

- Western World Insurance Company
- Tudor Insurance Company
- Stratford 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. \_\_\_\_\_

Check here if continued on Attachment to A52.

9. Please show number of
  - \_\_\_\_\_ Partners, Owners, Officers
  - \_\_\_\_\_ Full Time Staff
  - \_\_\_\_\_ Part Time Staff
  - \_\_\_\_\_ Independent Contractors
  - \_\_\_\_\_ Other (Please explain.) \_\_\_\_\_
  - \_\_\_\_\_ Other (Please explain.) \_\_\_\_\_
  - \_\_\_\_\_ Other (Please explain.) \_\_\_\_\_
  - \_\_\_\_\_ Other (Please explain.) \_\_\_\_\_

Yes  No Unstaffed Hours – If yes, please explain. \_\_\_\_\_

10. 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
11. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? *If yes, please provide full details on Attachment to A52.*  Yes  No
12. 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**? *If yes, please provide full details on Attachment to A52.*  Yes  No

13. Please provide the following facilities information.

Any spray tanning operations?  Yes  No      Are beds/booths controlled by timers?  Yes  No  
 Who controls the timers? \_\_\_\_\_      Location of timers? \_\_\_\_\_  
 Percentage of? UVA Bulbs \_\_\_\_\_ %      UVB Bulbs \_\_\_\_\_ %  
 Are clients required to use goggles?  Yes  No      List tanning sales. \$ \_\_\_\_\_  
 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  
 Does the facility have racquet ball/tennis/handball court(s)?  Yes  No      List # of courts. \_\_\_\_\_  
 Nutritional Counseling       Snack/Juice Bar/Restaurant (List type of food.) \_\_\_\_\_  
 Whirlpool       Sauna/Steam Room       Aerobics       Jogging Track  
 Treadmills       Stairclimbers       Trampoline       Climbing Wall  
 Free Weights       Contact Kick Boxing       Boxing or Wrestling Exposures  
 List other equipment or facilities \_\_\_\_\_

14. Do showers, pool, whirlpool area and steam room have non-skid floors?  Yes  No

15. List any products sold on premises? \_\_\_\_\_

Check here if continued on Attachment to A52.

16. 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

17. Total # of Members \_\_\_\_\_      Average Member Age \_\_\_\_\_

18. Are medical examinations required for new members?  Yes  No

19. Do staff members have training in CPR and First Aid?  Yes  No

20. Is there a defibrillator on the premises?  Yes  No

What is the procedure for handling accidents or injuries? \_\_\_\_\_

Check here if continued on Attachment to A52.

21. Annual Sales \$ \_\_\_\_\_      Hours of Operation – From: \_\_\_\_\_ To: \_\_\_\_\_

22. Name and phone number of person to contact for inspection/audit.

Name \_\_\_\_\_      Phone \_\_\_\_\_

23. **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 \$50,000 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) \$ \_\_\_\_\_

24. Effective Dates Desired – From: \_\_\_\_\_ To: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_      Date: \_\_\_\_\_

Title: \_\_\_\_\_      Producing Agent: \_\_\_\_\_

