



Personal Enhancement Insurance Programs

- bodyBeautiful liability insurance coverage for salon & day spa businesses
bodyMed liability insurance coverage for cosmetic laser & medispa businesses
bodyMod liability insurance coverage for tattoo & body piercing businesses

Marine Agency Corp

191 Maplewood Ave, Maplewood NJ 074040
Toll Free 800-763-4775 | Facsimile 973-763-1635
https://marineagency.com

APPLICANT INFORMATION

- 1. Name of Corporation or LLC (include "Inc", "Corp", "LLC", etc.):
2. Name of Business (your "dba" or "t/a" name):
3. Name of business owner(s):
4. Mailing address:
City: State: Zip Code:
5. Phone: Facsimile:
Website: Email Address:
6. FEIN (Federal Employer Identification Number) or Social Security Number:
7. Type of Entity: Corporation Partnership or Joint Venture Sole Proprietor (individual)
Limited Liability Company Other (describe):
8. Year started in this business/industry (if new, describe business experience):
9. List any professional associations in which the applicant is a member:
10. List all physical location addresses (if 100% "mobile" with no fixed location, indicate "mobile"):



INSURANCE INFORMATION

11. Previous insurance carrier (last five years):

Carrier Name	Policy Number	Policy Dates	Coverage Form
_____	_____	_____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Form
_____	_____	_____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Form
_____	_____	_____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Form
_____	_____	_____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Form
_____	_____	_____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Form

If previous policy was written on a claims-made basis, attach a copy of the prior policy declarations and provide the policy "retroactive date": \_\_\_\_\_

12. Have there been any claims in the last five years (whether or not insured)?  Yes  No

If yes, describe: \_\_\_\_\_

13. Has any previous carrier cancelled or not renewed a policy?  Yes  No

If yes, describe: \_\_\_\_\_

COVERAGE INFORMATION

14. Professional Liability Coverage Limits (check one):  \$1,000,000 per claim / \$2,000,000 annual aggregate  \$1,000,000 per claim / \$3,000,000 annual aggregate  \$2,000,000 per claim / \$4,000,000 annual aggregate

15. General Liability Coverage Limits (check one):  SAME as above  EXCLUDE general liability

16. Abusive Acts SubLimits (check one):  \$100,000 per claim / \$100,000 annual aggregate  EXCLUDE abusive acts liability

17. Policy Deductible (check one):  \$0 (zero) per claim  \$1,000 per claim  \$2,500 per claim  \$5,000 per claim

18. Defense Coverage Options (check one):  include coverage for defense in limits above  \$100,000 per claim / \$100,000 annual aggregate  \$250,000 per claim / \$250,000 annual aggregate  \$1,000,000 per claim / \$1,000,000 annual aggregate

**EXPOSURE INFORMATION**

19. Indicate the professional services performed at your business. Please note:

- Any professional services for which you do not provide such information will not be covered under this policy.
- Checking a professional service does not obligate us to insure it.

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Acupuncture</li> <li><input type="checkbox"/> Aromatherapy</li> <li><input type="checkbox"/> Body Massage</li> <li><input type="checkbox"/> Body Piercing</li> <li><input type="checkbox"/> Body Wraps</li> <li><input type="checkbox"/> Branding (burns with hot irons)</li> <li><input type="checkbox"/> Chemical Peels – Aesthetician Grade</li> <li><input type="checkbox"/> Chemical Peels – Medical Grade</li> <li><input type="checkbox"/> Chiropractic</li> <li><input type="checkbox"/> Colon Hydrotherapy</li> <li><input type="checkbox"/> Cosmetics/Make-up Application</li> <li><input type="checkbox"/> Cupping – Dry</li> <li><input type="checkbox"/> Cupping – Fire</li> <li><input type="checkbox"/> Cupping – Wet (with cutting/blood)</li> <li><input type="checkbox"/> Cryotherapy</li> <li><input type="checkbox"/> Dermaplaning</li> <li><input type="checkbox"/> Ear Piercing</li> <li><input type="checkbox"/> Electrolysis</li> <li><input type="checkbox"/> Endermology</li> <li><input type="checkbox"/> Facial &amp; Scalp Massage</li> <li><input type="checkbox"/> Facial &amp; Skin Cleansing</li> <li><input type="checkbox"/> Hair Cutting/Styling/Coloring</li> <li><input type="checkbox"/> Hormone Therapy (injected or otherwise)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Hydrotherapy</li> <li><input type="checkbox"/> Injections – Botox</li> <li><input type="checkbox"/> Injections – Dermal Fillers</li> <li><input type="checkbox"/> Injections – PRP (Platelet -rich Plasma)</li> <li><input type="checkbox"/> Ionic Foot Detox</li> <li><input type="checkbox"/> Laser/Intense Pulsed Light (“IPL”)</li> <li><input type="checkbox"/> Manicure/Pedicure</li> <li><input type="checkbox"/> Mesotherapy</li> <li><input type="checkbox"/> Microdermabrasion</li> <li><input type="checkbox"/> Micropigmentation / Cosmetic Tattooing</li> <li><input type="checkbox"/> Nutritional Counseling / Consultation</li> <li><input type="checkbox"/> Personal Training / Yoga Instruction</li> <li><input type="checkbox"/> Pigment Removal – Injectable Solution</li> <li><input type="checkbox"/> Pigment Removal – Laser</li> <li><input type="checkbox"/> Radio Frequency (“RF”) Skin Treatments</li> <li><input type="checkbox"/> Scarification</li> <li><input type="checkbox"/> Sclerotherapy</li> <li><input type="checkbox"/> Tanning Beds / Booths / Units</li> <li><input type="checkbox"/> Tattoo</li> <li><input type="checkbox"/> Ultrasonic / Ultrasound Skin Treatments</li> <li><input type="checkbox"/> Vitamin Therapy (injected or otherwise)</li> <li><input type="checkbox"/> Waxing</li> <li><input type="checkbox"/> Weight Loss</li> </ul> |
|--|--|
- Other (describe): \_\_\_\_\_

20. Indicate the number of people performing professional services for you or on behalf of your business.

- \_\_\_\_\_ Supervising Physicians that do not render services  
(if your supervising physician is also a service provider at the business, include below)
- \_\_\_\_\_ Laser/MediSpa service providers  
(injections, laser/IPL treatments, medical treatments/counseling, or pigment removal services)
- \_\_\_\_\_ Tattoo Artists & Body Piercers (body piercing and all forms of tattooing)
- \_\_\_\_\_ Spa professionals (aestheticians, electrologists, massage therapists)
- \_\_\_\_\_ All other service providers (hair, nails, cosmetics, personal trainers, yoga instructors)

21. Are you and your staff properly licensed (where required by law)?  Yes  No
22. Have all service providers received training in the covered services?  Yes  No
23. Can all **laser/medispa** service providers listed above document or attest to at least one year professional experience in the covered services?  Yes  No  n/a
24. Have all **tattoo/body piercing** service providers listed above completed an apprenticeship and/or formal training program?  Yes  No  n/a
25. Have all **tattoo/body piercing** service providers listed above received blood-borne pathogen training?  Yes  No  n/a
26. Are any services performed by students?  Yes  No
- a. If yes, are all such services performed under direct supervision?  Yes  No
27. Do you use piercing guns?  Yes  No
- a. If yes, are they used only on earlobes?  Yes  No
28. Have any service providers been the subject of a license revocation, suspension, or sanction related to the covered services in the last five years?  Yes  No
29. Describe your method of sterilization for tattoo/body piercing equipment (including needles) and both used and unused jewelry: \_\_\_\_\_
30. Do you offer piercing or tattooing services to minors (under age 18)?  Yes  No
- If yes, describe: \_\_\_\_\_
31. Do you offer massage services to minors (under age 18)?  Yes  No
- a. If yes, do you obtain criminal background checks on all massage therapists?  Yes  No
- b. If yes, do you obtain written consent from parent/guardian?  Yes  No
- c. If yes, is the parent/guardian present in the treatment room during services?  Yes  No
32. Do you provide any alcoholic beverages to customers?  Yes  No
- a. If yes, are all such beverages complimentary (free) with a service?  Yes  No
- b. If yes, are you in compliance with all state and local ordinances regarding distribution and consumption of alcohol?  Yes  No
- c. If yes, are all staff trained in appropriate protocol to avoid serving inebriated customers?  Yes  No



**APPLICANT WARRANTY**

By signing the Application the Applicant warrants the use of certain forms of client documentation on all customers receiving professional services that are the subject of this Application for insurance. Failure to obtain and keep documentation of same will be grounds for denial of coverage. These forms are as follows:

- Signed consent/release form
- Completed/signed medical history form
- Distribution of written post-treatment (“aftercare”) instructions
- Written consent of parent/guardian where required by law when providing services to a minor (under age 18)

We agree and confirm that written consent/release forms, medical history, and post-treatment instructions are not required for adjunct salon services including cosmetology (hair/nails/cosmetics), skincare (non-medical, non-laser/IPL), or bodywork (massage and/or body wrap).

**ATTESTATION**

By signing the Application the undersigned agrees that he/she is not aware of any fact or circumstance which reasonably might give rise to a future claim that would fall within the scope of the proposed coverage.

Receipt and review of this Application does not bind the insurer to provide this insurance.

If the Applicant has concealed or misrepresented any material fact, circumstance or fraud concerning this insurance resulting in deception to us which existed at the time of loss/claim and contributed to such loss/claim, this policy may be canceled and/or coverage denied as long as the deception was material; was made knowingly and with the intent to deceive; was relied and acted upon by the Insurer; and deceived the Insurance to the Insurer’s injury.

**STATEMENT FROM APPLICANT & SIGNATURE**

I hereby represent and confirm that the above information, to the best of my knowledge, is true and correct and further certify that I have read all of the questions and answers of this insurance application.

**APPLICANT**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Principal, Partner or President

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

**BROKER**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Agent/Broker

Print Name: \_\_\_\_\_ License #: \_\_\_\_\_



Coverholder at LLOYD'S

**Return completed/signed application materials and any requested attachments to coverholder for quotation to:**

**Marine Agency Corp**  
191 Maplewood Ave, Maplewood NJ 07404  
Toll Free 800-763-4775 | Facsimile 973-763-1635  
<https://marineagency.com>