If your answer requires a larger space, please use the supplementary page instead. Please indicate: "see supplementary page".

PERMANENT COLOR / DECORATIVE TATTOOING PROFESSIONAL LIABILITY CLAIMS-MADE INSURANCE APPLICATION

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 1.7,11.8,11.9 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 Lipliner 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. 1 1 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 III. 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 re-use 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	Claims-Made 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	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made 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

Supplementary Page

Please reference the number of the question to which these responses apply.