

APPLICANT'S INFORMATION

APPLICANT NAME:			
BUSINESS NAME:			
INSPECTION CONTACT:		PHONE:	
MAILING ADDRESS:			
INSURED ADDRESS:	<input type="checkbox"/> Same as above		
<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture			
<input type="checkbox"/> OTHER _____			

GENERAL INFORMATION

1. Is applicant engaged in, owned by, associated with or involved in any other enterprise? No Yes
 If yes, provide details _____
2. Date established ____/____/____
3. Provide details of licensing or certification needed for this operation. _____
4. State the number of the following personnel:

Partners/Owners	Full Time Staff	Part Time Staff
Independent Contractors	Professional Trainers	Other (specify)
5. How many Tanning Beds? _____

Are signs posted prohibiting the use of beds during pregnancy or if on medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are goggles provided?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are beds manufactured in the United States?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Self - timers?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are beds UL approved?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have all employees received training in the use of timers?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Is there a pool on the premises? No Yes

Are rules posted?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Lifeguard on duty?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If yes, is diving board at the deepest end of the pool?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
What is the depth at the deepest end?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Are there depth markers?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. Are any of the following facilities or activities available?

Aerobics	Trampolines	Nutritional counseling
Gymnastics	Electrode Machines	Weight machines/Free weights
Body Wraps	Stress Testing	Blood Analysis Protein diet plans
Karate	Climbing wall	Weight loss/diet centers
8. Any shower facilities? No Yes

If yes, do they have non-skid floors?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sauna or Steam facilities?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Jacuzzi?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

9. Number of Tennis courts? _____ Number of Racquetball/handball courts? _____
10. Are child care facilities provided? No Yes
 Maximum number of children at one time: _____ Age of youngest child you will accept: _____
 Number of child care attendants: _____
11. Pro shop on premises? No Yes - gross sales? \$ _____
12. Snack bar/Restaurant on premises? No Yes - gross sales? \$ _____
13. Total number of members: _____ Average age of members: _____
14. Are medical examinations required for new members? No Yes
15. What is your procedure for handling accidents or injuries? _____
16. Does your staff have training in CPR and First Aid? No Yes
17. Hours of operations: from _____ to _____
18. Annual Gross Receipts: Next 12 months \$ _____
 Last 12 months \$ _____
19. Has applicant had previous insurance for this enterprise? No Yes
 If yes, complete the following:
 Has applicant had previous insurance for this enterprise? No Yes
 If yes, please complete the following:
 Insurance Company _____
 Policy Period _____ to _____
 Limits of Liability _____
 Premium _____ Type of Coverage: Occurrence Claims Made
 Current General Liability Carrier _____
 Limits requested: 100/100 300/300 500/500 1/1 1/2 1/3
20. During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you?
 If yes, provide full details (Include description of claim, amounts paid, and reserves)

21. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? No Yes - provide full details _____
22. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance .. denied, policy canceled, or nonrenewed in the past five (5) years? No Yes
 If yes, provide full details _____
23. Additional Comments & Interests _____

Attach copies of all contractual agreements including those involved in off premises training.

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

 Applicant's Signature

 Sub-Producer

 Title/Date

 Producer

*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE E. Application MUST be correctly signed and dated to