Northland INSURANCE

APPLICATION - BEAUTY PARLORS/BARBER SHOPS

GENERAL INFORMATION

1. First Named Insured _____
   (The first Named Insured is responsible for premium payment, cancellation, and changes - refer to policy wording.)
2. Other Insured(s) _____
3. Mailing Address _____
   Street City County State ZIP Code
4. Location of Premises: ❒ Same as mailing address
   ❒ Other _____
5. Effective Date Desired _____ Term Desired _____
6. **PRIOR INSURANCE CARRIER AND LOSS HISTORY FOR THE PAST THREE YEARS**

Year	Carrier/Policy Number/Premium	Coverage	# of Losses	Amount	Description of Losses (Use separate sheet if necessary)

7. Missouri Applicants: **DO NOT** answer this question.
   Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?
   ❒ No ❒ Yes - If so, give name of company, date, and reason. _____
8. Years in Business _____ Years of Experience _____
9. Describe prior experience _____
10. Applicant is: ❒ Individual ❒ Partnership ❒ Corporation ❒ LLC
    ❒ Trust ❒ Other _____
11. Operating in: ❒ Home ❒ Hospital ❒ Beauty Salon ❒ Shopping Center
    ❒ Tanning Salon ❒ Nursing Home ❒ Other _____
12. Interest of Named Insured in premises: ❒ Owner ❒ General Lessee ❒ Tenant ❒ Other _____
13. Part occupied by Named Insured: ❒ Entire ❒ Portion (____%) ❒ None (Lessor's Risk Only)
14. Does applicant operate any other business from or on these premises? ❒ Yes ❒ No
    If yes, describe _____
15. **COVERAGES / LIMITS DESIRED**

❒ Premises-Operations	$ _____	Each Occurrence Limit
	$ _____	General Aggregate
❒ Products-Completed Operations	$ _____	Aggregate
❒ Personal and Advertising Injury	$ _____	Limit
❒ Damage to Premises Rented to You	$ _____	Limit
❒ Medical Payments	$ _____	Limit
❒ Contractual Liability (No Separate Limit)		
❒ Professional Liability	$ _____	Each Occurrence Limit
	$ _____	Aggregate

16. Does applicant: Sell private-label, repackaged or foreign-made products? ❒ Yes ❒ No
Manufacture, mix, blend, bottle or label any products? ❒ Yes ❒ No

PERSONNEL DATA

17. Complete for each employee and lessee. *(Attach additional sheet if necessary.)*

Name	Full or Part Time	# of Days per Week	Licensed Operator?	# Years Experience	Approximate Weekly Income
			Y N		
			Y N		
			Y N		
			Y N		

18. Have you or any of your employees had licensing violations? ❒ Yes ❒ No

19. Indicate total number for each category:

Beauty Parlor/Shop Chairs		Tanning Beds/Booths	
Beauticians/Barbers - Full Time		Manicurists	
Beauticians/Barbers - Part-time		Beauty School Teachers	

SERVICES

20. Indicate those you perform and the percentage of total receipts devoted:

	Performed YES	Performed NO	% of Total Receipts		Performed YES	Performed NO	% of Total Receipts
Permanent waves	❒	❒		Steam bath	❒	❒	
Hair cuts	❒	❒		Hair implants/transplants	❒	❒	
Hair dyeing	❒	❒		Hair weaving	❒	❒	
Manicures	❒	❒		Ear piercing	❒	❒	
Nail sculpturing/attachments	❒	❒		Permanent make-up	❒	❒	
Waxing (hot or cold)	❒	❒		(e.g. eyeliner)			
Electrolysis/hair removal	❒	❒		Tanning beds/booths	❒	❒	
Chiropody	❒	❒		Body wraps	❒	❒	
Wart or mole removal	❒	❒		Demonstrations for groups			
Reducing, slenderizing or exercising service	❒	❒		or sponsors	❒	❒	
Skin treatments or facials	❒	❒		Other - explain	❒	❒	

Additional Comments/Remarks: _____

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address