SASSI®
Salon & Spa Specialty Insurance

BROWNYARD® GROUP | Insurance when you know BETTER®

PROGRAM APPLICATION - REQUIREMENTS FOR SUBMISSION

Effective Date:

- Pages 1-5 MUST be completed
- Current Loss Information – 4 Years
- Excess – Brownyard Application & Auto Loss Runs
- Note: All Questions Must Be Answered
- Brownyard Application Must Be Submitted by Broker/Insured

Business Type: ☐ New Business ☐ Renewal

Line of Business: ☐ Professional Liability Only ☐ Professional Liability including General Liability

Interested in:
☐ Property (Attach req. forms: ACORD 125 and 140)
☐ Inland Marine (Attach req. forms: ACORD 125, 146, and 148)
☐ BOP (Attach req. form: ACORD 160)

1. Insured Company Name: _____
(Legal name of the entity/primary applicant as it should appear on the policy, including INC., CORP., LTD., ETC.)
2. DBA(s): _____
(List any and all names insured's company is Doing Business As [DBA] & please list additional named insureds on separate sheet for whom this proposed policy will provide coverage)
3. ☐ Individual ☐ Assoc ☐ Corp ☐ LLC ☐ LLP ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ Sole Proprietor ☐ Joint Venture ☐ Trust ☐ Non-Profit ☐ Other: _____
4. Mailing Address: _____
NO. STREET CITY STATE ZIP
5. Physical Address*: _____
NO. STREET (*Attach a list if multiple locations) CITY STATE ZIP
6. County: _____ NAICS/SIC Code: _____
7. Business Phone: _____ Fax: _____
8. Company Email: _____ Website: _____
9. Federal ID Number/FEIN: _____ License Number: _____
10. Owner/Principal: _____ Title: _____
Direct Phone: _____ Mobile: _____
Email: _____
11. Audit Contact: _____ Title: _____
Direct Phone: _____ Mobile: _____
Email: _____
12. A. Has the principal(s) of this firm previously operated a similar firm under a different name? ☐ Yes ☐ No
B. If yes, please provide the former name: _____
13. Policy proposed effective date: _____ Date established: _____
14. How did you hear about us? ☐ Internet Search ☐ Social Media ☐ Ad in which publication: _____
☐ Email ☐ Word of Mouth ☐ Other: _____

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Call Toll Free (800) 645-5820 • Phone (631) 666-5050 • Fax: (631) 666-5723

INSURANCE INFORMATION

1. Check limit of General Liability desired: ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000
2. Check Professional Liability limit desired: ☐ $1,000,000/$1,000,000
3. Requesting coverage for: ❑ Beauty/Nail Salon ❑ Beauty Spa ☐ Barber Shop ☐ Electrologist ❑ Beauty School
4. Please choose the desired deductible amount: ❑ $0 ❑ $250 ❑ $500

OPERATIONS/PRODUCTS

5. a) List any products repackaged, rebottled, manufactured by you or relabeled in any way, give details:

   _____

   _____

   b) List any cosmetics that are being sold for home use:

   _____

   _____

6. What volume of peroxide do you use on patrons? _____
7. Are records (names, addresses, dates, products used and name of operator) kept of patrons receiving services? ❑ Yes ❑ No
8. Do you collect, transmit, provide, acquire, or scan any biometric data from others? (Biometric data can be defined as retina/iris scans, fingerprint, voiceprint, or scan of hand or face geometry) ☐ Yes ☐ No

   a. If yes, please advise if you collect, transmit, provide, acquire, or scan it and identify the type of biometric exposure (facial recognition, fingerprints, iris scanning etc.):

   _____

9. Do you have a written biometric policy in place that complies with the regulations of the states you operate in?

   ☐ Yes ☐ No If yes, please provide copy.

BUSINESS DATA *(FOR EACH ACTIVE OWNER, ALSO COMPLETE THE PERSONNEL DATA SECTION)*

10. Total number of employees: _____ Full Time *(more than 2 days)* : _____ Part Time: _____
11. Are you: ☐ An Owner ☐ A Lessee of Booth Space/Chair Renter/Independent Contractor
12. Are you an Active Operator? ☐ Yes ☐ No If Yes, complete Personnel Data Section.
13. Years in business at this address: _____ Number of Stations: _____
14. Business located in: ☐ Store ☐ School ☐ Office Building ☐ Hotel ☐ Private Homes of Clients
    ☐ Your Home ☐ Other: _____
    ☐ Assisted Living/Nursing Home *(provide full name):* _____
15. Name and address of additional locations:

    _____

    _____

16. Do you rent booths/chairs to others? ☐ Yes ☐ No If so, number rented: _____

    Do you rent booths/chairs from others? ☐ Yes ☐ No Salon Name: _____

17. If you operate on premises of others, do you desire that their interest be included as additional insured? ❑ Yes ❑ No
    Name and address:

    _____

    _____

18. List additional owner(s), partner(s):

Name and Title (if corporation)	Active Operator (Y/N)	Duties	Home Address	Telephone

PERSONNEL DATA

19. a) Give following details For Each Active Owner, Employee, and Lessee of Booth Space/Independent Contractor

Name	Owner, Employee or Lessee/ Indepen-dent.	Years Experi-ence	# Days Per Week	Weekly Income (excluding tips)	Licensed (Y/N)	Services Rendered (Y/N)									
						Hair Cutting	Perm Waves	Hair Dyeing	Shampoo Only	Nails	Waxing	Skin Care	Massage Therapist	Laser	Electrology
				$											
				$											
				$											
				$											
				$											
				$											
				$											
				$											

b) If any personnel above are licensed, please provide a copy of each license.

FOR OWNERS OF A BEAUTY SCHOOL, PLEASE ALSO COMPLETE THE FOLLOWING

Check box if this doesn't apply: ☐

20. Number of years in business: _____ Estimated Annual Tuition and Clinic Receipts: _____

Number of instructors: _____ Estimated number of students graduated each year: _____

21. Is it your practice to have students work on each other*? ❑ Yes ❑ No

22. Is work done on the public? * ☐ Yes ☐ No If yes, what arrangements are made as to reduced prices, release etc.

_____

_____

23. Do you operate a Beauty Salon? ☐ Yes ☐ No If yes, at what location: _____

24. Do you now carry insurance covering claims for injuries to students and public? ❑ Yes ❑ No

If yes, name of company? _____ Rate: $ _____ Premium: $ _____

* BE SURE TO ATTACH A COPY OF THE FOLLOWING:
A Release Signed by Students, a Release Signed by the Public and a Sample of a Student Registration Form.

SERVICES	Check box if this doesn't apply: ☐

25. Estimated Annual Gross Sales (for entire business): $_____ (subject to audit)

26. Do you perform any of the following:

	Brand/Product Manufacturer's Name and Procedures Followed	Estimated Gross Annual Receipts
❑ Body Massage *(other than face or neck)* Also list any machines used		$
❑ Body Wrapping		$
❑ Chiropody or Podiatry		
❑ Ear Piercing *(provide type of method)*		
❑ Electric or Steam Bath *(send brochure)*		$
❑ Electrolysis *(provide machine model and serial number)* *		
❑ Electronic Tweezer *(provide machine model and serial number)* *		
❑ Hair Removal by Waxing or a Depilatory Product		
❑ Hair Implants or Transplants		
❑ Hair Straightening		
❑ Hair Weaving		
❑ Reducing, Slenderizing or Exercising Services Also list any machines used		$
❑ Reflexology		$
❑ Saunas		$
❑ Tanning Beds		
❑ Wart or Mole Removal		
❑ Other:		

Skin Treatments or Facials	Manufacturer's Name & Model of Machines
❑ Any other skin care machines	
❑ Facial Steamer	
❑ Laser Hair Removal	
❑ Microdermabrasion Machine	
❑ Spray Tanning	
Total Receipts for all Skin Care Services *(including totals from skin care machines)*	$

*Please complete electrolysis section on the next page

ELECTROLOGIST INFORMATION

Check box if this doesn't apply:

1. Does this state require licensing? ❑ Yes ❑ No
2. Give Following Education/Training Details for Each Electrologist

Name	Graduated? (Y/N)	Name of School	# of Course Hours	Graduated (mm/yy)	Non-Graduate Training (Y/N)	Training Location	# of Years' Experience

3. ❑ Yes ❑ No.....Do you keep a case history record for each person treated? If 'yes', please attach a blank copy.
4. ❑ Yes ❑ No.....Do you sterilize needles? If so, please describe procedure: _____

   _____
5. ❑ Yes ❑ No.....Do you use disposable needles?
6. ❑ Yes ❑ No.....Do you give electrolysis treatments to persons known to you to have a pacemaker?
7. ❑ Yes ❑ No.....Do you use radium or x-ray?
8. ❑ Yes ❑ No.....Do you remove warts, moles or other growths or hair there from?
9. ❑ Yes ❑ No.....Do you perform laser hair removal?
10. ❑ Yes ❑ No.....Do you remove hair from the nostrils or eyelids?
11. ❑ Yes ❑ No.....Do you advertise? Please enclose a copy of your personal card or copies of your advertising material.
12. ❑ Yes ❑ No.....Have you ever warranted, in writing or advertising, that the services rendered are safe & harmless?

PRIOR GENERAL LIABILITY INFORMATION

1. a. General Liability insurer and claims history for past five years *(Even if there are no losses, please provide insurer history.)*

Policy #					
Policy Term					
Insurer					
Premium					
Limits of Liability					
Revenue					
Deductible					
Losses					

b. Has any insurer cancelled or non-renewed your insurance over the past 5 years ☐ Yes ☐ No If yes, explain:

_____

_____

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

Applicable in AL, AR, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment of other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, OH and PA: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in NY: Applicable to all claim forms for insurance and all applications for commercial insurance and accident and health insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in NY: Applicable to all applications and claim forms for automobile insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

NOTE: THIS APPLICATION MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN OR CEO OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE. This request is for a cost-free, premium quotation only. In signing, I understand I am not obligated to purchase this insurance. This application shall not be binding unless and until confirmation by the company or its duly appointed representatives has been given, and that a policy shall be made, and then only as of the commencement date of said policy and in accordance with all terms thereof. The said applicant hereby covenants and agrees that the foregoing statements and answers are a just, full and true exposition, statement and explanation of all the facts and circumstances with regard to the risk to be insured, insofar as same are known to the applicant, and the same are hereby made the basis and conditions of the insurance and a warranty on the part of the insured.

APPLICANT'S SIGNATURE	TITLE	DATE

BROKER COMPANY	BROKER NAME	WEBSITE	
ADDRESS	CITY	STATE	ZIP
TELEPHONE	FAX	EMAIL	

BROKERS: To submit complete application, please email PDF to info@brownyard.com.
INSUREDS: Please save and share with your insurance agent/broker.