

Chris-Leef General Agency, Inc.
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PERMANENT COLOR / DECORATIVE TATTOOING

PART 1. GENERAL INFORMATION

- 1.1 Applicant legal business name, _____
Mailing Address- _____
Business Address- _____
County (Parish) _____ Phone Number _____
- 1.2 PROPOSED EFFECTIVE DATE OF COVERAGE: _____
- 1.3 LIMIT OF LIABILITY DESIRED: \$ _____ incident / \$ _____ aggregate
Is premises General Liability also desired? Yes _____ No _____ If Yes, square ft. area _____
- 1.4 Applicant is: (complete A or B)
(A) INDIVIDUAL _____ Employee (W-2) _____ Sole Practitioner, OR
(B) _____ Sole Proprietorship _____ Partnership _____ Corporation _____ Other, explain:

- 1.5 Type of business (where equipment is located): Beauty Salon _____ Tattoo Parlor _____
Independent Operator serving multiple locations _____ (If so, # _____) Clinic _____ Other,
describe _____
- 1.6 Are you in compliance with all applicable city, county and/or state ordinances? _____
Business License No. _____ (attach copy)

IF MULTIPLE OPERATORS TO BE COVERED, complete 1.7, 1.8, 1.9 for EACH & attach.

- 1.7 How long in business applying permanent color? _____ tattooing? _____
- 1.8 Have you had formal instruction in the application of permanent color? _____ tattooing? _____
If yes, attach all documents of certification. If no, attach description of training and experience.
- 1.9 How many procedures have you performed in the past 12 months for the following:
Eyeliner _____ Eyebrows _____ Lip liner _____ Lips _____ Cheek blush _____ Skin Repigmentation/
Camouflage _____ Decorative Tattooing _____ Other, explain: _____
- 1.10 Annual Gross Receipts:
A. Permanent Color Next 12 months \$ _____ Last 12 months \$ _____
B. Tattooing Next 12 months \$ _____ Last 12 months \$ _____
C. Products: Next 12 months \$ _____ Last 12 months \$ _____
(if products sold, complete question 1. 11 on page 2)

NOTICE

THIS POLICY (IF ISSUED) IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

1.11 Are Products Sold? Yes No If Yes, describe and give annual sales: _____

Are any products sold of foreign manufacture? Are any products sold under your own label?
Yes No If Yes, explain in detail. _____

PART 11. INFORMATION ABOUT YOUR PROFESSION

- 2.1 Do you use a medical history/client information form on everyone? Yes No
If yes, please attach a copy.
- 2.2 Do you use a hold harmless form? If yes, please attach a copy. Yes No
- 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, please attach a copy of all promotional materials.

PART 11. EQUIPMENT / PROCEDURES

- 3.1 Are all pigments you use from US manufacturers and deemed to be safe by the FDA? Yes No
- 3.2 Do you ever reuse needles? Yes No
If yes, please indicate your method of needle sterilization: _____
If sterilizer, please indicate make: _____
- 3.3 Is all your equipment in proper running order? Yes No
- 3.4 Do you wear gloves with each procedure? Yes No
- 3.5 Do you have hot and cold running water on site? Yes No
- 3.6 Do you dispose of your pigments after each client? Yes No
- 3.7 Please provide the following information on all applicators:
MANUFACTURER _____ MODEL _____ DATE OF PURCHASE _____
MANUFACTURER _____ MODEL _____ DATE OF PURCHASE _____
- 3.8 Is your office maintained in a sanitary manner, including physical cleanliness and antiseptic precautions? Yes No

PART IV. HISTORY

- 4.1 List prior professional liability insurers for the past five years: If none, so state.
- | | Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made | |
|----|---------|---------------|---------------------|---------|-----------|-------------|-------|
| | | | | | | Yes | No |
| 1. | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
- If claims-made, what is the most recent retroactive date? _____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limit of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

Yes No. If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary). _____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?

Yes No. If yes, describe the event and indicate the reason for anticipation of a claim, _____

I understand and agree this Application and any and all supplements attached hereto will be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. 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 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 to the company providing insurance coverage and Mid-Continent General Agency, Inc. 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.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

_____ Date _____ Applicant _____ Title

Agent: _____

Agent Address: _____