CRYO/FLOAT/WELLNESS CENTER INSURANCE APPLICATION

COMPLETE ONLY WHAT IS OUTLINED IN BLUE

Applicant Name: _____Phone Number: _____Mobile Number:_____

Business Name: _____

Email Address: _____ Website: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Business Address (1): _____

City: _____ State: _____ Zip code: _____

Type of Facility: _____ Square Footage: _____

Business Address (2): _____

City: _____ State: _____ Zip code: _____

Type of Facility: _____ Square Footage: _____

Business operated as: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Individual ☐ Independent Contractor

Business Operated as a Medispa? ☐ Yes ☐ No If Not, other: _____

How long in business? _____ Annual gross receipts from all operations? _____

Are you in compliance with all City, County and/or State Ordinances? ☐ Yes ☐ No

Do all professionals have licenses? ☐ Yes ☐ No

Are you teaching and/or offering in-house training? *(if yes, separate application required)* ☐ Yes ☐ No

Will you have other operations you do not wish to cover on this policy? ☐ Yes ☐ No

If Yes, provide details: _____

Do you need General Liability? ☐Yes ☐ No If no, what Company insures your General Liability coverage? _____

If Yes, Answer Below

Are you required to name any other person or entity as an Additional Insured on your Policy? ☐ Yes ☐ No

a. If Yes, please provide Name and Address: _____

_____

b. What is the interest of the Additional Insured? ☐ Landlord ☐ City or Government Agency ☐ Lessor ☐ Franchisor

☐ Other: _____

c. Does the additional Insured require the following: ☐ Primary/ Non Contributory Wording ☐ Waiver of Subrogation

Products Liability needed for take home products sold by you ☐ Yes ☐ No Gross receipts (excluding private label): _____

Do you private label products for sale? ☐ Yes ☐ No *If Yes, requires separate application*

Pick the best ONE for each technician	**Number to be Insured**
Beauty Services: *Hair, Nails, Eyelash & Brow Enhancements, Sugaring, Waxing, Threading, Topical Makeup Application*	
Massage Therapy: *Massage, Body Wraps, Endermologie, Reiki*	
Medical Aesthetics : *All beauty services AND Facials, Aesthetic Peels, Body Wraps, Massage, Electrology, Microdermabrasion, Ear Piercing, Ear Candling, Airbrush Tanning, Aesthetic Body Treatments, Needling/Collagen Induction Therapy, Medical Grade Peels, Cosmetic Ultrasound, LED/Microcurrent, Aesthetic Radio Frequency, Demaplaning, Wart Removal, Skin Tag Removal and *Cryo Spot Treatments*	
Cryo Spot Treatments is not CRYO facials or localized therapy. Skip this section **Total Number of Operators:**	

If you provide any of the following, please indicate how many operators – *may require separate application*

☐ Tattooing/ Body Piercing: _____ ☐ Permanent Makeup: _____ ☐ Personal Trainers: _____ ☐ Acupuncture: _____

☐ Removal of Warts: _____ ☐ Removal of Moles: _____ ☐ Colon Hydrotherapy: ____ ☐ Acne Subcisions: _____
(NP/MD Only)

OPERATOR SECTION

SECTION I: LIGHT/ENERGY If this Section does not apply, Check Here ☐

Includes IPL, Laser, Medical, Cold, and/or High Heat Radio Frequency, Ultrasound, High Frequency (not listed on page 1)

	Name of Operator	Medical Designation (if any)	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	
4.	

Indicate Service (s) being performed with Light/Energy Devices

☐ Hair Removal ☐ Photo Rejuvenation ☐ Skin Tag Removal ☐ Acne Treatments

☐ Rosacea ☐ Tattoo Removal ☐ Body Contouring/Cellulite Reduction ☐ Pain Therapy

☐ Age/Sun Spots ☐ Nail/Toe Fungus ☐ Wrinkle Reduction ☐ Psoriasis

☐ Acupuncture for Smoking Cessation and/or Allergy Testing ☐ Veins (Up to 3.0mm, Spider Veins) ☐ Vitiligo

☐ Vaginal Rejuvenation ☐ Intra Oral Tightening ☐ Energy Wave Therapy ☐ Scar Revision

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

☐ I am submitting my own consent and medical history form ☐ I will use PPIB consent and medical history approved forms

Do you provide goggles or eye shields to clients for all Laser/IPL work on faces? ☐ Yes ☐ No ☐ N/A

Are you in compliance with all FDA and State laws as to use Light/Energy Devices? ☐ Yes ☐ No

On Behalf of ALL Light/Energy Operators endorsed herein, I understand:

1. The Fitzpatrick Scale. I will not be insured to work on Skin Types V & VI unless I have 6 months of experience with Laser/IPLs
2. It is warranted that for Class III & IV devices googles must be worn by all people in the room at all times while the laser is in use. All reflective surfaces will be covered.
3. Every Client must sign a consent and medical history form. No coverage will apply if there is not a signed form on file.
4. For Class IV laser use, the room door will stay locked at all times while the laser is in use or a sign must be posted on door: LASER IN USE, DO NOT ENTER.
5. I understand there is no coverage for EMLA anesthetic use with laser/IPL.
6. No insurance will be offered for the following treatments
   - I. Any raised tissue with its own blood supple (such as moles).
   - II. Skin that is unclerated, broken (not Intact) blistered or has open sores.
   - III. Bulging veins, veins or cherry hemangiomas over 3.0mm.
7. I understand coverage for laser hair removal work on individuals under the age of 14 is excluded.
8. I understand all new Laser/IPL technicians must have 6 months' experience or 30 hours of training to be eligible for Laser/IPL use.
9. If I use Class III & IV Device (s), I will only use those that have been approved for sale by the FDA

Signature of Applicant: _____ **Date:** _____

MEDISPA SECTION

SECTION II: INJECTABLE PROFESSIONAL **If this Section does not apply, Check Here** ☑

	Name of Operator	Medical Designation (if any)	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	
4.	

Indicate Service (s) being performed

☐ Botox/Dysport/Xeomin ☐ Botox for Hyperhidrosis ☐ Botox for Platysmal Bands ☐ Botox for Masseters

☐ FDA Approved Dermal Fillers ☐ Dermal Fillers on Hands ☐ Dermal Fillers on Ear Lobes ☐ Carboxy Therapy

☐ Mesotherapy ☐ Sclerotherapy ☐ Blood Draws ☐ IV Therapy

☐ Flu Shots ☐ Chelation Therapy ☐ Kybella

☐ Vitamins/Supplements - *includes injection of Vitamin A, B, C, D, E, and K, Amino Acids and other Dietary Supplements*

☐ Allergy Immunotherapy (describe): _____

☐ Other: _____

Do you perform PRP Injections? ☐ Yes ☐ No If yes, indicate what PRP is used for below

☐ Vampire Face Lift ☐ Breasts Enhancements ☐ Hair Stimulation ☐ Vitiligo

☐ Wound Healing ☐ Joint Pain Reduction ☐ O Shot ☐ Priapus Shot

☐ Prolotherapy (describe): _____

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Are you in compliance with all AMA and/or State Laws as to use of Injectable Products? ☐ Yes ☐ No

On Behalf of ALL Injectable Operators endorsed herein, I understand:

1. I will only have coverage in specified facilities unless the no location limitation endorsement is purchased.
2. I will only buy injectables from Manufacturer directly or their approved wholesalers.
3. In regards to Mesotherapy, products must be purchased from licensed compounding pharmacies (acceptable ingredients only).
4. Botox, Dysport, Xeomin is only provided for work on patients over 18.
5. Every client must sign a consent form and no coverage will apply if there is not a signed form on file.
6. There is no coverage for prescription medications, except for anesthetics used with injectables, unless endorsed on.
7. In regards to Sclerotherapy, there is no coverage for work on veins over 3.00mm in diameter.
8. I understand each technician must have specific training or 6 months experience to be eligible for injectable coverage.

Signature of Applicant: _____ Date: _____

MEDISPA SECTION

SECTION III: WELLNESS PROFESSIONAL If this Section does not apply, Check Here ☑

	Name of Operator	Medical Designation (if any)	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	
4.	

Indicate Service (s) being performed

☐ hCG ☐ Phentermine ☐ Tenuate/Diethylpropion ☐ Didrex

☐ Phendimetrazine ☐ Belviq/Qsymia ☐ Nutritional/Diet Counseling ☐ Wellness Analysis

☐ Orlistat ☐ Bioidentical Hormones ☐ Ingestible Vitamins/Supplements ☐ Contrave

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Are you in compliance with all FDA and State Laws as to Weight Loss/ Hormone Services? ☐ Yes ☐ No

On Behalf of ALL Wellness Professionals, I confirm that my medical history and/or consent forms address the following:

1. No Guarantee of Results
2. There is a question regarding if client is pregnant, nursing or trying to get pregnant

Signature of Applicant: _____ Date: _____

SECTION IV: UNITS/DEVICES **If this Section does not apply, Check Here ☐**

Indicate Number of Units for each

Showers #: _____ Saunas/Steam Rooms #: _____ Soaking Pools #: _____

Inhalation Oxygen Devices #: _____ UV Tanning #: _____ Foot Detox Units #: _____

Salt Caves #: _____ Hyperbaric Oxygen Chambers #: _____ Flotation Devices #: _____

LED Teeth Whitening #: _____

Do you provide customers with home whitening products? ☐ Yes ☐ No

If Yes, do you provide written instructions for home use? ☐ Yes ☐ No

On Behalf of all LED Teeth Whitening Technicians, I Understand:

1. Ever client must sign a consent and dental history form. No coverage will apply if there is not a signed form on file
2. There is no coverage for any prescription anesthetic use
3. A written doctor's approval will be on file for treatment on pregnant women

Signature: _____ Date: _____

LED Hair Stimulation #: _____

Have all operators been trained in LED Hair Stimulation? ☐ Yes ☐ No

On Behalf of all LED Hair Stimulation Technicians, I understand:

1. Coverage is excluded for any guarantees of hair growth
2. Coverage is available only for units designed specifically for hair stimulation
3. For Coverage to apply, only trained technicians will turn on or operate the device
4. A signed consent & medical history form must be on file

Signature: _____ Date: _____

CRYOTHERAPY SECTION

SECTION V: CRYOTHERAPY If this Section does not apply, Check Here ☐

Total Number of Units excluding cryo pens: _____

Manufacturer of each Cryotherapy Unit: _____

Does your Liquor Nitrogen provider has specific limit requirements? ☐ Yes ☐ No

If Yes, please describe limits: _____

_____

Are you required to name them as an Additional Insured? ☐ Yes ☐ No

If Yes, please provide Name and Address: _____

_____

Do they require the following? ☐ Primary/ Non Contributory Wording ☐ Waiver of Subrogation

On Behalf of ALL Cryotherapy Operators, I understand:

1. That all cryotherapy units are single person booths, no multi – person "walk – in" booths are being used
2. The patients head must be elevated outside the chamber at room temperature at all times
3. Patients are provided with appropriate protective clothing to prevent rapid freezing
4. Waivers/ Consent Forms including possible side effects are used and signed by the patient before every Cryotherapy procedure
5. Cryotherapy Services are only available to patients age 18 and older
6. Cryotherapy Sessions are no longer than 3 mins at temperatures no lower than -200°F
7. Patients are supervised at all times while undergoing Cryotherapy
8. All technicians have been property trained

Signature of Applicant: _____ Date: _____

SECTION VI: MEDICAL DIRECTOR SECTION **If this Section does not apply, Check Here ☑**

Is there a Medical Director on your staff? ☐ Yes ☐ No

Do they work out of your office? ☐ Yes ☐ No

Name and Degree of your supporting Doctor? _____

Do you want to cover the doctor as Medical Director on the policy? ☐ Yes ☐ No

If yes, indicate any claims they have had in their medical career: _____

Is the doctor a medical director for other facilities? ☐ Yes ☐ No

If so, should coverage be extended? ☐ Yes ☐ No

Number of Facilities: _____ For what Services: _____

Does your Medical Director offer Direct Patient Care for services no otherwise listed on the application? ☐ Yes ☐ No

If Yes, Describe Services: _____

Does your Medical Director offer prescriptions not otherwise listed herein? ☐ Yes ☐ No

If Yes, List : _____

Will there be any Medical Assistants on staff? (If yes, answer below) ☐ Yes ☐ No

	Name	Services assisting with
1.		
2.		
3.		

MEDISPA SECTION

SECTION VII: INVASIVE PROCEDURES **If this Section does not apply, Check Here** ☑

	Name of Operator	Medical Designation	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	

Indicate Service (s) being performed ***Additional Premium May Apply***

☐ Neograft Hair Transplant ☐ Fue/Strip Hair Transplant ☐ Upper Blepharoplasty ☐ Fat Transfers

☐ Silhouette Face Lift ☐ PDO Threading ☐ Mini Tummy Tucks ☐ Tickle/Smart Lipo

☐ Tumescent Liposuction ☐ Laser/Ultrasound Assisted Lipolysis

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Advise what kind of anesthetics, if any, do you use? _____

Devices being used for procedures: _____

If you are doing Fat Transfers Answer the following?

A. Indicate Method of Removal: _____

B. Indicate the areas you re-inject: _____

C. Do you use the Brava System or something similar for injections in the breasts? ☐ Yes ☐ No ☐ N/A

D. Do you reinject fat into the person that is was removed from? ☐ Yes ☐ No

Signature of Applicant: _____ Date: _____

SECTION VIII: OTHER COVERAGE OPTIONS - OPTIONAL **If this Section does not apply, Check Here** ☐

Do you want coverage for Defense Outside the Limit? ☐ Yes ☐ No

Do you want coverage for HIPAA Reimbursement? ☐ Yes ☐ No

Do you want coverage for Sexual Abuse? ☐ Yes ☐ No

If Yes, what limit ☐ $25k/$50k ☐ $50K/$100k ☐ $100/$200K ☐ Other: _____

Do you want coverage for Property? *(separate application required)* ☐ Yes ☐ No

Do you want coverage for Cyber Protection? ☐ Yes ☐ No

What other services not listed already do you want coverage for? _____

_____

_____

SECTION IX: HISTORY

Note – ALL questions must be answered. Failure to disclose claims history could invalidate coverage

Do you Currently have Insurance coverage ☐ Yes ☐ No

Insurer	***Policy #***	***Liability Limits***	***Premium***	***Exp. Date***

If Claims Made, most Recent Retroactive Date: _____

Have you ever had professional liability insured refused, declined, cancelled or accepted on special terms? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

Has any liability suit, arbitration or other claim proceeding been brought against you, your business or any applicant for any alleged malpractice? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

Do you, or any applicant, have knowledge of an event, circumstance or occurrence prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? *If yes, describe details on a separate sheet* ☐ Yes ☐ No

Has any applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by, or to, any state or federal licensing board or regulatory agency? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

Have you ever or any applicant ever been charged or convicted of a criminal offense? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

ATTESTATION

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued. I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy. I understand this insurance is being provided through a surplus lines company and the insurer is not subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BE COMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY.

By signing below, I confirm on behalf of all technicians covered under this policy:

1. Technicians are licensed as necessary for all services being provided.
2. Technicians do not use any product that contains more than 2% formaldehyde.
3. I understand that no service or individual is covered unless listed and a premium paid.
4. That all technicians have been trained for the service they are performing or on the device they are using.
5. I understand that no coverage is provided under this policy for invasive or surgical procedures unless specifically listed

_____ _____

APPLICANT SIGNATURE **TITLE**

_____ _____ _____

DATE SIGNED **REQUESTED EFFECTIVE DATE** **LIABILITY LIMIT REQUESTED**

Can we Email your policy? (usually within 2-3 weeks) ☐ Yes ☐ No _____@_____

One box below must be checked:

☐ I ELECT TO PURCHASE TERRORISM COVERAGE AT AN ADDITIONAL PREMIUM

☐ I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT AN ADDITIONAL PREMIUM

LOCATION #1: Business Property Application

1.1 Applicant Name:_____ Phone:_____ Mobile:_____

Business Name:_____ Website:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Business Address:_____

County: _____ Square Footage of Business_____

Business operated as: ☐ Corporation ☐ Partnership ☐ Individual ☐ Independent Contractor ☐ LLC

1.2 Business operated as medispa? ☐ Yes ☐ No If not, other:_____

PROPERTY SECTION **MUST INSURE FOR AT LEAST 80% OF THE REPLACEMENT COST**

2.1 Age of building:_____ Construction:_____ Number of stories:_____

2.2 If building is over 20 years old, when were the following upgraded? **(*) Information is Required**

*Roof:_____ *Plumbing:_____ *Wiring:_____ Sprinklers: **Yes** ◯ **No** ◯

2.3 *Is there a Central Station Burglar Alarm? **Yes** ◯ **No** ◯ If yes, advise alarm provider:_____

*If yes, is the aforementioned alarm inside of your unit, active, and in your control? **Yes** ☐ **No** ◉

2.4 Other Occupancies in and next to building? (Describe)_____

2.5 Approximate distance from fire station:_____ Distance from fire hydrant:_____

2.6 Do you sell items not directly related to beauty or skincare? **Yes** ◯ **No** ◯ Inventory Value ($):_____

If yes, describe:_____

2.7 Name & address of loss payee:_____

COVERAGES DESIRED

A. CONTENTS - Total Limit Needed **EXCLUDING** LIGHT/ENERGY DEVICES: $_____ **Business Contents**

Total Limit Needed for **LIGHT/ENERGY DEVICES** (Such as Laser, IPL, Radiofrequency, Ultrasound, etc) $_____ **Devices/Equipment**

Does **ANY** of the contents noted above belong to employees or independent contractors that work under your business name? Yes ◯ No ◯

B. TENANT IMPROVEMENTS - Limit Needed: $_____

C. BUILDING - Do you own the building? Yes ◯ No ◯ Limit Needed: $_____

If yes, are there any tenants besides your business? Please explain:_____

If no, do you have a Triple Net Lease? Yes ◯ No ◯

D. BUSINESS INTERRUPTION - Amount per Month: _____ For how many months? _____

E. OUTDOOR SIGN(S) - Limit Needed: $_____

OPTIONAL COVERAGES (Additional Premium Will Apply)

☐ **Contingent Business Income** (Utility related Business Interruption) ☐ **Spoilage** (Temperature change on perishable items)

☐ **Coverage Extension** ($15,000 Blanket Total for: equipment breakdown, accounts receivable, valuable papers)

HISTORY

3.1 List all property claims in the past 5 years, whether or not insured:_____

_____

3.2 Current property insurance carrier, policy number:_____

COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

_____ _____

APPLICANT SIGNATURE DATE

LOCATION #2: Business Property Application

1.1 Applicant Name:_____ Phone:_____ Mobile:_____

Business Name:_____ Website:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Business Address:_____

County: _____ Square Footage of Business_____

Business operated as: ☐ Corporation ☐Partnership ☐Individual ☐Independent Contractor ☐LLC

1.2 Business operated as medispa? ☐ Yes ☐ No If not, other:_____

PROPERTY SECTION **MUST INSURE FOR AT LEAST 80% OF THE REPLACEMENT COST**

2.1 Age of building:_____ Construction:_____ Number of stories:_____

2.2 If building is over 20 years old, when were the following upgraded? **(*) Information is Required**

*Roof:_____*Plumbing:_____*Wiring:_____Sprinklers: **Yes** ◯ **No** ◯

2.3 *Is there a Central Station Burglar Alarm? **Yes** ◯ **No** ◯ If yes, advise alarm provider:_____

*If yes, is the aforementioned alarm inside of your unit, active, and in your control? **Yes** ◯ **No** ◯

2.4 Other Occupancies in and next to building? (Describe)_____

2.5 Approximate distance from fire station:_____Distance from fire hydrant:_____

2.6 Do you sell items not directly related to beauty or skincare? **Yes** ◯ **No** ◯ Inventory Value ($):_____

If yes, describe:_____

2.7 Name & address of loss payee:_____

COVERAGES DESIRED

A. CONTENTS - Total Limit Needed **EXCLUDING** LIGHT/ENERGY DEVICES: $_____ **Business Contents**

Total Limit Needed for **LIGHT/ENERGY DEVICES** (Such as Laser, IPL, Radiofrequency, Ultrasound, etc) $_____ **□e□ices/E□uipment**

Does **ANY** of the contents noted above belong to employees or independent contractors that work under your business name? Yes ◯ No ◯

B. TENANT IMPROVEMENTS - Limit Needed: $_____

C. BUILDING - Do you own the building? Yes ◯ No ◯ Limit Needed: $_____

If yes, are there any tenants besides your business? Please explain:_____

If no, do you have a Triple Net Lease? Yes ◯ No ◯

D. BUSINESS INTERRUPTION - Amount per Month: _____ For how many months? _____

E. OUTDOOR SIGN(S) - Limit Needed: $_____

OPTIONAL COVERAGES (Additional Premium Will Apply)

☐ **Contingent Business Income** (Utility related Business Interruption) ☐ **Spoilage** (Temperature change on perishable items)

☐ **Coverage Extension** ($15,000 Blanket Total for: equipment breakdown, accounts receivable, valuable papers)

HISTORY

3.1 List all property claims in the past 5 years, whether or not insured:_____

_____

3.2 Current property insurance carrier, policy number:_____

COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

_____ _____

APPLICANT SIGNATURE DATE

POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, **as defined in Section 102(1) of the Act, as amended:** The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2020, the date on which the TRIA Program is scheduled to terminate, or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 AND 80% BEGINNING ON JANUARY 1, 2020; OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A USD100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS USD100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED USD100 BILLION, YOUR COVERAGE MAY BE REDUCED.

THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

	I hereby elect to purchase coverage for acts of terrorism for a prospective premium of USD.....
	I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

_____
Policyholder/Applicant's Signature

_____
..... Syndicate on behalf of certain underwriters at Lloyd's

_____
Print Name

_____
Policy Number

_____
Date

LMA9104

12 January 2015