

PUBLIC LIABILITY / PROFESSIONAL INDEMNITY FACILITY.

- 1) Principal (s) or Firm(s):

- 2) Postal Address:

- 3) Situation of Salon(s):
(If mobile, please note accordingly).

4) Business operated as:

| | | |
|------------------------|-----------------|------------|
| Corporation | Partnership | Individual |
| Independent Contractor | Other (Specify) | |

5) Please advise the number of staff

| | |
|------------------------------------|--|
| Principals / Partners / Directors: | |
| Full-time qualified staff: | |
| Part-time qualified staff: | |
| Other: | |
| Total: | |

6) Qualifications and Experience of each Beauty Therapist:

| Name | Qualifications | Years Qualified |
|------|----------------|-----------------|
| | | |
| | | |
| | | |
| | | |

- 7) Do you use a medical history / client information form on everyone? Yes / No
(If yes, please attach a sample copy).
- 8) Do you use a hold harmless or informed consent form? Yes / No
(If yes, please attach a sample copy).
- 9) Please list Machinery and Equipment Used in your Operations:

| Type of Machine/Equipment | Quantity |
|---------------------------|----------|
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Insurance History

- 10) Do you currently have Liability insurance coverage? Yes / No

If yes, please indicate the following:

| Insurer: | Policy No: | Liability Limits: | Premium: | Expiry: |
|----------|------------|-------------------|----------|---------|
| | | A\$ | A\$ | |

- 11) Please list all past claims whether Insured or Not. If none, state so:

| Yr/Claim | Nature of Injuries | Equipment Used | Amount | Finalised |
|----------|--------------------|----------------|--------|-----------|
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- 12) Do you have any knowledge of any event, circumstance or occurrence (other than listed previously in this form) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence?

Yes / No If yes, describe details of the event on a separate attachment.

- 13) Please tell us which services you provide.

| Type of Treatment | Yes / No |
|--|----------|
| Body Wrapping | |
| Manicure | |
| Caci (Facial technique) | |
| Make-up | |
| Electrical Appellations (please note we do not cover this treatment when performed on Skin Types V & VI on the Fitzpatrick Scale). | |
| Nail Extensions | |
| Ear Piercing | |
| Pedicure | |
| Eyebrow Tinting | |
| Spa Treatments | |
| Facials | |
| Sugaring | |
| Hairdressing | |
| St Tropez | |
| Lash tinting & Eyebrow Shaping | |
| Waxing | |
| Aromatherapy | |
| Lymphatic Massage | |
| Reflexology | |
| Body Piercing (please note we do not cover piercing of genitalia or tongue) | |
| Electrolysis | |
| Cosmetic Tattoo/Micro pigmentation | |
| Laser Therapy | |
| LHE | |
| IPL VPL Treatment | |
| Acid Peels and microdermabrasion | |
| Sclerotherapy | |
| Red vein treatment | |
| Solarium | |

14) Please state your gross turnover for the last 12 months

A\$

15) Approx what percentage of this is from sale of products? %

16) Do you provide private – label Products for sale? Yes / No

Income from Private Label Products: A\$

(NB. No coverage is provided for Private Label Products)

17) **FACIALS:**

List all products you use and their percentage of Acids:

| Product | % Acid Content |
|---------|----------------|
| | |
| | |
| | |

Have you had specific training on the Peels you are using? Yes / No

18) **TANNING:**

Do you have sun beds or other tanning products? Yes / No

If Yes please describe below:

| |
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| |

19) Do you perform any activities other than those disclosed in this proposal? Yes / No

If Yes, provide details below.

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20) Combined Limit of Liability Requested:

| | |
|--------------|--------------|
| A\$1,000,000 | \$2,000,000 |
| A\$5,000,000 | \$10,000,000 |

I understand and agree this Application and any and all supplements attached hereto will be made 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 a voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorise 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 the Company 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.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown of the Certificate of Insurance issued with the Policy or Certificate on the date the Policy is cancelled or terminated, whichever comes first or as otherwise provided by the Policy.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT.

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Signature of Applicant:

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Print Name:

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Date:

/ /