

# 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: \_\_\_\_\_

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## 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?  
*(this does NOT mean bodily injury and property damage.)*  Yes  No

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

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## 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

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## 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, Lipliner, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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

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## 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:** *Eyebrow, Earlobe, Outer Rim Ear cartilage, Lower Lip-Sides and Center, Nostrils – Thin or Hyaline Cartilage Only, Navel, Nipples.*

**Limitations to work on Minors:**

**Minor Piercing** - *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.*

**Minor Tattooing** - *In states where legal age 16 or over with written parent consent.*

**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

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## 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: \_\_\_\_\_

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## 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, \$: \_\_\_\_\_

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## 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 forgoing 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