

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

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: \_\_\_\_\_

