

Western World Insurance Company
 Tudor Insurance Company

Application
 For
Health and Exercise Studios

1. Name of Applicant: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Applicant's Web Site Address: _____

2. Type of Organization: Individual Partnership Corporation Other
 (Please explain.) _____

3. Address of Location to be Insured (If same as above, write "same.")
 Street Address: _____
 City: _____ State: _____ Zip: _____

4. Date Established: _____

5. List full names of individuals or partners and their interests. _____

6. Please provide prior insurance information for this enterprise. If none, check here.

Insurance Company	Policy Period	Limits of Liability	Premium	Type of Coverage	Occurrence or Claims Made

7. Is the applicant engaged in, owned by, associated with or involved in any other enterprise? Yes No
 If yes, please provide full details on Attachment to A52.

8. Provide full details of licensing or certification needed for this operation. _____

Has your license ever been suspended or revoked? Yes No

If YES, provide full details: _____

Do you have any outstanding violations cited in an inspection that have not been corrected? Yes No

If YES, provide full details: _____

Check here if continued on Attachment to A52.

9. Please show number of

_____ Partners, Owners, Officers	_____ Other (Please explain.)
_____ Full Time Staff	_____ Other (Please explain.)
_____ Part Time Staff	_____ Other (Please explain.)
_____ Independent Contractors	_____ Other (Please explain.)

10. Hours of Operation: From: _____ To: _____
 Are there any unstaffed hours of operation? Yes No
 If YES, please explain: _____
 If members can use the facility when it is unstaffed, are there security cameras or other monitoring devices on premises? Yes No
 If YES, please describe: _____
 If there are security cameras, is monitoring on a "real time" basis? Yes No
 If YES, who monitors? _____
11. During the past **three (3) years**, have any claims been presented to your current or prior insurance carrier(s)? *If yes, please provide description of claim(s), date of loss, amount(s) paid and reserved on Attachment to A52.* Yes No
12. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? Yes No
If yes, please provide full details on Attachment to A52.
13. Has the applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy cancelled or non-renewed in the past **three (3) years**? Yes No
If yes, please provide full details on Attachment to A52.
14. Please provide the following facilities information.
- TANNING:**
 Any spray tanning operations? Yes No Are beds/booths controlled by timers? Yes No
 If spray tanning, is use of eye and hair protection required? Yes No Are FDA warning signs posted? Yes No
 Number of beds/booths _____
 Who controls the timers? _____ Location of timers? _____
 Percentage of? UVA Bulbs _____ % UVB Bulbs _____ %
 Are clients required to use goggles? Yes No List tanning sales. \$ _____
 Are all beds cleaned after each use? Yes No
- POOLS:**
 Does the facility have a pool? Yes No Is a lifeguard on duty? Yes No
 List the height of diving board(s) _____
 Are water depths marked on the pool? Yes No List maximum water depth _____ Feet
 Does pool comply with requirements of Federal Virginia Graeme Baker Pool & Spa Safety Act? Yes No
 Drain covers meet the ANSI/ASME A112. 19.8-2007 standard on **EVERY** drain/grate? Yes No
 Pool has an automatic shut-off system, gravity drainage system, Safety Vacuum Release System, suction limiting vent system or disabled drain? Yes No
 Are dual or multiple drains at least three (3) feet apart? Yes No
- COURTS:**
 Does the facility have racquet ball/tennis/handball court(s)? Yes No List # of courts. _____
 Is eye protection mandatory for all racquetball players? Yes No
- MARTIAL ARTS STUDIOS**
 List all styles and disciplines taught.
 Provide list of Protective equipment used by students: _____
-
- Are students or their parents/guardians (for minors) required to sign liability waivers and/or hold harmless agreements? Yes No
 Any use or sale of Martial Arts weapons? Yes No
- NUTRITIONAL COUNSELING/DIET CLINICS**
 Are any diets recommended under 1000 calories per day? Yes No
 Are counselors trained/credentialed in nutritional counseling? Yes No

OTHER OPERATIONS

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Nutritional Counseling | <input type="checkbox"/> Snack/Juice Bar/Restaurant (List type of food.) | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Jogging Track |
| <input type="checkbox"/> Whirlpool | <input type="checkbox"/> Sauna/Steam Room | <input type="checkbox"/> Trampoline | <input type="checkbox"/> Climbing Wall |
| <input type="checkbox"/> Treadmills | <input type="checkbox"/> Nautilus Type Equipment | <input type="checkbox"/> Boxing or Wrestling Exposures | |
| <input type="checkbox"/> Free Weights | <input type="checkbox"/> Contact Kick Boxing | <input type="checkbox"/> Sales of Martial Arts Weapons | |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Blood analysis | <input type="checkbox"/> Sales of Food Supplements including vitamins | |
| <input type="checkbox"/> Stress Testing | <input type="checkbox"/> Climbing walls (complete Supplementary App A 82) | <input type="checkbox"/> Floatation tanks/sensory deprivation chambers | |
| <input type="checkbox"/> Spa Services | <input type="checkbox"/> Gymnastics – with gymnastic apparatus | <input type="checkbox"/> Personal Trainer | |
| <input type="checkbox"/> Dance Studio | <input type="checkbox"/> Medically Monitored Exercise programs | | |

List other equipment or facilities _____

15. Do showers, pool, whirlpool area and steam room have non-skid floors? Yes No
16. List any products sold on premises. _____

Check here if continued on Attachment to A52.

17. Is childcare provided for clients? Yes No
 Number of children under care at any one time. _____ Number of child care attendants. _____
 Age of youngest child accepted. _____ Are sick children accepted? Yes No
18. Total # of Members _____ Average Member Age _____
 Are all members required to sign a waiver of liability form? Yes No
 Are all new members trained in the proper use of the equipment? Yes No
19. Are medical examinations required for new members? Yes No
20. Do staff members have training in CPR and First Aid? Yes No
21. Is there a defibrillator on the premises? Yes No If YES, have employees been trained in its use? Yes No
 What is the procedure for handling accidents or injuries? _____

Check here if continued on Attachment to A52.

22. Annual Sales \$ _____ Hours of Operation: From: _____ To: _____
23. Name and phone number of person to contact for inspection/audit.
 Name _____ Phone _____
24. **Limits of Insurance Requested:**
 General Aggregate Limit (Other Than Products – Completed Operations) \$ _____
 Products – Completed Operations Aggregate Limit \$ _____
 Personal and Advertising Injury Limit \$ _____
 Each Occurrence Limit \$ _____
 Damage to Premises Rented by You (Up To \$100,000 Limit Available) \$ _____ Any One (1) Premises
 Medical Expense Limit (Up To \$5,000 Limit Available) \$ _____ Any One (1) Person
 Each Professional Incident Limit (If Applicable) \$ _____
25. Effective Dates Desired - From: _____ To: _____

FOR SEXUAL MOLESTATION COVERAGE , PLEASE COMPLETE QUESTIONS 26 THROUGH 30.

\$25,000/50,000 limit is included at no additional charge. Higher limits are available for an additional premium charge (see below). If sexual molestation coverage is not desired, please check here Coverage is NOT requested.

26. Has your facility had any incidents or claims brought against it for sexual molestation? or any other allegation of misconduct? Yes No
 Please provide details: _____

27. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? Yes No

Describe: _____

28. Does your facility do background checks on all employees and volunteers? Yes No

Describe type of checks performed (prior employer, police, etc.) _____

29. Are there written guidelines in place regarding sexual misconduct? Yes No

If NO, please explain: _____

30. Please check the limits you are requesting:

\$25,000/50,000 – included \$50,000/100,000 \$100,000/300,000 Other

Applicant's Signature: _____

Date: _____

Title: _____

Producing Agent: _____

