BEAUTY SALON/OPERATOR APPLICATION

1.1 Applicant Name:______________________________ Phone:______________

Business Name:______________________________ Website:______________

Mailing Address:________________ City:____________ State:______ Zip:__________

Business Address:____

1.2 Business operated as: ☐ Corporation ☐ Partnership ☐ Individual ☐ Independent Contractor

1.3 Business operated as salon? ☐ If not, other:______________________

1.4 How long in business?______________ Do all professionals have licenses? ☐

1.5 Do you have operations not listed on the schedule? ☐ If yes, provide details: ______________

Do you have insurance for these operations? ☐ Name of insurance company:______________

1.6 Products liability needed? ☐ Gross receipts (excluding private label):______________

Do you private-label products for sale? ☐ (No coverage is provided for private label products)

SCHEDULE OF SERVICES

Category	Number to be Insured
1. Aesthetician Multiple Services	______
2. Aesthetician Including Microdermabrasion	______
3. Aesthetician Single Service List Service:______________________	______
4. Beautician/Nail Technician	______
5. Electrology (Excluding All Other Services)	______
6. Massage (Excluding All Other Services)	______
7. Other: (Describe) ______________________	______
TOTAL NUMBER OF OPERATORS	1

Definitions – CHECK ALL SERVICES YOU ARE PROVIDING

* AESTHETICIAN: ☐ Facials ☐ Peels ☐ Massage ☐ Waxing ☐ Body Wraps ☐ Electrology ☐ Eyelash & Brow Enhancements ☐ Hair ☐ Nails

* BEAUTICIANS: ☐ Hair ☐ Nails ☐ Eyelash & Brow Enhancements

2.1 Have you been trained in microdermabrasion? ☐ Yes ☐ No

2.2 Do you use a consent form for microdermabrasion? ☐ Yes ☐ No (If yes, attach copy)

2.3 Have you been trained in massage? ☐ Yes ☐ No

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

Category	Number to Insure	Category	Number to Insure
1. Tanning Units UV & Airbrush	______	5. Laser/IPL	______
2. Permanent Makeup	______	6. LED Unit(s)	______
3. Needling/MCA	______	7. Ear Piercing	______
4. Pigment Removal/Lightening	______	8. Body Tattoo/Piercing	______

PART IV. HISTORY

NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

4.1 Do you currently have insurance coverage? ☐ Yes ☐ No If yes, indicate the following:

Insurer *Policy #* *Liability Limits* *Premium* *Exp. Date*

____

If claims made, most recent retroactive date:____________________

4.2 List liability claims history arising from any permanent makeup, beauty, health or other professional activity, whether or not insured: If none, state so____________

YR/Claim *Nature of injuries* *Equip. Involved* *Details, if Pending* *Amt. if settled*

____

____

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence?
☐ Yes ☐ No. If yes, describe details of the event:

____

____

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

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

______________________________ ______________
APPLICANT SIGNATURE TITLE

__________ ______________________ ______________
DATE REQUESTED EFFECTIVE DATE LIABILITY LIMIT REQUESTED

Can we email you your policy (*usually within 2-3 weeks*) ☐ Yes ☐ No ____________________

One box below must be checked:

☐ **I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM**

☐ **1 DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM**

ADDITIONAL INSURED: @ $30 Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME:____

ADDRESS:____

Relationship to your business (Landlord, lienholder):____________________

BEAUTY SALON SUPPLEMENTAL APPLICATION

1.1 Applicant Name:____________________Phone:__________

Business Name:____________________Website:__________

1.2 How long in business?__________Do all professionals have licenses?__________

1.3 Do you have operations not listed on the schedule?___If yes, provide details: __________

Do you have insurance for these operations?_______Name of insurance company:__________

1.6 Products liability needed?__________Gross receipts (excluding private label):__________

Do you private-label products for sale?__________ (No coverage is provided for private label products)

1.7 Have you ever experienced a liability claim arising from any professional activity whether or not insured?
☐ Yes ☐No (If yes provide details on separate sheet)

SCHEDULE OF SERVICES

Category | **Number to be Insured**

1. Beautician/Barber (Hair) Include Names of Individuals
a. __________ b. __________
c. __________ d. __________ ______

2. Waxing
a. __________ b. __________
c. __________ d. __________ ______

3. Nails
a. __________ b. __________
c. __________ d. __________ ______

4. Body Wraps
a. __________ b. __________
c. __________ d. __________ ______

5. Massage (Note separate professional liability required)
a. __________ b. __________
c. __________ d. __________ ______

6. Eyelash & Brow Enhancements
a. __________ b. __________
c. __________ d. __________ ______

7. Topical Makeup Application
a. __________ b. __________
c. __________ d. __________ ______

8. Other: (Describe) ____________________ ______

TOTAL NUMBER OF OPERATORS ______
(Must add up to the numbers in column)

2.1 Have you been trained in massage? ☐ Yes ☐ No
2.2 Does the massage technician have separate insurance in force? ☐ Yes ☐ No (If yes, attach copy)

3

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

Category	Number to Insure	Category	Number to Insure
1. Tanning Units UV & Airbrush	______	**6. Laser/IPL/LED Units**	______
2. Permanent Makeup	______	**7. Facials, Peels Microderm**	______
3. Needling/MCA	______	**8. Body Tattoo/Piercing**	______
4. Pigment Removal/Lightening	______	**9. Electrology**	______

QUICK QUOTE FORM - MEDI-SPA PROGRAM

1.1 Business Name:____________________

1.2 Phone:(   )   -   Fax(   )   -   Email:____________________

1.3 Your name:____________________ How to send quote? ☐ Fax ☐ Email

1.4 Location Information: How many locations do you work out of?______ Square Feet?__________

Address:____________________City:__________State______Zip__________

1.5 How many landlords need proof of ins?_______

Note we offer coverage only in professional offices/medi-spas, medical facilities or salons

SCHEDULE OF SERVICES – Only Complete Services You Want Coverage For

LASER / IPL HAIR REMOVAL

Name of Non Doctors

1.
2.
3.
4.
5.
6.

Name of Doctor Operators

1.
2.
3.

LASER/IPL PROFESSIONAL (hair removal, rosacea, age/sun spots, wrinkle reduction, veins, cellulite, acne, photo facials

Include Tattoo Removal? ☐ Yes ☐ No

Name of Non Doctors

1.
2.
3.
4.

Name of Doctor Operators

1.
2.
3.

BOTOX/ DERMAL FILLERS:

Name & Degree of Technician

1.
2.
3.

MESOTHERAPY/LIPODISSOLVE

Name & Degree of Technician

1.
2.
3.

SCLEROTHERAPY

Name & Degree of Technician

1.
2.
3.

MEDICAL GRADE PEELS

Name of Technician

1.
2.
3.

AESTHETIC FACIALS, PEELS

Include Microdermabrasion? ☐ Yes ☐ No

Include Wax Removal? ☐ Yes ☐ No

1.
2.
3.

LASER LIPOLYSIS (List Name & Degree)

1.
2.

PERMANENT MAKEUP

1.
2.

DOCTOR SUPERVISIOR TO BE INSURED? ☐ YES ☐ NO?____________________

LEDs/Microcurrent (no hair removal)

Number Performing Service__________

LED TEETH WHITENING

Number of Units__________

OTHER: List Services & name of technicians:__________

Limit to be quoted? $100,000 $300,000 $500,000 $1,000,000 Higher aggregate? Y/N $2 ml or $3 ml

Property Coverage? Business Personal Property:________ Loss of Income:________ Sign:______ Glass at $2,500 Y / N

PERMANENT COLOR LIABILITY INSURANCE APPLICATION

PART I. GENERAL INFORMATION

1 Your Name:__________ Phone:__________

Your Business Name:__________ Email address:__________

Mailing Address:__________ City:__________ State:_____ Zip:_____

Business Address #1: __________

Business Address #2:__________ Add premises liability? ☐

(There is an additional charge if premises liability is needed for more than one location.)

1.2 Working as: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Employee

1.3 Type of business (where equipment is located): ☐ Salon ☐ Clinic Independent, multiple locations, Number_____

Other, describe __________

1.4 Are you in compliance with all city, county and/or state ordinances? ☐
Business License No.__________ (Attach copy)

1.5 How long in business applying permanent color? __________

1.6 Have you had formal instruction in the application of permanent color: ☐ Yes ☐ No
If Yes, attach all certificates of training. If no, attach description of training and experience.

1.7 How many procedures have you performed in the past 12 months for the following:
Eyeliner____ Eyebrows_____ Lipliner_____ Lips_____ Cheek blush_____ Skin Repigmentation/Camouflage______
Decorative Tattooing _____ Other, explain:__________

PART II. INFORMATION ABOUT YOUR PROFESSION

2.1 Do you use a medical history/client information form on everyone? ☐ Yes ☐ No
If yes, attach a copy.

2.2 Do you use a hold harmless or informed consent form? ☐ Yes ☐ No
If yes, attach a copy

2.3 Do you take before and after photos of cover-ups and cosmetic work? ☐ Yes ☐ No

2.4 Do you schedule a follow-up appointment after the procedures? ☐ Yes ☐ No
If yes, when? __________

2.5 Do you advertise other than a listing in the local telephone directory? ☐ Yes ☐ No
If yes, attach a copy of all promotional materials.

PART III. EQUIPMENT AND PROCEDURES

3.1 Are all pigments you use from US manufacturers? ☐ Yes ☐ No
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? ☐ 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/devices:

MANUFACTURER__________ PURCHASE DATE __________

MANUFACTURER__________ PURCHASE DATE __________

3.9 What anesthetics, if any, do you use?__________

PART IV. HISTORY

NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

4.1 Do you currently have insurance coverage? ☐ Yes ☐ No If yes, indicate the following:

Insurer	*Policy #*	*Liability Limits*	*Premium*	*Exp. Date*

If claims made, most recent retroactive date:____________

4.2 List liability claims history arising from any body piercing, tattoo, permanent makeup or other professional activity, whether or not insured: If none, state so____________

YR/Claim	*Nature of injuries*	*Equip. Involved*	*Details, if Pending*	*Amt. if settled*

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No. If yes, describe details of the event:

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer is not subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

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

____________________ APPLICANT SIGNATURE ____________ TITLE

____________ DATE SIGNED ____________ REQUESTED EFFECTIVE DATE ☐ LIABILITY LIMIT REQUESTED

Can we email you your policy *(usually within 2-3 weeks)* ☐ Yes ☐ No ____________

One box below must be checked:

☐ **I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM**

☐ **I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM**

ADDITIONAL INSURED: @ $30 Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME:____________

ADDRESS:____________

Relationship to your business (Landlord, lienholder):____________

SCHEDULE OF SERVICES

Indicate which services you provide, the number of operators and if we are to insure them. Independent contractors are not covered unless coverage is specifically extended to them.

Service	Number	INSURE WITH US?
MANICURISTS	NUMBER_____	☐ Yes ☐ No
BEAUTICIANS	NUMBER_____	☐ Yes ☐ No
BROW/LASH ENHANCEMENT	NUMBER_____	☐ Yes ☐ No
FACIALS	NUMBER_____	☐ Yes ☐ No
Include Peels? ☐ Yes ☐ No		
List products & percentage of acids if including peels: ____________________		
MICRODERMABRASION	NUMBER_____	☐ Yes ☐ No
LED/MICROCURRENT	NUMBER_____	☐ Yes ☐ No
WAX REMOVAL	NUMBER_____	☐ Yes ☐ No
Are all the facialists doing wax removal as well? ☐ Yes ☐ No		
BODY WRAPS	NUMBER_____	☐ Yes ☐ No
List the type of wraps you use: ____________________		
MASSAGE	NUMBER_____ CERTIFIED?_____	☐ Yes ☐ No
ELECTROLOGY	NUMBER_____	☐ Yes ☐ No
EAR PIERCING	NUMBER_____	☐ Yes ☐ No
Indicate gross receipts from Ear Piercing: ____________________		
AIRBRUSH TANNING	UNITS_______	☐ Yes ☐ No
PRODUCTS	Gross Receipts: ____________	☐ Yes ☐ No
Are Products Privately Labeled by you? ☐ Yes ☐ No If yes a separate application is required.		
PERM. MAKEUP	NUMBER_____	☐ Yes ☐ No
TEACHING	NUMBER_____	☐ Yes ☐ No
CAMOUFLAGE	NUMBER_____	☐ Yes ☐ No
PIGMENT REMOVAL /LIGHTENING ☐ SALINE ☐ REJUVI ☐ ELIMININK		
NEEDLING / MCA MCA = Multitrepanic Collagen Actuation	NUMBER_____	☐ Yes ☐ No
BODY TATTOO	NUMBER_____	☐ Yes ☐ No

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

Service	Number	INSURE WITH US?
UV TANNING – UNITS	UNITS_______	☐ Yes ☐ No
If including tanning, complete the tanning bed supplement application		
BODY PIERCING	NUMBER_____	☐ Yes ☐ No

LIABILITY LIMIT REQUESTED: ☐ NUMBER OF OPERATORS:__________

IMPORTANT: SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. Coverage becomes effective only when accepted by the insurance company.

_________________________ APPLICANT

_________________________ TODAY'S DATE

PRIVATE LABEL PRODUCTS INSURANCE PROGRAM

I. Applicant Information

Applicant Name:______________________ Phone:______________

Business Name:______________________ Website:______________

Mailing Address:______________ City:__________ State:_____ Zip:________

Business Address:______________________________

1.2 Business operated as: ☐ Corporation ☐ Partnership ☐ Individual ☐ Independent Contractor

1.3 Business operated as salon? ☐ If not, other:______________

1.4 How long in business?______________ Do all professionals have licenses? ☐

1.5 Do you have operations not listed on the schedule? ☐ If yes, provide details: ______________

Do you have insurance for these operations? ☐ Name of insurance company:______________

II. Location and Product Information

2.1 Type of business

☐ Salon/Spa/Aesthetic Clinic ☐ Laser/Medi-Spa ☐ Wholesale Distributor

☐ Retail Supply Store ☐ Other (describe) ______________

2.2 Are all products purchased from a manufacturer or supplier within USA? ☐ Yes ☐ No

Estimated Annual Private Label Product sales: $______________

2.3 Do all manufacturers name you as an additional insured vendor? ☐ Yes ☐ No
(If yes provide copies of certificates)

2.4 Describe all products sold by you under your own label.

2.5 List all suppliers of private label products

2.6 Do you sell products that you do not private label? ☐ Yes ☐ No

If yes provide gross receipts for all non private label products: $______________

2.7 Square footage of your location: ______________

2.8 Do you exhibit at one or more trade shows per year? ☐ Yes ☐ No

2.9 Does your landlord need to be named as additional insured? ☐ Yes ☐ No

Does your landlord require a waiver of subrogation? ☐ Yes ☐ No

PART III. HISTORY

NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

3.1 Do you currently have insurance coverage? ☐ Yes ☐ No If yes, indicate the following:

Insurer	Policy #	Liability Limits	Premium	Exp. Date

If claims made, most recent retroactive date:____________________

3.2 List liability claims history arising from any product sales, general liability or other professional activity, whether or not insured: If none, state so____________

YR/Claim	Nature of injuries	Details, if Pending	Amt. if settled

3.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence?

☐ Yes ☐ No. If yes, describe details of the event:

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

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

______________________________ APPLICANT SIGNATURE

______________________________ TITLE

______________________________ DATE REQUESTED

______________________________ REQUESTED EFFECTIVE DATE

______________________________ LIABILITY LIMIT REQUESTED

ADDITIONAL INSURED: @ $50 Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME:______________________________

ADDRESS:______________________________

Relationship to your business (Landlord, lienholder):______________________________

Business Owners Application

1.1 Applicant Name:______________________________ Phone:____________________

Business Name:______________________________ Website:____________________

Mailing Address:____________________ City:____________ State:______ Zip:____________

Business Address:____

County: ____________________ Square 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 schedule?___ 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 If building is over 20 years old, when were the following upgraded? (*) Information is Required

*Roof:____________ *Plumbing:______________ *Wiring:______________ Sprinklers:__________

2.3 *Central Station Burglar Alarm? ☐ Yes ☐ No If yes advise alarm provider :______________________

2.4 Other Occupancies in building? (Describe)____

2.5 Adjoining Occupancies: LEFT:____________________ RIGHT:____________________

2.6 Approximate distance from fire station:______________ Distance from fire hydrant:______________

2.7 Do you sell clothing? Yes ☐ No ☐ If yes, 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

CONTENTS – Limit Needed:	$____________________	Deductible $1,000
BUILDING – Limit Needed:	$____________________	Deductible $1,000
EARNINGS – Limit Needed:	$____________________	For What Period? ____________
SIGN – Limit Needed:	$____________________	Deductible $100

CLAIMS

3.1 List all property claims in the past 5 years, whether or not insured:______________________________

____

3.2 Current property insurance carrier, policy number:______________________________

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Business Owners Application

PART IV. HISTORY

NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

4.1 Do you currently have insurance coverage? ___Yes ___No If yes, indicate the following:

Insurer	*Policy #*	*Liability Limits*	*Premium*	*Exp. Date*

If claims made, most recent retroactive date:____________________

4.2 List liability claims history arising from any permanent makeup, beauty, health or other professional activity, whether or not insured: If none, state so____________

YR/Claim	*Nature of injuries*	*Equip. Involved*	*Details, if Pending*	*Amt. if settled*

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? _______Yes _______No. If yes, describe details of the event:

____

____

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

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

______________________________ APPLICANT SIGNATURE

______________________________ TITLE

______________________________ DATE

______________________________ REQUESTED EFFECTIVE DATE

______________________________ LIABILITY LIMIT REQUESTED

ADDITIONAL INSURED: @ $50 Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME:____

ADDRESS:____

Relationship to your business (Landlord, lienholder):______________________

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 COVERAGE MAY BE REDUCED.

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 coverage for acts of terrorism for a prospective premium of ________________
	I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

____
Policyholder/Applicant's Signature

<u>Underwriter's at Lloyd's, London</u>
Insurance Company

____
Print Name

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Policy Number

____
Date

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