

Proposed First Named Insured & Other Named Insured(s):

Location Address                      Street                      City                      County                      State                      ZIP Code

**BUSINESS INFORMATION**

1. Number of years' experience: \_\_\_\_\_
2. Operating in:     Home                       Hospital                       Beauty Salon/Tanning Salon  
                          Nursing Home                       Other:

	Yes	No
3. Do you sell private label, repackaged or foreign-made products?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you manufacture, mix, blend, bottle or label any products?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are all employees properly licensed?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you or any of your employees had licensing violations?	<input type="checkbox"/>	<input type="checkbox"/>
7. Indicate total number for each category:		
Beauty School Chairs		Tanning Beds/Booths
Beauticians/Barbers – Full Time		Manicurists Sales
Beauticians/Barbers – Part Time		Beauty School Teachers

**SERVICES**

Indicate services you perform and the percentage of total receipts devoted:

	Performed?		% of Total Receipts		Performed?		% of Total Receipts
	Yes	No			Yes	No	
Body Piercing	<input type="checkbox"/>	<input type="checkbox"/>		Permanent Make-up (e.g. eyeliner)	<input type="checkbox"/>	<input type="checkbox"/>	
Body Wraps	<input type="checkbox"/>	<input type="checkbox"/>		Permanent Waves	<input type="checkbox"/>	<input type="checkbox"/>	
Botox Injections	<input type="checkbox"/>	<input type="checkbox"/>		Plastic Surgery	<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"/>	
Dermabrasion	<input type="checkbox"/>	<input type="checkbox"/>		Sensory Deprivation Chamber (water or float)	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Piercing	<input type="checkbox"/>	<input type="checkbox"/>		Stand Alone Diet Center	<input type="checkbox"/>	<input type="checkbox"/>	
Electrolysis/Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>		Steam Bath	<input type="checkbox"/>	<input type="checkbox"/>	
Facelifting	<input type="checkbox"/>	<input type="checkbox"/>		Tanning Beds/Booths	<input type="checkbox"/>	<input type="checkbox"/>	
Hair Cuts	<input type="checkbox"/>	<input type="checkbox"/>		Wart or Mole Removal	<input type="checkbox"/>	<input type="checkbox"/>	
Hair Dyeing	<input type="checkbox"/>	<input type="checkbox"/>		Waxing (hot or cold)	<input type="checkbox"/>	<input type="checkbox"/>	
Hair Implants/Transplants	<input type="checkbox"/>	<input type="checkbox"/>		Wrinkle Removal	<input type="checkbox"/>	<input type="checkbox"/>	
Hair Weaving	<input type="checkbox"/>	<input type="checkbox"/>		X-Rays or Laser Related Services	<input type="checkbox"/>	<input type="checkbox"/>	
Manicures	<input type="checkbox"/>	<input type="checkbox"/>					
Other (explain):	<input type="checkbox"/>	<input type="checkbox"/>					

Additional Comments/Remarks:

---

**IMPORTANT NOTICE  
DECLARATION**

---

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

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

---

**SIGNATURES**

Applicant Signature	Title	Date
Producer Signature		Date
Producer Name and Address		

---