



EQUIPMENT AFFIRMATION

Tanning beds, booths, and tanning lamps utilize ultraviolet wavelengths and are classified as Class II Medical Devices by the FDA and therefore, must comply with electronic product performance standards in Title 21 Code of Federal Regulations (Subchapter J, Radiological Health) Parts 1010 and 1040.20. Please contact your equipment manufacturer or distributor for information regarding compliance with FDA regulations, replacement lamp compatibility, etc.

AFFIRMATION:

Maintenance Acknowledgment: The Applicant/Insured acknowledges and understands the importance of maintaining all equipment in optimal working condition. The Applicant further affirms that they will adhere to the manufacturer's specifications, guidelines, and recommendations for equipment maintenance.

Regular Inspections: The Applicant/Insured commits to conducting regular inspections of the equipment to identify signs of wear, damage, or malfunction. Any issues discovered during these inspections will be addressed promptly by qualified personnel.

Training: The Applicant/Insured ensures that its personnel are responsible for equipment operation, inspection, and maintenance possess appropriate training and expertise.

Record Keeping: The Applicant/Insured agrees to maintain accurate records of all equipment inspections, maintenance activities, and repairs, including all purchase records and invoices for replacement tanning lamps, parts, and service. These records will be made available to the Insurer upon request.

Compliance with Standards: The Applicant/Insured agrees to operate and maintain the equipment in compliance with all relevant laws, regulations, and safety standards.

By signing below, the Applicant/Insured acknowledges and agrees to the terms outlined in this Equipment Affirmation.

This statement must be signed by an Officer or representative duly authorized by the Applicant. The undersigned hereby affirms that he or she is authorized to sign on behalf of the Applicant:

Applicant's/Insured's Name: _____

Applicant's/Insured's Address: _____

By Name (Signature): _____ Date: _____

Name (Printed): _____

Title: _____

Universal Insurance Programs
1220 E Osborn Rd
Phoenix, AZ 85014



Phone: 602-222-8300
processing@uiprograms.com
www.uiprograms.com

TANNING INSURANCE APPLICATION

Non-Admitted

EMAIL TO:
processing@uiprograms.com

CLIENT ID #: (Office Use Only)

DATE:

Effective Date: _____

Expiration Date: _____

CUSTOMER INFORMATION

Legal Entity Name: _____
(If more than one, please list on the last page of this Application, under 'REMARKS')

DBA: _____

Years in Business: _____ Prior Business Management Experience (in years): _____

Contact Name: _____

Phone: _____ Alt. Phone: _____

Email Address: _____

Mailing Address: _____

City/State/Zip: _____

Current Insurance Carrier: _____ Current Expiration Date: _____

Current Premium by Line of Coverage: \$ _____

Franchise Name: _____ How did you hear about us? _____

LOSS HISTORY

Has any insurance ever been cancelled, denied or non-renewed? Yes No

If Yes, give reason: _____

Please list all losses in the past five years: No Losses

(Please check the No Losses checkbox if during the past five (5) years there have been no incidents, occurrences, or losses which have resulted in claims or which may reasonably be expected to result in a future claim or claims being asserted against you for any coverage requested in this application.)

DESCRIPTIONS:

DATES:

AMOUNTS PAID:

DESCRIPTIONS:	DATES:	AMOUNTS PAID:



PROFESSIONAL LIABILITY

POLICY TYPE: _____ (For Office Use Only)

1. How many locations? _____
2. Professional Liability Limit Desired: \$300,000/\$300,000 \$500,000/\$500,000 \$1,000,000/\$2,000,000
3. Professional Liability Deductible: \$1,000 \$2,500 Other \$ _____
Excess over Professional: Yes No If Yes, Limit: _____
4. Is your current Professional Liability Policy Claims Made? Yes No Do you need prior acts? Yes No
(Please send the schedule of retroactive dates from your previous Carrier) **Retro Date:** _____
5. Do all operators receive professional training such as NTTI, Smart Tan or SAE? Yes No
If Yes, Name of Program: _____
6. Type of Business: Tanning Day Spa Salon Other: _____
7. Total number of UV units at all locations? _____
8. How many sessions per year per unit? _____
9. Total sunless/spray booths at all locations? _____
Do you have an Automatic Shut Off Valve on booth(s)? Yes No
10. How are tanning bed timers controlled: Computer Remote Other – Describe: _____

Computer – UV beds are connected to front desk computer and controlled by staff using management software.
Remote – No computer or management software and timers are manually set by staff at the front desk.
Other – Timers are located anywhere but the front desk.

11. Floor Mats:
 - a. Are floor mats used at entrance/exits of equipment where water or other liquid may collect and cause a slip event? Yes No
 - b. Are all floor mats used identified as non-slip or anti-slip? Yes No
 - c. Are mats cleaned daily to avoid build up Yes No
12. List the number of employees and independent contractors performing the following services:

	Full Time	Part Time
Hair Stylist	_____	_____
Cosmetologist	_____	_____
Nail Technician	_____	_____
Estheticians	_____	_____
Massage	_____	_____
Body Wrap	_____	_____
Airbrush	_____	_____
Other	_____	_____

Employment Practices Liability Coverage

Add Coverage? Yes No

If 'Yes':

Limit: \$25,000 \$50,000 \$75,000 \$100,000 \$250,000

Deductible: \$5,000 \$10,000 \$25,000

Third Party: Yes No

DISCLAIMER: Not available in all states.

13. Any other services offered? Yes No If Yes, please list: _____



PROFESSIONAL LIABILITY

13. Is all equipment in compliance with FDA standards? Yes No
- Does all equipment carry the approval of:
1. Underwriters Laboratory (UL): Yes No
2. Electrical Testing Laboratory (ETL): Yes No
14. Maximum time for individual sessions: 15 minutes 30 Minutes Other (Specify): _____
15. Are the lamps utilized the same (or comparable) as those recommended by the manufacturer? Yes No
If No, please explain: _____
16. How often is tanning equipment inspected, tested, and cleaned? Weekly Bi-Weekly Monthly Quarterly
Please describe procedures: _____
17. Are customers required to use protective eyewear? Yes No
18. If provided by you, is protective eyewear cleaned and disinfected after each use? Yes No
19. Is tanning equipment cleaned and disinfected after each use? Yes No
20. Are medical and prior tanning records obtained and kept for each customer? Yes No
21. Prior to their initial exposure, are customers instructed about and warned of the possible effects of ultraviolet exposure, and required to sign a waiver acknowledging that this information has been provided and understood? Yes No
22. Are minors (18 or under) required to have the written consent signed by a parent or legal guardian in person? Yes No
23. If a customer is taking a prescription drug, do you prohibit tanning, or require a physician's written approval? Yes No
If No, describe: _____
24. Do you prohibit tanning during pregnancy, or require a physician's written approval? Yes No
If No, describe: _____
25. Are all signs required by regulation prominently displayed? Yes No

REMARKS:



PROFESSIONAL LIABILITY **Abuse & Molestation Application**

If you would like a Quote for Abuse and Molestation, please complete this Supplemental Application:

1. Abuse & Molestation Limit Desired (Please be advised that the limit availability is subject to change)

\$100,000/\$300,000 \$300,000/\$300,000 \$500,000/\$500,000 \$1,000,000/\$1,000,000

Deductible: \$1,000 \$5,000 \$10,000 \$25,000 OTHER \$: _____

2. Are 50 State Criminal Background and Registry Checks performed? Yes No

3. Provide Vendor used for background checks: _____

4. Has the Salon established a Code of Conduct policy that defines staff-to-customer physical boundary limitations? Yes No

5. Has the applicant received a complaint of inappropriate contact from a customer? Yes No

If Yes, please describe: _____

6. Have any of the service providers received a complaint of inappropriate contact from a customer in the past? Yes No

7. # of new employees hired in the past 12 Months: _____ Total Employee Count: _____

8. Is there a written policy with procedures for screening and performing background checks of all prospective employees? Yes No *If Yes, describe:* _____

9. Is there a written policy with procedures for screening all employees that includes a personal interview? Yes No *If Yes, describe:* _____

10. Are signed and dated Employment Applications required of all Employees? Yes No

11. Do the Employment Applications include a question(s) concerning whether the individual has ever been convicted of any crime, including any sex-related crime? Yes No

12. Are application references checked and documentation maintained? Yes No

13. Are all employees required to sign an acknowledgement of receipt, and understanding of the Abusive Act Policy? Yes No

14. How frequently is training conducted? _____

15. Have procedures been created and shared to employees for reporting, and investigating alleged incidents of abusive acts? Yes No

Please Include the Following:

Loss Runs

Employment Application

Code of Conduct/Operating/Employee Manual (that includes Abuse & Molestation procedures)



PACKAGE - PROPERTY & BUSINESS LIABILITY

(Property limits are based off Replacement Cost Value)

Location # _____ of _____ (If you have more than one location, please complete this page for each location.)
Street Address: _____ City: _____ State: _____ Zip: _____
Protection Class: _____

If this location is NOT a Salon or Spa, Check Type of Business:

Office Clothing Gym Other _____

ANSWER QUESTIONS 1-4 ONLY IF YOU OWN THE BUILDING:

1. Building Limit \$: _____
2. Square Footage of Entire Building: _____
3. % of Building Occupied by Insured: _____
4. List of Other Tenants: _____
5. Business Personal Property \$ _____ (Value of all personal property related to the Salon, including tenant improvements and items required by your lease)
6. Wind and Hail Coverage: Included Excluded **Wind and Hail Deductible:** N/A _____
7. Square Footage of space occupied: _____ Gross Sales: \$ _____
8. Year Built: _____ Construction Type: _____
- If the Building is over 30 years old, when were the below items updated? _____ Plumbing _____ Roof _____ Electrical _____ HVAC
9. How many stories in Building? _____ If more than 1, describe other tenants: _____
10. Burglar Alarm? Yes No Smoke Detectors? Yes No
11. Security Cameras? Inside Outside
12. Automatic Sprinkler System? Yes No Date of Last Inspection: _____
13. Whether anti-slip mats are placed in all areas prone to moisture? Yes No
14. The minimum age for unattended minors to be on the premises: _____
15. Property Deductible: \$1,000 \$2,500 \$5,000 \$10,000 OTHER \$ _____
16. Equipment Breakdown: Included Excluded
17. Business Liability Limit Desired: \$1,000,000/\$2,000,000 \$2,000,000/\$4,000,000
18. Business Income - Actual Loss Sustained (Subject to Limit listed): 6 Months 12 Months (Subject to Underwriting Approval)
Annual Gross Sales \$: _____
19. Damage to Premises Rented to You: \$300,000 \$500,000 \$1,000,000
20. Medical Payments: \$5,000 \$10,000 Excluded
21. Hired and Non-Owned Auto Coverage at \$1,000,000? Yes No
Does your company own any vehicles? Yes No
If Yes, specify any protocols implemented regarding use: _____
22. Number of Employees at this location: _____ Full Time _____ Part Time
23. Employee Benefits Liability: Yes No Limit: \$300,000 \$500,000 \$1,000,000
24. Cyber Liability: Yes (If Yes, Cyber Application to follow) No Limit: \$50,000 \$100,000 \$250,000
25. Stop Gap Coverage for ND, OH, WA, and WY at \$1,000,000: Yes No
26. Employment Theft Coverage: Yes No If Yes, Limit: \$5,000 \$10,000 \$ _____
Deductible: \$ _____



PACKAGE - PROPERTY & BUSINESS LIABILITY

(Property limits are based off Replacement Cost Value)

Location # _____ of _____ (If you have more than one location, please complete this page for each location.)

Street Address: _____ City: _____ State: _____ Zip: _____

Protection Class: _____

23. Excess over General Liability? Yes No If Yes, limit \$: _____

Any other policies that the Excess goes over? If Yes, list: _____

24. Any apartments or personal residence in building? Yes No If Yes, Describe: _____

25. Any re-packaging, re-labeling, repair, re-manufacturing, and/or mixing or blending of products? Yes No

If Yes, Describe: _____

26. Percentage of Sales of Goods other than Beauty Products? _____ %

If Yes, Describe: _____



Equipment Information

Equipment Type	Equipment Manufacturer	Year Manufactured

(* If more space is needed, please send a schedule of equipment and services offered.
** Example of equipment type – Tanning Bed, Spray Booth, Red Light Therapy, Float Pod, Etc.)

1. If purchased used, provide the name of dealer or private party: _____
If purchased used, was the equipment inspected by a 3rd party qualified vendor? Yes No
2. Do you regularly maintain and inspect the equipment? Yes No
3. Are Inspections and Maintenance performed in accordance with manufacturer's specifications? Yes No
**Please provide a copy of the schedule of maintainance.

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ADDITIONAL INSUREDS/LOSS PAYEES/MORTGAGEES

Location # _____ Additional Insured on General Liability Additional Insured on Professional Liability Loss Payee Other: _____

Name: _____

Address/City/State/Zip: _____

Email Address: _____

Business Relationship: Landlord Leasing Grantor of Franchise Lender Other: _____

Location # _____ Additional Insured on General Liability Additional Insured on Professional Liability Loss Payee Other: _____

Name: _____

Address/City/State/Zip: _____

Email Address: _____

Business Relationship: Landlord Leasing Grantor of Franchise Lender Other: _____

The applicant warrants that the statements set forth herein are true, and that if the information supplied on this application changes between the date of this application and the date on which coverage is bound, the applicant will immediately notify the insurance company of such changes. The signing of this application does not bind the insurance company to provide the requested coverage, but it is agreed that if a policy is issued, this application shall be the basis for the policy, and it will be attached to and made part of the policy.

NOTICE TO APPLICANTS:

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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signed: _____
(Applicant)

Signed: _____
(Agent/Producer)

Date: _____

Date: _____

AGENT - AGENCY INFORMATION (If other than Universal)

Agency Name: _____

Agent Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

REMARKS: