

Salon, Spa and Personal Enhancement Questionnaire

Please answer all questions. Submit this questionnaire with a completed ACORD application and prior carrier loss runs.

Named Insured: _____

PROHIBITED CIRCUMSTANCES

1. Are any of the aestheticians paramedical aestheticians; or do any operate under a physician's supervision or perform services based on medical referrals? Yes No

2. Do you provide any of the following services?

- | | | |
|---|--|--|
| <input type="checkbox"/> Permanent make-up or tattoos | <input type="checkbox"/> Piercings (other than ear lobe) | <input type="checkbox"/> Cellulite reduction |
| <input type="checkbox"/> Laser hair removal | <input type="checkbox"/> Colon hydrotherapy | <input type="checkbox"/> Ear candling |
| <input type="checkbox"/> Ear stapling | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Subcutaneous injections (Botox) |
| <input type="checkbox"/> Microneedling | <input type="checkbox"/> Weight loss advice | <input type="checkbox"/> Sensory deprivation chambers |

If any services listed above are offered, this risk is not eligible for coverage unless the service is excluded.

Answer the following questions only if you have a tanning exposure.

- | | |
|--|--|
| 3. Are timers controlled by the customer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Are customers allowed to tan for more than 20 minutes during any session? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Is the tanning salon unattended at any time? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Does the salon use any tanning beds that are not UL Listed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Is the salon part of a national or regional tanning franchise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If any "YES" answers to questions 1-7 above, risk is not eligible for coverage.

HAIR, NAIL AND SKIN SERVICES (COMPLETE WHEN APPLICABLE)

1. What is the total number of employees?

Employee Type	Employees or Independent Contractors	
	Full Time (20+ hrs/week)	Part Time (<20 hrs/week)
Beauticians/Barbers, Nail Technicians or Aestheticians		
Electrologists (include employees performing facial chemical peels and microdermabrasion services)		
Massage Therapists		

2. Check all applicable items that describe additional services offered:

- | | | |
|---|--|--|
| <input type="checkbox"/> Facial/Body waxing | <input type="checkbox"/> Facial chemical peels | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Body Wraps | <input type="checkbox"/> Exercise activities | |
| <input type="checkbox"/> Other: _____ | | |

- | | |
|--|--|
| a. Body wraps or exercise activities: are more than 20% of annual sales from these operations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Facial chemical peels or microdermabrasion: are customers required to wear eye protection? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Do you manufacture, repackage or re-label any products? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. Describe products: _____ | |
| 4. Do you dispense or sell any herbal supplements or medications? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

TANNING OPERATIONS (COMPLETE WHEN APPLICABLE)

- | | |
|--|-----------------------------|
| 1. spray tanning booths: | Number of beds and/or _____ |
| 2. have all of the following: | Please certify that you |
| a. | Automatic shut off control |
| b. mixing medication with UVA and UVB rays | FDA warning provided on |
| c. a waiver of liability prior to using the tanning beds | Customers require to sign |
| d. wear eye protection when using the tanning beds | Customers required to |
| e. each use | Beds disinfected after |

I certify that all the statements above in question 2 are verified: **Yes – I certify this**

TEETH WHITENING SERVICES (COMPLETE WHEN APPLICABLE)

- | | |
|---|---------------------------|
| 1. have all of the following: | Please certify that you |
| a. limited to carbamide and hydrogen peroxide | Bleaching agents are |
| b. concentration of carbamide peroxide used is 22% | The maximum |
| c. not used to accelerate the whitening process | Lasers and UV light are |
| d. business | This is not a kiosk-based |
| e. 16; or women that are nursing or pregnant are prohibited from receiving teeth whitening services | Persons under the age of |

I certify that all the statements above in question 1 are verified: **Yes – I certify this**

POOLS / SAUNAS / STEAM ROOMS / WHIRLPOOLS (COMPLETE WHEN APPLICABLE)

1. What is the total number of the following?

Pools: _____*	Hot tubs/Whirlpools: _____	Saunas/Steam rooms: _____
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- a. If any hot tubs, Jacuzzis, steam rooms or saunas; please certify that the following requirements are met:
- i. Warnings and directions for use clearly posted.
 - ii. All thermostats are tamper-resistant.
 - iii. All emergency shutoffs are in the same area.
 - iv. All of these features are equipped with a timer for automatic shut-off.

I certify that all the statements above regarding safeguards are verified: **Yes – I certify this**

*Complete CGE 160 – Swimming Pool/Water Features Questionnaire if applicable

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a

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fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(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.)

Applicant Signature

Title

Date

Producer Signature

Date