

## QUESTIONNAIRE – DAY SPA

Please answer all questions fully. Submit this Questionnaire with a **completed** ACORD Commercial Insurance Applicant Information Section and prior carrier loss runs.

Named Insured:

Is the business operated as a:                     Salon                     Day spa                     Other: \_\_\_\_\_

Do all professionals, and the business, have current licenses where required by statute?  Yes  No

### OPERATIONS

**Check all applicable items that describe services offered:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Beauty/Barber Shop | <input type="checkbox"/> Manicurists       | <input type="checkbox"/> Facials including peels |
| <input type="checkbox"/> Waxing             | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Electrology             |
| <input type="checkbox"/> Spray Tanning      | <input type="checkbox"/> Locker Rooms      | <input type="checkbox"/> Sauna                   |
| <input type="checkbox"/> Shower Rooms       | <input type="checkbox"/> Steam Rooms       | <input type="checkbox"/> Sun Tanning Units       |
| <input type="checkbox"/> Whirlpool          | <input type="checkbox"/> Body Wrap         | <input type="checkbox"/> Other (Describe below)  |

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### GENERAL INFORMATION

1. Please describe any other insurance you have for your operation.

Name of insurance company: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Limits: \_\_\_\_\_ Effective date: \_\_\_\_\_  
 Description: \_\_\_\_\_

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2. Please describe all products sold:

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3. Do you sell private-label products?  Yes  No  
 (Please note: No coverage is provided for private-label products.)  
 Receipts from private-label products: \$ \_\_\_\_\_
4. Do you manufacture, repackage or re-label any products?  Yes  No  
 If yes, provide details: \_\_\_\_\_
5. Estimated Gross receipts: (excluding private-label products) \$ \_\_\_\_\_
6. Have you or a member of your staff been sued for malpractice?  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**STAFF**

**Please note:** An Operator is considered full-time if they work 15 hours or more per week; less than 15 hours per week is part time

Name:	Status: (E)mployee; (O)wner; (I)nd. Cont.	Beautician/ Barber, Nail Technician, Waxing		Facial, including peels.		Microderm		Electrologists		Massage Therapists		Body Wrap	
		Full	Part	Full	Part	Full	Part	Full	Part	Full	Part	Full	Part
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1. Do you employ students that have not received certification?  Yes  No  
If yes, please explain: \_\_\_\_\_
2. Do you, staff, or covered independent contractors engage in off site activities?  Yes  No  
If yes, please describe the activities: \_\_\_\_\_

**AESTHETICIAN (COMPLETE WHEN APPLICABLE)**

1. Are microdermabrasion or facial chemical peel services performed by a licensed aesthetician?  Yes  No  
If no, please explain: \_\_\_\_\_
2. Are customers required to wear eye protection during any microdermabrasion or facial chemical peel service?  Yes  No  
If no, please explain: \_\_\_\_\_
3. Do you employ any paramedical aestheticians?  Yes  No  
If yes, please describe: \_\_\_\_\_
4. Does staff operate under a physician's supervision or instruction?  Yes  No  
If yes, please explain: \_\_\_\_\_
5. Do the facial chemical peel compounds or formulas used have Glycolic Acid?  Yes  No  
If yes, please explain and provide percentage used: \_\_\_\_\_
6. Do the facial chemical peel compounds or formulas used have Lactic Acid?  Yes  No  
If yes, please explain and provide percentage used: \_\_\_\_\_
7. If none of the facial chemical peel solutions have Glycolic or Lactic Acid, please provide a list of the compounds and formulas used along with who manufacturer/brand, acid percentage and type:

Compounds / Formulas	Manufacturer	Acid %	Acid Type

**ELECTROLYSIS OPERATIONS (COMPLETE WHEN APPLICABLE)**

1. How frequently is all wiring and electrical equipment inspected? Who performs inspections?  
 \_\_\_\_\_  
 \_\_\_\_\_
  
2. Does the insured travel to clients' homes or to hospitals to perform electrolysis?  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**TANNING EQUIPMENT (COMPLETE WHEN APPLICABLE)**

Manufacturer / Model	# Beds	# Booths	# Facial Units	Other	UA %	UVB %

1. Does any of the equipment use accelerator bulbs?  Yes  No
2. Does all of the equipment shut off automatically?  Yes  No
3. Does all of the equipment have
  - a. An automatic shut off control?  Yes  No
  - b. A UL Label?  Yes  No
  - c. A FDA warning on mixing medication with UVA and UVB rays?  Yes  No
4. Are timers located on all of the equipment?  Yes  No  
 Please describe any other safety features: \_\_\_\_\_  
 \_\_\_\_\_  
 How often are switches and timers tested: \_\_\_\_\_
5. Are all employees trained in the use of the timers?  Yes  No
6. Do only employees operate equipment?  Yes  No  
 If not, are they operated by the customer?  Yes  No
7. Are instructions on use of the equipment posted?  Yes  No
8. What is the maximum exposure time allowed at each session? \_\_\_\_\_
9. Do you require customers to wear protective goggles?  Yes  No
10. Is all of the equipment cleaned by employees between uses?  Yes  No
11. Is medical history obtained for new customers?  Yes  No  
 If so, how often are records updated or maintained: \_\_\_\_\_  
 How long are records retained: \_\_\_\_\_



- 12. Do customers receive information on potentially harmful medications that react to Tanning?  Yes  No
- 13. Are hold harmless waivers with schedules/times of exposure obtained?  Yes  No  
How long are waivers retained: \_\_\_\_\_

**SAUNAS / STEAMROOMS / WHIRLPOOLS (COMPLETE WHEN APPLICABLE)**

- 1. Are warnings and directions for use clearly posted?  Yes  No
- 2. Do all doors open outward?  Yes  No  N/A
- 3. Do all doors have a visibility window?  Yes  No  N/A
- 4. Does the heating element in the sauna have a guardrail?  Yes  No  N/A
- 5. Are thermostats tamper-resistant?  Yes  No
- 6. Is the sauna, steam room, and/or whirlpool cleaned daily?  Yes  No
- 7. Do saunas have emergency shutoff?  Yes  No  N/A
- 8. Is the whirlpool emergency shutoff in same area?  Yes  No  N/A
- 9. Warnings posted regarding use; i.e. pregnancy, alcohol, medications, etc.?  Yes  No

**EMERGENCY INFORMATION**

- 1. Is emergency medical care easily accessible?  Yes  No
- 2. Are emergency numbers posted by all phones?  Yes  No
- 3. Are members of staff trained to administer:
  - a. First aid?  Yes  No
  - b. CPR?  Yes  No
  - c. Defibrillation?  Yes  NoIf yes, how often are they re-certified? \_\_\_\_\_
- 4. Is a defibrillator available and accessible at each business location?  Yes  No
- 5. Are exits properly marked and easily accessible?  Yes  No
- 6. Is there a back-up power system?  Yes  No
- 7. Is there emergency lighting with battery back up?  Yes  No



### IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

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Applicant Signature Title Date

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Producer Signature Date

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Producer Name and Address