



Thank you for your trust in PPIB to support you with your Insurance needs. We're thrilled to do business with you and help protect what matters most to you. To get started, please follow these steps:

How to Submit Application

1. Complete Application -- Fill out the required information on the next few pages.
2. Save Application -- Once completed, save a copy to your computer so you can email it.
3. Sign Application -- Ensure it is signed by the business owner, either electronically or printed and signed.
4. Submit Application -- Send signed application to **submissions@ppibcorp.com**.

What to Expect Next?

After receiving your application, we will send you a confirmation email acknowledging receipt.

Within 3-5 business days, one of our insurance experts will reach out to you with any follow-up questions or a quote, depending on the status of your submission.

If you need the quote expedited, please indicate this when you submit your application via email.

If you need further assistance with the application, or have additional questions, please feel free to contact us at:

PHONE:

415.475.4300

877.655.0123

Submissions: submissions@ppibcorp.com

FAX:

415.475.4303

Let's Get Started

Fill Out Application on Next Page



BODY ART / SALON & SPA APPLICATION

SECTION I: GENERAL INFORMATION

1. Applicant Name (First, Last): _____ Phone Number: _____
2. Business Name: _____
3. Email Address: _____ Website: _____
4. Your Mailing Address: _____
City: _____ State: _____ Zip code: _____
5. Your Business Address (1): _____
City: _____ State: _____ Zip code: _____
County: _____ Sq. Ft. _____
Do you hold the lease for this location? ☐ Yes ☐ No
6. Your Business Address (2): _____
City: _____ State: _____ Zip code: _____
County: _____ Sq. Ft. _____
Do you hold the lease for this location? ☐ Yes ☐ No
7. Business operated as: ☐ Corporation ☐ LLC ☐ Partnership ☐ Individual ☐ Independent Contractor
8. Is your business open 24 hours? ☐ Yes ☐ No
9. How long have you been in business? _____ Annual gross receipts for all product sales: _____ Annual gross receipts from all operations: _____
10. Is your business part of a franchise? ☐ Yes ☐ No If Yes, which one? _____
11. Do you provide services out of your home? ☐ Yes ☐ No If Yes, describe: _____
12. Do you provide services in homes of clients? ☐ Yes ☐ No If Yes, describe: _____
13. Are you in compliance with all city, county, state ordinances? ☐ Yes ☐ No
14. Are you in compliance with CDC / Health Department guidelines? ☐ Yes ☐ No
15. Do all professionals have licenses / certifications for all states where services are performed? ☐ Yes ☐ No
16. Does the business have a company-wide privacy policy for keeping customers information secure? ☐ Yes ☐ No
17. Do you obtain written consent for any client photos you post online? ☐ Yes ☐ No ☐ N/A
18. Check ONE of the below regarding coverage for your technicians and / or artists:
- ☐ I intend to cover technicians and/or artists working under my business name OR ☐ I require all technicians and/or artists to obtain their own insurance and name my business as additional insured under their policy for professional and general liability
19. For new clients only, do you currently have Insurance coverage? ☐ Yes ☐ No
- Insurer:** **Policy #:** **Limits:** **Premium:** **Exp. Date**

If Claims Made, provide Retroactive Date: _____

BODY ART / SALON & SPA APPLICATION

SECTION II: GENERAL LIABILITY

If this Section does not apply, Check Here ☐

1. Do you need General Liability? ☐ Yes ☐ No

If No, what Company insures your General Liability coverage? _____

2. Do you have any of the following units?

a. Wet Saunas / Steam Rooms: ☐ Yes ☐ No

b. Soaking Pools / Tubs: ☐ Yes ☐ No

c. Showers: ☐ Yes ☐ No

3. Does your lease require higher than \$50K for Damage to Rented Premises? ☐ Yes ☐ No

(this does NOT mean bodily injury and property damage.)

If Yes, select limits: ☐ \$100,000 ☐ \$300,000 ☐ \$500,000 ☐ \$1,000,000

4. Do you sell non – beauty / tattoo / body piercing related products? ☐ Yes ☐ No

If Yes, describe: _____ Gross receipts: _____

5. Do you sell any CBD / Hemp Products? ☐ Yes ☐ No If Yes, Gross receipts: _____

6. Do you private label products for sale? ☐ Yes ☐ No

If Yes, answer questions a-i:

a. Provide gross receipts for private label products ONLY: _____

b. Describe products being sold: _____

c. Do you manufacture any of these products? ☐ Yes ☐ No

d. Are the ingredients / component parts purchased from the US/Canada? ☐ Yes ☐ No

If No, where are they purchased? _____

e. Any new products being introduced in the next 12 months? ☐ Yes ☐ No

If Yes, explain: _____

f. Any foreign sales? ☐ Yes ☐ No

If Yes, what percentage to what countries? _____

g. Do you have a written recall plan in place? ☐ Yes ☐ No

h. Are your products tested for contaminants, potency, etc.? ☐ Yes ☐ No

If No, explain: _____

i. Are written instructions included with products or a list of inherent hazards and warning against misuse? ☐ Yes ☐ No

7. Mark if either of the following coverage is needed? ☐ Non-Owned Auto ☐ Hired Auto

If so, answer questions a-f:

a. Do you currently have a commercial auto policy? ☐ Yes ☐ No

b. Do you have a contractual requirement to carry Hired Auto? ☐ Yes ☐ No

c. Under which circumstances do the employees use their personal vehicles? _____

d. Approximate combined number of Non-Owned Auto trips annually? ☐ None ☐ 1-25 ☐ 25+

e. Approximate combine number of Hired Auto trips annually? ☐ None ☐ 1-25 ☐ 25+

f. Do you require your employees to carry their own insurance, with at least state minimum requirements, and obtain proof of insurance before you authorize them to use their own auto on company business? **If No, coverage will be excluded.** ☐ Yes ☐ No

BODY ART / SALON & SPA APPLICATION

SECTION III: TEACHING OF ANY SERVICE(S)

If this Section does not apply, Check Here ☐

1. Are you teaching or training any services to students who are not your current employees? ☐ Yes ☐ No

If Yes, answer questions a-f:

a. Are all students that are being taught 18 years of age or older? ☐ Yes ☐ No

b. How many students will be trained in the next 12 months? _____

c. How many hands-on procedures will each student perform for each service being taught? Describe (per service):

d. Do you use a consent form that expressly states individuals are being worked on by students? ☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own forms (if already approved by PPIB, no need to resubmit)

OR

☐ I will use PPIB approved forms (<https://www.ppibcorp.com/clientforms/>)

e. Do you guarantee Job Placement / Employability? ☐ Yes ☐ No

f. Provide name of each teacher: *If need to add additional teachers provide a list on a separate sheet.*

Name: _____ Name: _____

Name: _____ Name: _____

SECTION IV: COSMETOLOGY, AESTHETICS & WELLNESS SERVICES

If this Section does not apply, Check Here ☐

Schedule of Services

of People Performing

Barber Services: *Hair and Related Services*

Cosmetologist: *Hair Dressing, Manicures / Pedicures and Related Services, Topical Makeup Application, Eyelash Extensions / Tinting, Eyebrow and Facial Hair Threading, Waxing, Sugaring*

Massage Therapist: *Massage, Body Wraps, Endermologie, Reiki, Wet / Dry Cupping (No Heat / Fire)*

Natural Wellness Services: *Chakra Healing, Non-Cryo Compression Therapy, Yoga / Pilates Instruction, One-on-one Personal Training, Guided Meditation, Energy Healing, Hypnosis*

Basic Aesthetics: *Facials including Aesthetic level Peels up to 40% Glycolic Acids, Airbrush / Spray Tanning, Electrology, Microdermabrasion, Needling / Collagen Induction Therapy under 1.0mm deep with Class I device, Dermaplaning, LED Services, Microcurrent, Piercing for Earlobe and Outer Rim of Cartilage Only, infrared therapy including infrared saunas*

Advanced Aesthetics: *Aesthetic Plasma Services, LED Teeth Whitening, Skin Tag Removal, Wart Removal, Treatment of Age / Sunspots, Clogged Pores, Milia and Whiteheads, Smoothing & Tightening of the Skin, and/or Reduction of Minor Skin Imperfections using a Class I Non-Invasive Ultrasound, Aesthetic Radiofrequency, High Frequency, Cryopen / Cryoclear, Cryo Spot Treatments, and/or "Aesthetic Plasma Device"*

Additional Aesthetic Services

<input type="checkbox"/> Ear Candling	<input type="checkbox"/> Medical Peels	<input type="checkbox"/> Vajazzling	<input type="checkbox"/> Vajacials / Penacials
<input type="checkbox"/> Simple Nostril Piercing	<input type="checkbox"/> Henna Tattoos	<input type="checkbox"/> Airbrush Tattoo	<input type="checkbox"/> Temporary Sticker Tattoos
<input type="checkbox"/> Tooth Jewels	<input type="checkbox"/> Body Jewels (excluding Vajazzling)	<input type="checkbox"/> Face and/or Body Painting	
<input type="checkbox"/> Colon Hydrotherapy	<input type="checkbox"/> Permanent Jewelry	<input type="checkbox"/> Microneedling over 2.0mm Deep	
<input type="checkbox"/> Non-Needle, Non-Prescription Spring Pressure Treatments		<input type="checkbox"/> Body Contouring / Cellulite Reduction	

Total Number of Technicians at Facility: _____

Do you teach any of the above services? ☐ Yes ☐ No

BODY ART / SALON & SPA APPLICATION

SECTION V: AESTHETIC UNITS / DEVICES

If this Section does not apply, Check Here ☐

1. Answer Yes / No for each of the below:

a. UV Tanning Beds/Booths: ☐ Yes ☐ No

b. Foot Detox Unit: ☐ Yes ☐ No

c. Oxygen Inhalation Device: ☐ Yes ☐ No

d. Vaginal Steam Bath (VSB): ☐ Yes ☐ No

If yes, I confirm my VSB consent form does warn clients of heat exposure.

☐ Yes ☐ No

SECTION VI: SUPERVISING PHYSICIAN / MEDICAL DIRECTOR

If this Section does not apply, Check Here ☐

1. Are you required to have oversight for any services being performed by a Supervising Physician / Medical Director?

☐ Yes ☐ No

If Yes, provide name(s) and designations of supervising staff:

Name: _____ Medical Designation: _____

Name: _____ Medical Designation: _____

SECTION VII: PERMANENT COSMETIC SERVICES

If this Section does not apply, Check Here ☐

DEFINITIONS:

Permanent Cosmetics / Pigment Removal: Includes Ombre, Microblading, Microshading, Eyeliner, Eyebrows, Microblading, Lips, Lip liner, Nipple Areola, Beauty Marks, Pigment Removal using commercially prepared Saline or Acid-Based solutions, Scar Camouflage, Bald Spot Repigmentation, Cheek Blush, Tiny Tattoos (2"x2" max)

Name(s) of Technicians(s) to be Insured <i>If space is needed to add additional technicians provide a list on a separate sheet</i>		Years of Experience	Do you teach any of these services?
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No

TRAINING & EDUCATION

If less than 12 months of experience, provide training detail for each technician specific to these services and provide a copy of certificate of training.

	# of Hours in Person	# of Hours of Online	Name of School	Date(s) Attended	# of Procedures
1.					
2.					
3.					

1. Do you have everyone sign a Consent Form and complete a Medical History Form?

☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own forms (if already approved by PPIB, no need to resubmit)

OR

☐ I will use PPIB approved forms
(<https://www.ppibcorp.com/clientforms/>)

2. Do you take before and after photos of all work and schedule a follow-up appointment after each procedure?

☐ Yes ☐ No

3. Are all pigments / removal products you use from US or Canada manufacturers and / or to EU / UK standards?

☐ Yes ☐ No

BODY ART / SALON & SPA APPLICATION

SECTION VIII: DECORATIVE TATTOO & / OR BODY PIERCING

If this Section does not apply, Check Here ☐

1. Do all artists have formal training and/or have completed an apprenticeship in Tattooing and/or Body Piercing? ☐ Yes ☐ No
2. For minors, do you require a parent / guardian written permission prior to service? ☐ Yes ☐ No ☐ N/A
3. Do you use a Consent Form and After Care Form on every client? ☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own consent forms
(if already approved by PPIB, no need to resubmit)

OR

☐ I will use PPIB approved consent forms
(<https://www.ppibcorp.com/clientforms/>)

4. Do you offer tooth jewels? ☐ Yes ☐ No

Indicate number of Technicians			# to be Insured		
<i>All Tattoo/Body Piercers must have at least 1 year experience or be working under an apprenticeship for coverage to apply</i>		Total Number of Tattoo Artists and/or Body Piercers:			
If you have 7 or less Technicians, please indicate name and service (s) performed:					
1.		<input type="checkbox"/> Tattoo	<input type="checkbox"/> Body Piercer	<input type="checkbox"/> Both	
2.		<input type="checkbox"/> Tattoo	<input type="checkbox"/> Body Piercer	<input type="checkbox"/> Both	
3.		<input type="checkbox"/> Tattoo	<input type="checkbox"/> Body Piercer	<input type="checkbox"/> Both	
4.		<input type="checkbox"/> Tattoo	<input type="checkbox"/> Body Piercer	<input type="checkbox"/> Both	
5.		<input type="checkbox"/> Tattoo	<input type="checkbox"/> Body Piercer	<input type="checkbox"/> Both	
6.		<input type="checkbox"/> Tattoo	<input type="checkbox"/> Body Piercer	<input type="checkbox"/> Both	
7.		<input type="checkbox"/> Tattoo	<input type="checkbox"/> Body Piercer	<input type="checkbox"/> Both	
Piercers under 1 Year Experience are limited to the following: <i>Eyebrow, Earlobe, Outer Rim Ear cartilage, Lower Lip-Sides and Center, Nostrils – Thin or Hyaline Cartilage Only, Navel, Nipples.</i>					
Limitations to work on Minors: Minor Piercing - <i>Ear, Nose, Lips, Tongue (midline only) & Eyebrow piercing on minors age 13 years or over with written parental consent (ear lobes children age 3 months or older) – if state law specifies an older age, you must follow state law.</i> Minor Tattooing - <i>In states where legal age 16 or over with written parent consent.</i>					

Equipment and Procedures –If Piercing answer questions 5-6

5. Is all jewelry you use made within US guidelines and/or meets EU/UK standards? ☐ Yes ☐ No
6. For new piercings, do you use jewelry specifically made for that purpose? ☐ Yes ☐ No

Equipment and Procedures –If Tattooing answer questions 7-8

7. Are all pigments you use from US or Canada manufacturers and/or EU/UK standards? ☐ Yes ☐ No
8. Do you EVER re-use needles? ☐ Yes ☐ No

BODY ART / SALON & SPA APPLICATION

SECTION IX: OTHER SERVICES

additional application may be needed

If this Section does not apply, Check Here ☐

1. Do you provide any of the following? If so, indicate the number of people performing.

- a. Injectables? ☐ Yes ☐ No Number of Technicians: _____
- b. Laser / Intense Pulse Light? ☐ Yes ☐ No Number of Technicians: _____
- c. Prescription Weight Loss? ☐ Yes ☐ No Number of Technicians: _____

2. Do you provide services and/or operations not listed above? ☐ Yes ☐ No

If Yes, provide details: _____

SECTION X: OPTIONAL COVERAGES

If this Section does not apply, Check Here ☐

1. Do you want coverage for Defense Outside the Limit? ☐ Yes ☐ No Limit Requested: _____
2. Do you want coverage for Sexual Abuse at \$25K / 50K? ☐ Yes ☐ No Other Limit Requested: _____
3. Do you want Communicable Disease Limit up to \$100K (\$50K already included) ☐ Yes ☐ No
4. Do you want coverage for Cyber Liability? ☐ Yes ☐ No If Yes, Indicate Limit: ☐ \$250K ☐ \$500K

SECTION XI: ADDITIONAL INSURED

If this Section does not apply, Check Here ☐

Please note policies with General Liability coverage automatically include blanket Additional Insured coverage for all Landlords, Lessors of Leased Equipment, Tradeshow Sponsors, City / Health Departments and/or Permitting Offices, including Waiver of Subrogation and Primary / Non-Contributory Wording if contractually required.

1. Do you have an Additional Insured (AI) not included above who needs to be listed as an AI under the General Liability coverage? ☐ Yes ☐ No

a. AI Name #1: _____

b. Address: _____ Business Location #: _____

c. Does the AI require the following? ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation

d. Interest of Additional Insured? ☐ Franchisor ☐ Mortgagee ☐ City/ Government agency ☐ Vendors

☐ Other: _____

a. AI Name #2: _____

b. Address: _____ Business Location #: _____

c. Does the AI require the following? ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation

d. Interest of Additional Insured? ☐ Franchisor ☐ Mortgagee ☐ City/ Government agency ☐ Vendors

☐ Other: _____

2. Do you have an Additional Insured (AI) who needs to be named for Professional Liability? ☐ Yes ☐ No

a. Name: _____

b. Address: _____ Business Location #: _____

c. Interest of Additional Insured? ☐ Franchisor ☐ Mortgagee ☐ City/ Government agency ☐ Vendors

☐ Other: _____

BODY ART / SALON & SPA APPLICATION

SECTION XII: PROPERTY (Complete this section for EACH location)

If this Section does not apply, Check Here ☐

1. Location #: _____ Address: _____

2. Year Built: _____ Construction Type: _____ Number of stories: _____ Square Footage: _____

3. If building is over 20 years old, what year were the following upgraded? (*) information required
*Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____

4. Roofing Material (Tile, Metal, Wood Shingles, etc.): _____

5. Are there sprinklers inside your unit? ☐ Yes ☐ No

6. Is there a Central Station Burglar Alarm inside your unit and in your control? ☐ Yes ☐ No

7. Do you sell or use jewelry? ☐ Yes ☐ No
a. Do any of the pieces have a wholesale value of more than \$250 per item? ☐ Yes ☐ No
If Yes, please check value of jewelry ☐ \$5k ☐ \$10k ☐ \$25k ☐ \$50k ☐ over \$50k

8. Name and address of Loss Payee: _____

Coverage Desired

Contents: \$: _____ Flash (if any) \$: _____

Tenant Improvements: \$: _____

Building: \$: _____ Do you own the Building? ☐ Yes ☐ No

Business Interruption: Amt Per Month \$: _____ Months to be covered: _____

Outside Sign: \$: _____

Optional Coverages

9. Do you want coverage for Property of Independent Contractors? ☐ Yes ☐ No

10. Do you want coverage for Contingent Business Income? ☐ Yes ☐ No \$10K limit (Off Premise Power Outage)

11. Do you need coverage for any of this property in Transit or at a temporary Location? ☐ Yes ☐ No If Yes, \$: _____

1. Location #: _____ Address: _____

2. Year Built: _____ Construction Type: _____ Number of stories: _____ Square Footage: _____

3. If building is over 20 years old, what year were the following upgraded? (*) information required
*Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____

4. Roofing Material (Tile, Metal, Wood Shingles, etc.): _____

5. Are there sprinklers inside your unit? ☐ Yes ☐ No

6. Is there a Central Station Burglar Alarm inside your unit and in your control? ☐ Yes ☐ No

7. Do you sell or use jewelry? ☐ Yes ☐ No
a. Do any of the pieces have a wholesale value of more than \$250 per item? ☐ Yes ☐ No
If Yes, please check value of jewelry ☐ \$5k ☐ \$10k ☐ \$25k ☐ \$50k ☐ over \$50k

8. Name and address of Loss Payee: _____

Coverage Desired

Contents: \$: _____ Flash (if any) \$: _____

Tenant Improvements: \$: _____

Building: \$: _____ Do you own the Building? ☐ Yes ☐ No

Business Interruption: Amt Per Month \$: _____ Months to be covered: _____

Outside Sign: \$: _____

Optional Coverages

9. Do you want coverage for Property of Independent Contractors? ☐ Yes ☐ No

10. Do you want coverage for Contingent Business Income? ☐ Yes ☐ No \$10K limit (Off Premise Power Outage)

11. Do you need coverage for any of this property in Transit or at a temporary Location? ☐ Yes ☐ No If Yes, \$: _____

BODY ART / SALON & SPA APPLICATION

SECTION XIII: HISTORY

Note – ALL questions must be answered. Failure to disclose claims history could invalidate coverage.

Do you have any past claims including Professional, General Liability, Cyber and/ or Property, whether or not insured? ☐ Yes ☐ No

If Yes, describe:

Do you have knowledge of an event, circumstance, or occurrence (other than listed above) prior to the effective date of the proposed policy that may result in a claim or incident? ☐ Yes ☐ No

If Yes, describe:

SECTION XIV: ATTESTATION

On Behalf of ALL Technicians and Operations, I confirm:

1. No insurance will be offered for any service or individual unless specifically endorsed on to the policy and a premium is paid.
2. All Technicians have been properly trained and licensed as necessary for all services they are performing or on the devices they are using.
3. All technicians are properly licensed in each jurisdiction they are performing services in.
4. Technicians do not use any product that contains more than 2% formaldehyde.
5. All Permanent Cosmetic, Decorative Tattooing, Body Piercing, Body Contouring/Cellulite Reduction, Non-Invasive Ultrasound, Aesthetic Radio Frequency, Aesthetic Plasma Services, Vaginal Steam Bath and/or Colon Hydrotherapy clients must sign a consent form for the particular service being provided prior to the treatment. No coverage will apply if there is not a signed & completed form on file. If I change a consent for Decorative Tattooing, Body Piercing or Permanent Cosmetics, it must be approved by the insurance company.
6. All Permanent Cosmetics, Decorative Tattooing and Body Piercing equipment is pre-sterile, one-time use or sterilized to medical grade standards.
7. The business is in compliance with all AMA, FDA, CDC and / or State Laws for all devices, products, and services.
8. I understand there are limitations to work on minors and individuals.
9. I understand and agree this Application and any supplements attached hereto will be relied upon for the insurance policy.
10. I understand and agree that failure to provide true and accurate response to the foregoing questions may result in the voiding of the insurance issued in reliance on this application and/or denial of claims under the policy issued.
11. I authorize and consent to investigation of information 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.
12. If I am aware of any claim or incident arising from any time prior to today, I must advise the company at this time.
13. The liability policy applied for may apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the policy or the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.
14. This insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund or similar entity.

For UV Tanning Units (if any), I confirm:

1. That lighting will not exceed 10% UVB in each unit.
2. Maximum tanning exposure in each unit will NOT exceed 30 minutes per session per 24-hour period.
3. All clients will wear goggles.
4. Tanning controls will ONLY be set by a staff member.
5. Tanning beds will be tested daily to ensure switches and timers operate properly.
6. Drug reaction list and the FDA warning sign are posted as required by law.

On behalf of ALL Permanent Jewelry technicians (if any), I confirm:

1. A barrier between is used between the client's skin and the welding device.

On behalf of all Body Contouring / Cellulite Reduction technicians (if any), I confirm:

1. Will only use Class I or Class IIa devices.

On behalf of all Colon Hydrotherapy technicians (if any), I confirm:

1. The nozzle is discarded after use, or re-sterilized to medical standards.
2. Services are not performed on any individuals under 15 years of age.
3. A physician's prescription and parent/guardian permission is required prior to services being performed on individuals between the ages of 15 and 17 years.

(For a full list of terms and conditions, consult the policy forms)

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS PRIOR TO BINDING (60 DAYS FOR RENEWALS). SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY.

APPLICANT SIGNATURE

TITLE

DATE SIGNED

REQUESTED EFFECTIVE DATE

LIABILITY LIMIT REQUESTED:

☐ \$500k ☐ \$1M ☐ \$1M/\$2M ☐ \$1M/\$3M ☐ \$2M/\$2M

**POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE**

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, **as defined in Section 102(1) of the Act, as amended:** The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2027, the date on which the TRIA Program is scheduled to terminate, or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 80% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A USD100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS USD100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED USD100 BILLION, YOUR COVERAGE MAY BE REDUCED.

THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

	(ACCEPT) I hereby elect to purchase coverage for acts of terrorism for a prospective premium of USD.....
	(DECLINE) I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

Policyholder/Applicant's Signature

Carrier

Print Name

Policy Number

Date