to every person or entithorization bearing upon the foregoins	ne foregoing questions may, at the option ander any policy issued. In bearing upon moral character, profesentity, public or private, to release all g. I understand and agree these investigations.	so of the company, result in the voiding of the insurance issues is a sional reputation and fitness to engage in the activities of relayd's of London participating syndicates, any document is a single participation shall not be confined to information submitted in the
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Business Owners Application

1.1	Applicant Name:	Phone:
	Business Name:	Website:
	Mailing Address:	City: State: Zip:
	Business Address:	StateZip:
	County: Squ	uare Footage of Business
	Business operated as: Corporation	☐ Parternship ☐ Individual ☐ Independent Contractor
1.2	Business operated as salon?	_ If not, other:
1.3	How long in business?	Do all professionals have licenses?
1.4	Do you have operations not listed on the school	edule?If yes, provide details:
	Do you have insurance for these operations?	Name of insurance company:
	PROPERTY SECTION	MUST INSURE FOR 100% OF THE REPLACEMENT COST
2.1	Age of building: Construction:_	Number of stories:
2.2		e following upgraded? (*) Information is Required
	*Roof:*Plumbing:	*Wiring:Sprinklers:
2.3	*Central Station Burglar Alarm? Yes	No If yes advise alarm provider :
2.4		
2.5	Adjoining Occupancies: LEFT:	
2.6	Approximate distance from fire station:	Distance from fire hydrant:
2.7	Do you sell clothing? Yes □ No □ If you	es, Inventory Value: \$
2.8	Do you sell or use jewelry? Yes □ No □	If yes, Jewelry Value: \$
2.9	Name & address of loss payee:	
		COVERAGES DESIRED
	NTENTS – Limit Needed:	Deductible \$1,000
	ILDING – Limit Needed: \$ RNINGS – Limit Needed: \$	Deductible \$1,000
	RNINGS - Limit Needed: \$ N - Limit Needed: \$	For What Period?
		Deductible \$100
		CLAIMS

Business Owners Application

PART IV. HISTORY

Insurer	Policy #	e? <u>Yes</u> No If y <i>Liability Limits</i>	es, indicate the following: Premíum	Exp. Dat
If claims made, n	nost recent retroactive da	te:		s
		ny permanent makeup, beau	uty, health or other profession	nal activity, whether
insured: YR/Claím	If none, state so	Equip. Involved	Details, if Pending	Amt. if set
he proposed police	cy, or do you foresee that		ner than listed in 4.2 above) p s a result of said event, circum nt:	
nsurance issued in reli	ance on this application and/or	denial of claims under any policy		•
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POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, as defined in Section 102(1) of the Act, as amended: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States-to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2014, the date on which the TRIA Program is scheduled to terminate or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 85% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A \$100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR

THE PREMIUM CHARGED FOR THIS COVERAGE WILL BE PROVIDED IF ACCEPTED, PRIOR TO BINDING. IT WILL NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

I hereby elect to purchase cover- premium of	age for acts of terrorism for a prospective
I hereby elect to have coverage that I will have no coverage for le	for acts of terrorism excluded from my policy. I understand osses arising from acts of terrorism.
Policyholder/Applicant's Signature	Underwriter's at Lloyd's, London Insurance Company
Print Name	Policy Number
Date	