

COMMERCIAL BEAUTICIANS PROPOSAL

Please ensure that you complete this form fully to enable us to provide you with an accurate and speedy quotation. The truth of the statements made in this form and any other documentation you may provide to us will be incorporated within your policy should our terms be accepted. If the space provided is insufficient, a separate sheet should be attached with information documented with the same numbering as the Proposal Form.

The completion of this form does not bind you or us to any contractual arrangement unless you accept our terms for the issuing of an insurance policy.

From the date that you sign this proposal any change in risk or any claims or circumstances that may give rise to claims against you at a later date, must be declared to us. This applies whether or not the completion of this proposal is for a new policy or renewal of an existing policy. It is our intention that any Contract Of Insurance with you shall be based upon the answers and information provided in this Proposal Form and any other additional information provided by the you. If a quotation is offered it is our intention to offer coverage only in respect of these entities/the individual named in answer to Question 1. Where cover is being sought for a Company/ Legal Entity, then the proposal form must be signed by a Partner in the Practice where cover is to include any Company through which the Practice provides professional services, the Partner signing the Declaration shall be deemed to be the duly Authorised Agent of such Company.

Existing insurances with us and generally with other Insurers will lapse at midnight on the last day of your expiring policy. Any extensions of cover or requests to hold covered must be received and agreed by this office prior to the expiry of the current policy.

Policies are written on a "Claims Made" basis which means that:

1. Indemnity provided is in respect of claims made against you or you becoming aware of circumstances occurring that could lead to claims being made against you during the currency of the policy.
2. Policies have a "Retroactive Date" which excludes claims emanating from work undertaken prior to this date.
3. Provided there has been no gap in cover we will allow the "Retroactive Date" to remain unchanged on any new policy issued by us.

PARTICULARS OF PROPOSER

- 1. Full name of the company/group name/individual's full name and surname _____
- 2. Trading name (if different from above) _____
- 3. Date of birth (if sole practitioner) _____
- 4. Have you ever engaged in a similar activity under a different name YES NO
If YES, then please provide full information hereunder or on a separate sheet that is to be attached to this proposal form
- 5. Postal address _____
Postal code _____
- 6. Physical address _____
Postal code _____
- 7. Telephone number _____
- 8. Email address _____
- 9. Please provide details of any practice/trading address/es if different from the above _____
- 10. Company/close corporation registration number _____
- 11. VAT registration number _____
- 12. When was business established 12.1 As currently constituted _____
12.2 As initially established _____
- 13. Present legal constitution (please mark relevant box below)

13.1 Sole practitioner	13.2 Partnership	13.3 Private company
13.4 Public company	13.5 Close corporation	

ACTIVITIES OF PROPOSER

- 1. Please state the discipline(s) in which the Proposer is engaged _____
- 2. Please indicate what standard approved beauty treatments you perform

Body wrapping	<input type="checkbox"/>	Spa treatments	<input type="checkbox"/>	Caci (facial technique)	<input type="checkbox"/>
Sugaring	<input type="checkbox"/>	Electrical Epilations/Hair removals	<input type="checkbox"/>	Tanning applications	<input type="checkbox"/>
Ear piercing	<input type="checkbox"/>	Waxing	<input type="checkbox"/>	Eyebrow tinting	<input type="checkbox"/>
Laser hair removal	<input type="checkbox"/>	Facials	<input type="checkbox"/>	Botox injections	<input type="checkbox"/>
Microdermabrasion (sodium crystals)	<input type="checkbox"/>	Chemical peels (maximum strength 30%)	<input type="checkbox"/>	Lash tinting and eyebrow shaping	<input type="checkbox"/>
Hairdressing	<input type="checkbox"/>	Manicure	<input type="checkbox"/>	Laser vein removal	<input type="checkbox"/>
Make up	<input type="checkbox"/>	Electrolysis	<input type="checkbox"/>	Nail extensions	<input type="checkbox"/>
Photo rejuvenation	<input type="checkbox"/>	Pedicure	<input type="checkbox"/>	Sunbeds	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>				<input type="checkbox"/>

Note: No cover for any treatments not approved or not standard to the beauty industry or any trial treatments/procedures

3. List the type of products you supply to patients/clients

Note: No cover for any products used in treatments/procedures that are not approved and registered in terms of legislation as amended from time to time

NAMES AND QUALIFICATIONS

1. Please provide full details of the sole practitioner or principals or partners or members or directors (depending on the legal constitution as set out under Question 13 above)

Name	Qualifications	Date qualified	How long principal in this practice
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Are you a member of any professional organisation and/or registered with any self-regulating body YES NO

If YES, please state: 2.1 Which body _____
 2.2 Period of membership/registration _____
 2.3 Membership number _____

3. Has any membership or registration with such organisation/body ever been suspended, withdrawn, amended, declined or had any specific conditions attached YES NO

If YES, then please provide full information

STAFF COMPLEMENT

1. Please state the number of employees in each of the following classifications:

Partners/members/directors/principals _____
 Qualified staff _____
 Other staff (ex. admin) _____
 Administrative staff (typists, etc.) _____
 Contract hired staff _____

2. Does any person involved in the treatment and care of any patient/client suffer from any disability, transmittable diseases, i.e. Hepatitis, H.I.V., etc. or any other impediments which may affect the performance of his/her professional duties or place any patients/clients at risk YES NO

If YES, please provide full details

3. Have you and/or any of your partners and/or employees ever been convicted for an act committed in violation of any law or ordinance other than traffic offences YES NO

If YES, please give details

FINANCIAL INFORMATION

1. When was your immediate past financial year end _____

2. Please state:

	As at immediate past financial year end	As at previous inancial year end
Gross revenue from fees	R _____	R _____
Gross revenue from any other source	R _____	R _____
Provide details		
Total revenue	R _____	R _____

CLAIMS EXPERIENCE

1. Have any claims ever been made against the proposed Insured/Partners/Directors/Members or Employees for the type of cover for which you are now applying YES NO

If YES, please provide full details

2. Are any of the Proposed Insured/Partners/Directors/Members or Employees, after enquiry, aware of any circumstances which would be covered under a policy of this type that may result in any claims or a possible claim being made against YES NO

If YES, please provide full details

INSURANCE HISTORY

1. Are you in the present or have you in the past been insured YES NO

If YES, then please state:

1.1 Name of Insurer _____

1.2 Limit of indemnity _____

1.3 Excess (each and every claim) _____

1.4 Premium _____

1.5 Date of expiry of coverage _____

1.6 Retro-active date _____

2. For the type of insurance now being proposed:

- | | | |
|--|-----|----|
| 2.1 Did any Insurer ever decline to quote or renew insurance | YES | NO |
| 2.2 Did any Insurer require an increased premium or impose special terms | YES | NO |
| 2.3 Did any Insurer ever cancel your insurance | YES | NO |

If any answer is YES to any of the above questions (2.1 to 2.3), please provide full details:

REQUIRED COVER

- | | | |
|---|-------|---|
| 1. Please state what Limit(s) of Indemnity you require us to quote on | Limit | R |
| <hr/> | | |
| 2. If you currently have insurance in place for the same cover now being applied for and you require us to agree to the same retroactive date as is in place currently, please attach to this proposal form the signed copy of your current insurance policy schedule. Note that we will only agree to your current insurance’s retroactive date on condition that your insurance has been in place uninterrupted and subject to any other terms and conditions we may apply, if any. | | |

ADDITIONAL INFORMATION

Is there any further information that should be made known to the Underwriters in order that they may form a proper estimate of the risk YES NO

If YES, please attach relevant brochures or publications, copies of contract conditions, or provide full details on a separate page.

DECLARATION

We declare that the statements and particulars in this Proposal Form are true to the best of our knowledge and belief and that we have not misstated, suppressed or omitted any material facts.

We agree that this Proposal Form together with any other information supplied by us shall form the basis of any contract of Insurance effected thereon and shall be incorporated therein.

We undertake to inform Insurers of any material alteration of these facts whether occurring before or after completion of the contract of Insurance.

Signing this Proposal Form does not bind the Proposer to complete this Insurance.

We acknowledge that if this proposal is accepted, the contract of insurance will be subject to the terms and conditions as set out in the policy wording as issued or as otherwise specifically varied in writing by Insurers.

PROTECTION OF PERSONAL INFORMATION

In order to provide you with insurance, we have to process your personal information. We will share your personal information with other insurers, industry bodies, credit agencies and service providers. This includes information about your insurance, claims and premium payments. We do this to provide insurance services, prevent fraud, assess claims and conduct surveys. We will treat your personal information with caution and have put reasonable security measures in place to protect it. By signing this application for insurance, you agree to the processing and sharing of your personal information.

Dated at _____ on this the _____ day of _____ 20 _____

For and on behalf of _____

Signed by:

Partner/Director/Member

Partner/Director/Member

PLEASE NOTE: This Proposal Form should be completed by YOU and signed by YOU. If the Proposal Form has been completed by your BROKER, review the Proposal Form before signing it. DO NOT sign a BLANK Proposal Form.