

3B – Beauty, Barber and Body Program Questionnaire

(To be attached to Application)

Named Insured: _____ Policy Number: _____

Please note: An Operator is considered full-time if they work 20 hours or more per week; whereas, part time is considered less than 20 hours per week. You must use the highest classification applicable.

Employee's Name	Independent Contractor's Name	Owner/Operator	Beautician/Barber, Nail Technician or Aesthetician		Electrologists		Massage Therapists	
		Yes/No	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time

- | | | |
|--|--------------------------|--------------------------|
| 1 How many years has the insured been in business? _____ | YES | NO |
| 2 Are all operators licensed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Do you employ students? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Do you perform: (Please note: all activities listed below are not acceptable, and thus coverage is not provided.) | | |
| Wart or Mole Removal? | <input type="checkbox"/> | <input type="checkbox"/> |
| Podiatry / Chiropody? | <input type="checkbox"/> | <input type="checkbox"/> |
| Permanent Cosmetic application? | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical training programs, diet advice or body building? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Is the 24-hour predisposition test given to patrons whose hair has not been previously tinted or dyed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Do you engage in any off site activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Do you manufacture, repackage or re-label any products? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Are premises equipped with hot tubs, saunas or steam baths? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 Do you engage in Health and Exercise Activities (including body wrapping)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, is operation less than 20% of total sales? (Operations in excess of 20% not eligible for Businessowners Policy) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Do you rent to Independent Contractors / Booth Renters? | <input type="checkbox"/> | <input type="checkbox"/> |
| Indicate the number of full and part time operators that rent from you. | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| Please provide name, occupation and liability carrier. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 Are you an Independent Contractor? | <input type="checkbox"/> | <input type="checkbox"/> |

Aesthetician Operations:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 12 Do you perform microdermabrasion services? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 Do you perform facial chemical peel services? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please answer the following questions: | | |
| 14 Are microdermabrasion or facial chemical peel services performed by a licensed aesthetician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 Are customers required to wear eye protection during any microdermabrasion or facial chemical peel service? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 Are any of the aestheticians para medical aestheticians or operate under a physician's supervision or instructions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17 Do the facial chemical peel compounds or formulas used have Glycolic Acid? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, is the percentage of Glycolic Acid 30% or less? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 Do the facial chemical peel compounds or formulas used have Lactic Acid? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, is the percentage of Lactic Acid 50% or less? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 If none of the facial chemical peel solutions have Glycolic or Lactic Acid, please list the types of acids, acid percentages and manufacturer/brands of compounds or formulas used. | | |
| _____ Acid, _____%, manufacturer/brand: _____ | | |
| _____ Acid, _____%, manufacturer/brand: _____ | | |

Tanning/Toning Operations:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 20 What percentage of U.V.B. radiation do your beds produce? _____% | | |
| 21 Are records kept on each customer for each visit and exposure time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22 Does each customer sign a waiver of liability prior to using these beds? (Attach a copy of the waiver to the application) | <input type="checkbox"/> | <input type="checkbox"/> |
| 23 Are all customers furnished information regarding bed and rays used? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24 Are all customers furnished or required to wear eye protection when using the tanning beds? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 Are all tanning bed controls operated by the insured, not the customer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26 Are all beds disinfected after each use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27 Maximum number of minutes customers are limited to in a session: _____ min. | | |
| 28 Are these beds UL listed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29 Do you use coin or slot tanning beds? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30 Do you provide airbrush-tanning services? | <input type="checkbox"/> | <input type="checkbox"/> |
| Number of Tanning Beds: _____ Number of Spray Tan Booths: _____ | | |
| Number of Toning Beds: _____ | | |

Massage Operation:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 31 Are the insured and any therapists working with or for the insured members of the American Massage Therapy Association? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32 Has the insured ever been sued for malpractice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33 Does the insured keep through records on all clients? | <input type="checkbox"/> | <input type="checkbox"/> |

Electrolysis Operation:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 34 Is all wiring and electrical equipment inspected frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35 Does the insured travel to clients' homes or to hospitals to perform electrolysis? | <input type="checkbox"/> | <input type="checkbox"/> |

Other Operations:

Describe any services or treatments rendered in your business not generally engaged in by beauty salons? _____

I hereby declare to the best of my knowledge and belief that all of the foregoing statements are complete and true and that these statements are offered as an inducement to the company to issue the policy for which I am applying. It is understood and agreed that the completion of this questionnaire does not bind the insurance company.

Producer's Signature: _____ Date: _____

Applicant's Signature: _____ Date: _____