



Coverys Specialty Insurance Company

**SUPPLEMENTAL APPLICATION – BEAUTY SALONS, BARBER SHOPS, SPA**

1. Name of applicant or insured: \_\_\_\_\_
2. Total number of staff, including independent contractors: \_\_\_\_\_
3. Are all employees, including independent contractors, required to maintain appropriate license/certification for services provided and are those licenses displayed according to state regulations?  Yes  No
4. Has any employee's license been revoked or suspended at any point in the past year?  Yes  No

If "Yes," please provide detailed explanation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Please provide areas of practice by percentages, total must equal 100%:

AREA OF PRACTICE	PERCENTAGE	AREA OF PRACTICE	PERCENTAGE
Body wrapping	%	Body waxing	%
Non-surgical facelifts	%	Laser vein removal	%
Collagen fillers	%	Massage	%
Ear piercing	%	Microdermabrasion	%
Electric or steam baths	%	Nail technician	%
Exercising services	%	Chemical peels	%
Photofacials	%	Weight loss counselor	%
Photorejuvenation	%	Hair weaving	%
Skin treatments/facial	%	Diet or physical fitness (does not apply to the use of physical fitness)*	%
Any hair removal by electrolysis or any surgical procedure to remove or replace hair*	%	Chiroprody and/or podiatry*	%
Botox dermal filler, sclerotherapy, laser or IPL removal, tattoo removal, restylane or hylaform, photo rejuvenation, veins/rosacea/sunspots or wrinkle removal or reduction*	%	Tanning the skin via bed or booth*	%
Any application of permanent cosmetic makeup, tattoos or other implantation of pigments into skin pores*	%	Hair implants/transplants*	%
Any cosmetic surgery, plastic surgery, invasive medical or surgical procedure to improve or alter the appearance of skin including, but not limited to injections, dermabrasion, laser surgery or cryosurgery; including the removal or attempted removal of any warts, moles or other growths*	%	Body piercing, other than piercing of ears*	%
		Other (please describe): _____ _____	%



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6. Are any products sold under applicant's name or label?  Yes  No

If "Yes," describe products: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Does the applicant offer any service, treatment, advice or instruction that requires the performance, care, prescription or supervision by a medical doctor?  Yes  No

If "Yes," describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE IN FULL: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

**ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED**

Agency Name and Address: \_\_\_\_\_

Person Submitting Application: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_