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ALLIED MEDICAL EXERCISE & HEALTH STUDIOS SUPPLEMENTAL APPLICATION

SUBMIT WITH ACORD APPLICATION

APPLICANT'S INFORMATION: DESIRED EFFECTIVE DATE:

APPLICANT NAME:				
BUSINESS NAME:				
INSPECTION CONTACT:			PHONE:	
MAILING ADDRESS:				
CITY, STATE, ZIP:				
INSURED ADDRESS:	☐ Same as above			
TYPE OF ENTERPRISE:	☐ Corporation	☐ Individual	☐ Partnership	☐ Municipality
	☐ For Profit	☐ Joint Venture	☐ 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? ☐ No ☐ Yes
   Are goggles provided? ☐ No ☐ Yes
   Are beds manufactured in the United States? ☐ No ☐ Yes
   Self-timers? ☐ No ☐ Yes
   Are beds UL approved? ☐ No ☐ Yes
   Have all employees received training in the use of timers? ☐ No ☐ Yes
6. Is there a pool on the premises? ☐ No ☐ Yes
   Are rules posted? ☐ No ☐ Yes
   Lifeguard on duty? ☐ No ☐ Yes
   If "Yes," is diving board at the deepest end of the pool? ☐ No ☐ Yes
   What is the depth at the deepest end?__________ Are there depth markers? ☐ No ☐ Yes

7. Check any of the following facilities or activities that are available:

☐ Aerobics ☐ Trampolines ☐ Nutritional Counseling
☐ Gymnastics ☐ Electrode Machines ☐ Weight Machines/Free Weights
☐ Body Wraps ☐ Stress Testing ☐ Blood Analysis
☐ Karate ☐ Climbing Wall ☐ Weight Loss/Diet Centers ☐ Protein diet plans

8. Any shower facilities? ☐ No ☐ Yes
If "Yes," do they have non-skid floors? ☐ No ☐ Yes
a. Sauna or Steam facilities? ☐ No ☐ Yes
b. Jacuzzi? ☐ No ☐ Yes

9. Number of Tennis Courts? ______________
Number of Racquetball/Handball courts? ______________

10. Are child care facilities provided? ☐ No ☐ Yes
If "Yes," maximum number of children at one time: ______________
a. Age of youngest child you will accept: ______________
b. Number of child care attendants: ______________

11. Pro shop on premises? ☐ No ☐ Yes
If "Yes," gross sales: ______________
a. Do you sell any diet/nutritional supplements? ☐ No ☐ Yes
If "Yes," please explain:______________________________
b. Are any products manufactured under your specifications or sold under your label? ☐ No ☐ Yes
If "Yes," please explain:______________________________

12. Snack bar/Restaurant on premises? ☐ No ☐ Yes
If "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?______________________________

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16. Does your staff have training in CPR and First Aid? ☐ No ☐ Yes

17. Hours of operations: Day(s) of the Week:______________From:______________To:______________
Day(s) of the Week:______________From:______________To:______________
Day(s) of the Week:______________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:
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 years, have any claims been presented to your current or prior insurance carrier or to you? ☐ No ☐ Yes
If "Yes," provide full details (include description of claim, amounts paid, and reserves):______________________________

____

21. Is applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? ☐ No ☐ Yes
If "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 non-renewed in the past five years? ☐ No ☐ Yes
If "Yes," provide full details:____________________

23. Additional Comments and Interests:____________________

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Please attach copies of all contractual agreements including those involved in off-premises training.

* Any person who knowingly and with intent to defraud any insurance company or other 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

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. Application MUST be currently signed, completed and dated to be considered for quotation.