Strickland
E & S Brokers

BEAUTY PROGRAM
PROFESSIONAL LIABILITY SUPPLEMENT

Business Name _____

Description of Business _____

_____

Is your business and all its operators in compliance with all city, county and/or state ordinances? □YES □NO

How many years in business? _____

Business License Number: _____
Please attach a copy.

I. SCHEDULE OF SERVICES

PLEASE INDICATE WHICH SERVICES YOUR BUSINESS WISHES TO INSURE. THE NUMBER (#) OF OPERATORS, AND ATTACH COPIES OF ALL REQUIRED CERTIFICATES, LICENSES AND/OR DESCRIPTION OF TRAINING WITH NUMBER OF YEARS EXPERIENCE FOR EACH OPERATOR. IF THERE IS AN M.D. (i.e. physician, dentist, etc.) TO BE INSURED, PLEASE INDICATE IF THEY ARE SUPERVISING (**"S"**) OR PRACTICING **("P")** AND PROVIDE EVIDENCE OF MEDICAL MALPRACTICE INSURANCE.

SERVICE		YES	NO	# of Operators	M.D. (Indicate type) "S", "P" or N/A
1.	Manicurists	□	□	_____	_____
2.	Beautician	□	□	_____	_____
3.	Wax Removal	□	□	_____	_____
4.	Body wraps	□	□	_____	_____
5.	Massages	□	□	_____	_____
6.	Electrology	□	□	_____	_____
7.	Ear Piercing	□	□	_____	_____
8.	Tanning	□	□	_____	_____
9.	Facials, NO PEELS	□	□	_____	_____
10.	Facials W/Peels & Microdermabrasion	□	□	_____	_____
11.	MCA/Needling	□	□	_____	_____
12.	Permanent Cosmetics Including Full Lips	□	□	_____	_____
13.	Camouflage	□	□	_____	_____
14.	Cheek Blush	□	□	_____	_____
15.	Nipple Areola	□	□	_____	_____
16.	Pigment Removal (limited to skin types I-IV) Saline/Rejuvi	□	□	_____	_____
17.	Decorative Tattooing	□	□	_____	_____
18.	Temporary Tattooing/Henna	□	□	_____	_____

SERVICE		YES	NO	# of Operators	M.D. (Indicate type) "S", "P" or N/A
19.	Body Piercing	☐	☐	_____	_____
20.	Body Piercing including Minors with written parental consent	☐	☐	_____	_____
21.	Body Piercing Ampallang, Ampadravya and/or Nape	☐	☐	_____	_____
22.	Photofacial/Skin Rejuvenation (IPL)	☐	☐	_____	_____
23.	Veins	☐	☐	_____	_____
24.	Age/Sun Spots	☐	☐	_____	_____
25.	Rosacea	☐	☐	_____	_____
26.	Nonablative Wrinkle Reduction	☐	☐	_____	_____
27.	Acne Treatment	☐	☐	_____	_____
28.	Cellulite Treatment	☐	☐	_____	_____

PLEASE NOTE: COVERAGE IS EXCLUDED FOR ANY OF THE ABOVE SERVICES HIGHER THAN THE FDA APPROVED CLASS II OR USING MORE THAN 20 JOULES/CM SQUARED OR INFRARED LIGHT:

LED/LASER SERVICES:

29.	Photofacial/Skin Rejuvenation	☐	☐	_____	_____
30.	Veins	☐	☐	_____	_____
31.	Age/Sun Spots	☐	☐	_____	_____
32.	Rosacea	☐	☐	_____	_____
33.	Nonablative Wrinkle Reduction	☐	☐	_____	_____
34.	Acne Treatment	☐	☐	_____	_____
35.	Cellulite Treatment	☐	☐	_____	_____
36.	Laser/ILP Hair Removal Skin Types I-IV Only	☐	☐	_____	_____
37.	Laser/ILP Hair Removal Skin Types V-VI	☐	☐	_____	_____

*If YES, and Laser Hair Removal Operator is not an M.D. please provide the name and address of your Supporting Medical Professional: _____

_____

38.	Laser Tattoo Removal	☐	☐	_____	_____

*If YES, and Laser Tattoo Removal Operator is not an M.D. please provide the name and address of your Supporting Medical Professional: _____

_____

39.	Laser Hair Stimulation	☐	☐	_____	_____
40.	Sclerotherapy	☐	☐	_____	_____
41.	Dermal Fillers	☐	☐	_____	_____
42.	Off-Label Botox (Forehead & Crows Feet Only)	☐	☐	_____	_____

*If YES, and Botox Operator is not an M.D. please provide the name and address of your Supporting Medical Professional:_____

_____

43.	Medical Strength Peels Skin Types V & VI excluded	☐	☐	_____	_____

*If YES, and Medical Strength Peels Operator is not an M.D. please provide the name and address of your Supporting Medical Professional:_____

_____

DO YOU HAVE OPERATIONS **NOT** LISTED IN THE ABOVE SCHEDULE OF SERVICES? □YES □NO
If YES, provide details: _____

_____

TOTAL # OF OPERATORS to be insured? _____

ANNUAL GROSS RECEIPTS FOR ALL SERVICES #1-28 $_____
ANNUAL GROSS RECEIPTS FOR ALL SERVICES #29-43 $_____

II. OPERATIONS

		YES	NO
1.	Do all operators understand the Fitzpatrick Scale?	□	□
2.	Does your facility require all operators to be trained in accordance with all FDA regulations and state laws for every service provided?	□	□
3.	Does your facility require every client to sign an information/consent and release form? If Yes, please attach a copy.	□	□
4.	Do you provide all clients with written aftercare instructions? If Yes, please attach a copy.	□	□
5.	Do you take client "before and after" photos of all cover-up and cosmetic work?	□	□
6.	Do you schedule follow-up appointments?	□	□
7.	Do you perform any work on minors? (anyone under 18 years)?	□	□
8.	Do you require a signed parental consent form for all minors (anyone under 18 years)? If Yes, please attach a copy.	□	□
9.	Do you keep a copy of all signed client forms & photos on file for a minimum 1 year?	□	□
10.	Does your business have a valid CPR certificate posted?	□	□
11.	Do operators follow Health Department Center For Disease Control Sanitation Guidelines?	□	□
12.	Are new gloves worn for every procedure?	□	□
13.	Do you ever re-use needles?	□	□
14.	Do you dispose of pigments after each procedure?	□	□
15.	Does all jewelry meet the standards of the Association of Professional Piercers?	□	□
16.	Do you use piercing guns for any area other than the earlobes?	□	□
17.	Are all apprentice operators supervised by an experienced operator?	□	□
18.	Are all products, equipment and devices sterilized for every procedure?	□	□
19.	Are all products, equipment and devices for all services approved according to the FDA guidelines?	□	□
20.	Are all products, equipment and devices tested, maintained and in proper working order?	□	□
21.	Are all operators in compliance with all FDA and state laws as to the use of lasers/IPLs/ light devices?	□	□
22..	Are all laser services performed in a private & locked room with an ANSI compliant door activated shut-off system?	□	□
23.	Is a sign posted "Laser In Use, Do Not Enter" on all rooms where laser services are being performed?	□	□
24.	Are all reflective surfaces covered in all rooms where laser services are being performed?	□	□
25.	Do you provide and require goggles be worn by every person in a room where laser services are being performed?	□	□
26.	Are you in compliance with all AMA and state laws as to use of Botox and dermal fillers?	□	□

Please name any professional association you or any operators are members of that promotes safe techniques and provides continuing professional education for its members:

_____

_____

Do you currently have insurance coverage? □YES □NO

If YES, Please provide the following:

INSURER: _____
POLICY#: _____
LIABILITY LIMITS: _____
PREMIUM: _____
EXPIRATION DATE: _____
RETROACTIVE DATE: _____

PLEASE ATTACH 5 YEAR LOSS HISTORY FOR ALL COVERAGES REQUESTED.
Provide detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.

I UNDERSTAND AND AGREE THERE IS NO COVERAGE FOR THE FOLLOWING:
Any equipment, product or services not approved by Federal Food & Drug Administration (FDA)
Medical Peels for Skin Types V and VI

The undersigned represents and warrants that all statements and answers to questions are true, complete and accurate and that there has been no suppression or misstatement of fact. The undersigned agrees that any policy issued will rely on the truth of the statements. If the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify NIPC of such changes, and NIPC may withdraw or modify any outstanding quotations and/or agreements to bind insurance.

I understand and agree this Application and any and all supplements attached hereto will be made part of any policy issued, and such policy will be issued in reliance upon the representation made herein.

_____ _____
APPLICANT'S NAME (Please print) TITLE

_____ _____
TODAY'S DATE REQUESTED EFFECTIVE DATE

_____ _____
APPLICANT'S SIGNATURE REQUESTED LIMIT OF LIABILITY

PLEASE NOTE: COVERAGE BECOMES EFFECTIVE ONLY WHEN ACCEPTED BY THE INSURANCE COMPANY, SIGNING THIS FORM DOES NOT BIND COVERAGE.

The producer represents that all of the insurance requirements of the applicant's home state have been or will be complied with.

Producing Agency Submitting to NIPC: _____

Address: _____

Telephone: (____)_____ Fax: (____)_____ Email: _____