THOMCO™
THOMPSON INSURANCE ENTERPRISES, LLC

DaySpa, MediSpa & Beauty Salon Application

Submission #

Spa Choice

PO Box 440549 Kennesaw, GA 30160
Phone: (866) 671-0520
www.spachoiceins.com

Send Completed Application to: Fax: (678) 290-2200 or Email: newsub@thomcoins.com

The Following Items Are Required To Be Submitted With This Application: Proposed Effective Date: ____________

1. Four Years of Loss Runs   2. Certificate of Insurance for all Medical Doctors on Staff
3. Copies Of Current Medical Licenses & Training Certificates for Medical Estheticians, Medical Doctors, & Nurse Practitioners

BASIC INFORMATION:

Named Insured: ____________ DBA: ____________

Loss Control Contact Name: ____________ Phone: ____________ Fax: ____________

Website Address: ____________ Email Address: ____________

Mailing Address: ____________

Physical Address: ____________

Type of Entity: ☐ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture ☐ LLC ☐ Other: ____________

FEIN/Social Security Number: ____________ Date business started under current ownership: ____________

Current Carrier & Limits of Liability: ____________ Retro Date: ____________

Is this policy being non-renewed: ☐ Yes ☐ No   Is the expiring policy written as Claims Made? ☐ Yes ☐ No

Is this a new venture? ☐ Yes ☐ No   If no, expiring premium: ____________ Name of Franchise: ____________

List all losses in the past 5 years whether or not insured(Attach additional sheet if necessary):

Date of Claim	Description of Claim	Open/Closed	Paid $	Reserve $

LIABILITY LIMITS & COVERAGE (per occurrence limit/ aggregate limit):

General Liability Limit (choose one): ☐ Occurrence ☐ Claims Made   Retro Date: ____________

☐ $1,000,000 / $2,000,000   ☐ $500,000/ $1,000,000   ☐ $300,000 / $600,000

Please choose a GL Deductible: ☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000

Professional Liability Limit (choose one): Note: The limit chosen cannot exceed the GL per occurrence limit chosen above

☐ Occurrence ☐ Claims Made   Retro Date: ____________

☐ N/A ☐ $300,000 ☐ $500,000 ☐ $1,000,000

Please choose a PL Deductible: ☐ $0 (N/A for MediSpa) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $5,000

Medical Payments Limit (Automatically included at $5,000)   Higher limit available: ☐ $10,000

Damage to Premises Rented To You (Automatically included at $300,000)

Higher Limits Available if required by lease (copy of lease required): ☐ $500,000 ☐ $750,000 ☐ $1,000,000

Stop Gap Limit (Available in ND, OH, WA, WY only)(choose one): Total WC Payroll: ____________

☐ $500,000 / $500,000 / $500,000 ☐ $100,000 / $500,000 / $100,000 ☐ $1,000,000 / $1,000,000 / $1,000,000

Employee Benefits Liability: ($1,000 Deductible applies)   Retro Date: ____________ Number of employees per location: ____________

Limit (choose one) ☐ N/A ☐ $100,000 / $ 100,000 ☐ $300,000 / $300,000 ☐ $500,000 / $ 500,000
☐ $500,000 / $ 1,000,000 ☐ $1,000,000 / $ 1,000,000

Abuse Liability Limit (automatically provided at $100,000 per occurrence/ $300,000 aggregate):

Higher Limits Available: ☐ $500,000/ $1,000,000 ☐ $1,000,000/ $2,000,000

Hired & Non-Owned Auto: Do you have any owned autos? ☐ Yes ☐ No

☐ Reject ☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

Employment Practices Liability Limit (choose one)**:**   Deductible: ☐ $2,500 ☐ $5,000

☐ N/A ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $250,000 ☐ $500,000 ☐ $1,000,000

Number of full time employees: ____________ Number of part time employees: ____________

Do you want to purchase Employment Practices Third Party Liability coverage? ☐ Yes ☐ No

Optional Liability Coverages Available:

☐ Data Compromise - $50,000 Limit   ☐ Identity Theft Recovery - $25,000 Limit

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(A Copy of this Page is Required for Each Additional Location)

GL COVERAGE: Location # ________ Annual Revenue: ____________ Sq Feet: ____________

Location Address: ______________________________

Which best describes the premises at this location: ☐ Main Operations ☐ Office Only ☐ Warehouse Only ☐ Kiosk

Which best describes the operations at this location: ☐ DaySpa* ☐ MediSpa* ☐ Beauty/Barber Shop ☐ Teeth Whitening

Are any childcare services provided at this location?* ☐ Yes ☐ No

Do you have any retail food sales? ☐ Yes ☐ No Annual Food Sales: ________

Do you have any retail product sales? ☐ Yes ☐ No Annual Product Sales: ________

Which equipment do you have at this location? (Check all that apply)

☐ Aqua Massage - How Many? ____	☐ Jacuzzi - How Many? ____	☐ Vichy Shower - How Many? ____
☐ Exercise Equipment -How Many? ____	☐ Oxygen Bar - How Many? ____	☐ Tanning Beds/Booths - How Many? ____
☐ Hydration Station -How Many? ____	☐ Spa Pool - How Many? ____	☐ Misc Tanning - How Many? ____
☐ Hydrotherapy Tub - How Many? ____	☐ Sauna - How Many? ____	☐ Toning Machine - How Many? ____
☐ IPL Therapy - How Many? ____	☐ Steam Room - How Many? ____	☐ Whirlpool - How Many? ____

PL COVERAGE **(Only complete if you are purchasing this coverage):**

Do you use independent contractors? ☐ Yes ☐ No Do you require a copy of their insurance? ☐ Yes ☐ No

If yes, do you require the independent contractor/operator to carry Professional Liability limits of at least $300,000? ☐ Yes ☐ No

Which Professionals do you have at this location? (Check all that apply)

Professional	# Employed	# Contracted
☐ Acupuncturists	____	____
☐ Barbers	____	____
☐ Beauty School Students	____	
☐ Body Wrap Techs - Licensed	____	____
☐ Body Wrap Techs - Unlicensed	____	____
☐ Cosmetologists	____	____
Do they perform chemical peels, microdermabrasion, hot wax, laser or IPL therapies?	☐ Yes ☐ No	☐ Yes ☐ No
☐ Ear Piercing Technician	____	____
☐ Electrologists	____	____
☐ Esthetician - Medical	____	____
☐ Esthetician - Non Medical	____	____
Do they perform chemical peels, microdermabrasion, hot wax, laser or IPL therapies?	☐ Yes ☐ No	☐ Yes ☐ No
☐ Massage Therapists	____	____
Where are the Massage Therapists located?	☐ Therapy Center	☐ Health & Fitness or Spa Facility
Do you perform massages on pregnant women?	☐ Yes	☐ No
If yes, during the 1st trimester?	☐ Yes	☐ No
Do you require a doctor's release?	☐ Yes	☐ No
Do you provide hot stone massages?	☐ Yes	☐ No
☐ Medical Directors	____	____

Professional	# Employed	# Contracted
☐ Medical Doctors	____	____
Do they have their own medical malpractice insurance whichcovers the insured?	☐ Yes ☐ No	☐ Yes ☐ No
☐ Nail Technicians	____	____
☐ Nurses	____	____
☐ Perm Make Up Operators	____	____
☐ Paramedical Makeup	____	____
☐ Personal Trainers	____	____
☐ Physician Assistants	____	____
☐ Physical Therapists	____	____
☐ Shampoo Technicians	____	____
☐ Teeth Whitening Technicians		
Type of services offered:	☐ Self Admin ☐ Assisted ☐ Both	☐ Self Admin ☐ Assisted ☐ Both
☐ Waxing Technicians	____	____

*Requires the completion of a supplemental application

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(A Copy of this Page is Required for Each Additional Location)

PROPERTY LIMITS AND COVERAGE – (If applicable)

Location #: ______________

Address: ____

Property Deductible (choose one): ☐ $250 ☐ $500 ☐ $1000 ☐ $1,500 ☐ $2,500 ☐ $5,000

Wind/Hail Deductible (choose one): ☐ Not Applicable ☐ Exclude

(Applicable in coastal states only- subject to state requirements) ☐ Percent - ☐ 1% ☐ 2% ☐ 3% ☐ 5%

☐ Flat - ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000

Building Coinsurance Percentage (choose one): ☐ 80% ☐ 90% ☐ 100% ☐ No Coverage

Personal Property Coinsurance Percentage (choose one): ☐ 80% ☐ 90% ☐ 100% ☐ No Coverage

Business Income Coinsurance (choose one): ☐ No Coverage ☐ 1/3 Monthly Limit ☐ 1/4 Monthly Limit ☐ 1/6 Monthly Limit

☐ 80% ☐ 90% ☐ 100%

Choose the coverages desired or are required to carry:

☐ Building $ ______________ Inflation Guard ________

☐ Business Personal Property $ ______________ Inflation Guard ________

☐ Tenant Improvements & Betterments $ ______________

☐ Business Income $ ______________

☐ Glass ($5,000 automatically included) $ ______________

Tell Us About Your Building - REQUIRED FOR QUOTE - DO NOT LEAVE BLANK

Construction Type (choose one): ☐ Frame ☐ Joisted Masonry ☐ Masonry Non-Combustible

☐ Non-Combustible ☐ Semi-Fire Resistive ☐ Fire Resistive

Year Built: ______________ Sprinklered: ☐ Yes ☐ No

Year Updated: Plumbing: __________ Heating: __________ Roof: __________ Electrical: __________

Business/exposure to your: Left: ______________ Right: ______________ Rear: ______________

Type of Alarm System: ______________ Number of Stories: ________

Do you own the building at this location? ☐ Yes ☐ No

Are you contractually responsible for insurance placement for the building? ☐ Yes ☐ No

COVERAGE ENHANCEMENTS

The following coverages are included. However, you may increase the limits of the coverages for an additional premium. Please indicate the limit you wish to purchase:

Coverage	**Limit Provided**	**Available Limits to Purchase**	**Limit Requested**
Outdoor Sign	$15,000	Any limit In increments of $1,000	$ __________
Employee Equipment (On premises/In Transit/ At Client's premises)	$5,000/$2,500/$2,500	$10,000/$2,500/$2,500	$ __________
Fire Department Service Charge	$5,000	$7,500 or $10,000	$ __________
Money and Securities Off Premises	$5,000	$10,000	$ __________
Forgery or Alteration	$10,000	$25,000	$ __________

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Optional Coverages Schedule

PROPERTY COVERAGE FOR EQUIPMENT TAKEN OFF PREMISES:

Deductible: ☐ $250 ☐ $500 ☐ $1,000

Item #	Equipment Description	Cost New

EMPLOYMENT PRACTICES SUPPLEMENT WHEN EPLI LIMITS EXCEED $100,000

Please complete the following information if you selected Employment Practices Liability Limits over $100,000

Have there been any EPLI claims, suits or complaints or are there any now pending claims against the insured or any executive, officer or owner? ☐Yes ☐No

If Yes, describe: ____________________

Does the insured and any executive, officer, or owner have any knowledge or information of any act, error, or omission which could reasonably be expected to give rise to an EPLI claim, suit or complaint? ☐Yes ☐No

If Yes, describe: ____________________

Has the insured been in business for at least three continuous years with no bankruptcy filings? ☐Yes ☐No

If No, explain ____________________

Are all job applicants required to complete and sign an employment application? ☐Yes ☐No

If No, explain: ____________________

Does the insured have an employment handbook, website or written employment materials, such as anti-harassment or anti-discrimination policies, to advise exmployees of their rights to work free of harassment and discrimination in the workplace? ☐Yes ☐No

If No, explain ____________________

In the last twelve months and the comming twelve months combined, have there been or does the insured expect any layoffs or staff reductions totaling more than 15% of the total employee count? ☐Yes ☐No

If Yes, describe: ____________________

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DaySpa Supplement

Only Non-Surgical Treatments and those that use FDA approved products are eligible for this program.

Please select which services are provided:

☐ Airbrush Tattoo - no henna tattoos

☐ Body Wraps and Scrubs

Type of Body Wraps: ______________________

☐ Cellulite Treatment

☐ Chemical Peels

What solution and concentration are used for the chemical peel treatments? ______________________

☐ Cosmetology

☐ Dermaplaning

☐ Ear Candling

☐ Ear Piercing

☐ Electrolysis

☐ Esthetics

☐ Facials

☐ Make Up Application and Lesson

☐ Manicures/Pedicures

Do you do fish pedicures? ☐ Yes ☐ No

☐ Massage Therapy

☐ Microdermabrasion

Do you go below the dermal layer? ☐ Yes ☐ No

☐ Prescription Drug Weight Loss

☐ Tanning

☐ Teeth Whitening - cosmetic only, non dental

☐ Tissue Tightening Radio Frequency Treatment

☐ Waxing

☐ Other: ______________________

Do any services provided at this location include the use of a laser? ☐ Yes ☐ No

(If Yes, a Medi-Spa supplement must be completed)

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MediSpa Supplement

Only Non-Surgical Treatments and those that use FDA approved products are eligible for this program.

Please select which services are provided:

- ☐ Acupuncture
- ☐ Airbrush Tattoo - no henna tattoos
- ☐ Body Piercing not including ear piercing
- ☐ Body Wraps and Scrubs
  - Type of Body Wraps: ______________________________
- ☐ Cellulite Treatment
- ☐ Chemical Peels
  - What solution and concentration are used? ________________
- ☐ Computerized Photocomplexion Analysis
- ☐ Cosmetology
- ☐ Dermaplaning
- ☐ Ear Candling
- ☐ Ear Piercing
- ☐ Electrolysis
- ☐ Esthetics
- ☐ Facials
- ☐ Injectable Fillers (Please complete below)
  - ☐ Botox Parties
- ☐ Intense Pulse Light Laser Treatments (Please complete below)
- ☐ Leg Spider Vein Treatment
- ☐ Make Up Application and Lesson
- ☐ Manicures/Pedicures
  - Do you do fish pedicures? ☐ Yes ☐ No
- ☐ Massage Therapy
- ☐ Mesotherapy
- ☐ Microdermabrasion
  - Do you go below the dermal layer? ☐ Yes ☐ No
- ☐ Prescription Drug Weight Loss
- ☐ Procedures requiring Anesthesia or Surgical Excision
- ☐ Sclerotherapy
  - What is the largest size vein you will treat? ____________
- ☐ Skin Tightening Treatments
  - ☐ Thermage
- ☐ Skin Treatments
- ☐ Tanning
- ☐ Teeth Whitening - cosmetic only, non dental
- ☐ Tissue Tightening Radio Frequency Treatment
- ☐ Waxing
- ☐ Other: ____

Injectable Fillers

Who administers the injections?

☐ Cosmetologist ☐ Electrologist ☐ Medical Esthetician ☐ Non Medical Esthetician ☐ Medical Doctor

☐ Physician Assistant ☐ Other: ____

Types of Injectable Fillers Used (Check all that apply)

☐ Artefill ☐ Botox Cosmetic ☐ Collagen ☐ Juvederm ☐ Restylane

☐ Lipodissolve ☐ Other: ____

Intense Pulse Light Laser Treatments

Who administers the IPL treatments?

☐ Cosmetologist ☐ Electrologist ☐ Medical Esthetician ☐ Non Medical Esthetician ☐ Medical Doctor ☐ Nurse

☐ Physician Assistant ☐ Other: ____

Treatments done with IPL Laser (Check all that apply)

☐ Acne Scars ☐ Hair Removal ☐ Photo Facials ☐ Photo Rejuvenation ☐ Rosacea

☐ Tattoo Removal ☐ Other: ____

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Tanning Supplement

1. How is tanning exposure time controlled? ☐ User ☐ Salon Operator ☐ Token ☐ Key Card
2. Is protective eye wear provided for customers? ☐ Yes ☐ No

   Is it sanitized after each use? ☐ Yes ☐ No
3. Are the beds sanitized after each use? ☐ Yes ☐ No
4. Is the maximum exposure time for tanning within manufacturer guidelines? ☐ Yes ☐ No
5. Is a drug reaction list posted in your salon or provided to your customers? ☐ Yes ☐ No
6. Do you use customer history cards? ☐ Yes ☐ No
7. Are all beds UL listed? ☐ Yes ☐ No
8. Do you manufacture your own tanning beds? ☐ Yes ☐ No
9. Are customers required to read & sign an acknowledgement of the risks involved with the tanning exposure? ☐ Yes ☐ No

A COPY OF YOUR HOLD HARMLESS AGREEMENT IS REQUIRED WITH THE APPLICATION

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Permanent Makeup Supplement

1. How long has the permanent makeup operator been applying permanent color? (Please enter a year) ______________

2. How many procedures have been performed in the past 12 months for the following:

   Eyeliner ________ Eyebrows ________ Lipliner ________ Lips ________ Cheek Blush ________

   Skin Repigmentation/Camouflage ________ Decorative Tattooing ________

3. Do you ever re-use needles? ☐ Yes ☐ No

4. Is all of your equipment pre-sterile, one-time use? ☐ Yes ☐ No

   If no, indicate your method of sterilization: ______________________________

5. Do all operators wear gloves with each procedure? ☐ Yes ☐ No

6. Do you dispose of your pigments after each client? ☐ Yes ☐ No

7. Do you take before and after photos? ☐ Yes ☐ No

8. Are all of your pigments from US manufacturers? ☐ Yes ☐ No

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

Additional Interest Schedule For Location #

Name: ______ ☐ Additional Insured ☐ Loss Payee ☐ Both

Address: ______ City: ______ State: ____ Zip: ______

Interest is (choose one): ☐ Landlord ☐ Mortgage/Leasing Company ☐ Other: ______

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RISK ASSESSMENT

1. Do you have a formal safety program? ☐ Yes ☐ No
2. Any policy or coverage declined, cancelled or non-renewed during the prior three years? (N/A in Missouri) ☐ Yes ☐ No

   If yes, please select the reason: ☐ Carrier no longer writing coverage ☐ Loss History ☐ Other:
3. Have any crimes occurred or been attempted on your premises within the last 3 years? ☐ Yes ☐ No
4. Any bankruptcies, tax or credit liens against you in the last 5 years? ☐ Yes ☐ No

   If yes, please explain: ______________________
5. Are you a member of any certifying organizations? ☐ Yes ☐ No

   If yes, which ones? ______________________
6. Do you provide any services that are in addition to or outside of your licensure? ☐ Yes ☐ No

   If yes, please explain: ______________________

RISK MANAGEMENT

1. Do you use customer history cards or use a computer software program to track client visits? ☐ Yes ☐ No

   Please provide the name of the software program (if applicable): ______________________

   Please provide a copy of any customer history cards being used.
2. Are signed consent forms obtained for each service performed? ☐ Yes ☐ No
3. Are aftercare instructions provided for each service performed? ☐ Yes ☐ No
4. Do you obtain parental consent forms for minors? ☐ Yes ☐ No
5. Are employees required to obtain a signed form prior to use of the equipment by minors? ☐ Yes ☐ No
6. Do you manufacture, blend or formulate your own products? ☐ Yes ☐ No

   ****If you answer yes, there is no coverage - you must provide proof of other insurance coverage for your product manufacturing****
7. Are any products sold under the insured's name? ☐ Yes ☐ No

   ****If you answer yes, there is no coverage - you must provide proof of other insurance**
8. Do you perform pre-employment screenings such as background checks, drug testing, etc? ☐ Yes ☐ No
9. Do you have a formal training program for new employees? ☐ Yes ☐ No
10. Are all products used in any of your services FDA approved? ☐ Yes ☐ No
11. Are all state laws followed regarding treatment procedures for all of the services provided? ☐ Yes ☐ No
12. Are all individuals licensed and/or certified in the jurisdiction where services or treatments are provided? ☐ Yes ☐ No
13. When servicing clients with serious health problems, do you obtain a release from their physician prior to performing services? ☐ Yes ☐ No

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FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another 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 insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: ______________________ Date: ______________

Producer's Signature:
(Only applicable if using a producer) ______________________ Date: ______________

Producer's License Number: ______________________ Exp. Date: ______________