

WELLINGTON SPECIALTY INSURANCE COMPANY

EXERCISE & HEALTH SUPPLEMENTAL APPLICATION

Wellington
Specialty
Insurance Company



(All Questions Must be Answered and the Application Must Be Signed by the Applicant)

Agent Name: _____
Agent Address: _____
Applicant Name: _____
Mailing Address: _____
Location Address: _____
Contact Person: _____ Title: _____
Phone Number: _____ Fax Number: _____

LIMITS OF INSURANCE

General Aggregate Limit (Other than Products – Completed Ops) \$ _____
Products – Completed Operations Aggregate Limit \$ _____
Personal & Advertising Injury Limit \$ _____
Each Occurrence Limit \$ _____
Fire Damage Limit (any one fire) \$ _____
Medical Expense Limit (any one person) \$ _____
Deductible \$ _____

BUSINESS DESCRIPTION AND LOCATION OF PREMISES

Corporation Individual Joint Venture Partnership Other (Describe) _____

1. Business Description: _____

2. Location of all premises you own, rent or occupy: _____

3. Years of business at this location: _____

4. Number of the following at this location:

a. Members _____

b. Instructors _____

c. Management Staff _____

d. Supervisory Staff _____

e. Doctors, nurses, LPN, Dietician, etc.

f. Other Employees (Specify): _____

Total Number of employees (add b. through e.) _____

5. Are the instructors employees of the applicant? Yes No

6. If subcontractors are used, are Certificates of Insurance provided? Yes No

7. Are employees trained in CPR, First Aid, etc.? Yes No

8. Are eye guards required on racquetball/squash courts? Yes No

9. Are incident reports compiled daily for all injuries? Yes No
10. Are release forms signed? (If 'Yes', attach copies) Yes No
11. If the customer is under 18 yrs. old, is the parent's signature required on the release form? Yes No
12. Days and Hours of Operation: _____

13. Indicate if applicant: Owns building Leases building Total square footage of premises: _____

14. Any cooking on the premises? Yes No
 If 'Yes', please describe: _____

15. Is any food or beverage sold on the premises? Yes No
 If 'Yes', please describe: _____

16. Is any liquor served on the premises? Yes No

17. Check appropriate box for applicable operations:

- | | |
|---|---|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Martial Arts (describe): _____ |
| <input type="checkbox"/> Barber/Beauty Shop | <input type="checkbox"/> Masseur |
| <input type="checkbox"/> Basketball Courts | <input type="checkbox"/> Physical Therapists |
| <input type="checkbox"/> Bicycle Tracks | <input type="checkbox"/> Pro Shop |
| <input type="checkbox"/> Body Toning Units | <input type="checkbox"/> Sauna/Steam Room |
| <input type="checkbox"/> Dance Instruction | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Diet Counseling | <input type="checkbox"/> Swimming Pool (see below) |
| <input type="checkbox"/> Game Room | <input type="checkbox"/> Tanning Units (see below) |
| <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Tennis Courts |
| <input type="checkbox"/> Handball, Racquetball or Squash Courts | <input type="checkbox"/> Trampolines (describe): _____ |
| <input type="checkbox"/> Jacuzzi | <input type="checkbox"/> Tumbling |
| <input type="checkbox"/> Jogging Tracks | <input type="checkbox"/> Whirlpool |
| <input type="checkbox"/> Locker Room | <input type="checkbox"/> Other: _____ |

RECEIPTS

18. Gross income from all sources for the last 12 months:

- | | |
|--|----------|
| Clothing - Retail | \$ _____ |
| Membership Fees | \$ _____ |
| Restaurant/Snack Bar | \$ _____ |
| Sports Equipment – Retail | \$ _____ |
| Other – classes etc. (describe): _____ | \$ _____ |
| Total Receipts | \$ _____ |

TANNING UNITS

Equipment Manufacturer	# of Beds	# of Booths	# of Facial	Other	Describe the type & percentage used (UVA, UVB etc.)	When installed	New or Used
							<input type="checkbox"/> New <input type="checkbox"/> Used

19. Tanning units installed by: _____
20. Number of timers: _____ Operated by employees? Yes No
21. Are timers tested and logged daily? Yes No
22. Do the tanning units conform to local building and electrical codes? Yes No
23. Are goggles worn by all patrons? Yes No
24. Are all of the employees trained in the use of timers? Yes No
25. Are all of the units cleaned between patrons' use? Yes No
26. Is the medical history taken for new patrons? Yes No
27. Do patrons get clear information on potentially harmful medications which react to tanning? Yes No
28. Are Hold Harmless cards and sign-in cards maintained on file permanently? Yes No
- *Please attach a sample copy of all client information to this application as well as a copy of the Hold Harmless card and the sign-in card.
29. FDA requires posting the following sign. Have you complied? Yes No

FDA REQUIREMENT – DANGER – Ultraviolet reaction. Follow all instructions. As with natural sunlight, overexposure may cause premature aging of skin and skin cancer. Medications or cosmetics applied to the skin may increase your sensitivity to ultraviolet light. Consult your physician before entering booth if taking medication or if you believe yourself especially sensitive to sunlight.

NURSERY

30. Maximum number of children: _____ Ages: _____ Number of Attendants: _____ Ages: _____
31. Are attendants trained in child care? Yes No
32. Are children allowed to stay if their parents leave the center? Yes No
33. Describe procedures for supervision of the children: _____
34. List the types of play equipment: _____

SWIMMING

- Indoor Outdoor Lap Pool Only Maximum Depth: _____
35. Do you provide lifeguards? Yes No
36. Are rules posted and depths marked? Yes No
37. Is lifesaving equipment provided? Yes No
- If 'Yes', please describe: _____
38. Does the pool have a diving board or slide? Yes No
- If 'Yes', number of meters in height: _____ Describe: _____

39. Enter complete prior carrier information for the preceding 3 years:

	Year:	Year:	Year:
Carrier Name			
Policy Number			
Coverage			
Limits			
Premium			

40. Enter all claims or occurrences that may give rise to claims for the prior 3 years.

Check here if none Attached is a current dated loss summary

Occurrence Date	Line	Claim Details	Date of Claim	Amount Paid	Amount Reserved	Claim Status
						<input type="checkbox"/> Open <input type="checkbox"/> Closed
						<input type="checkbox"/> Open <input type="checkbox"/> Closed
						<input type="checkbox"/> Open <input type="checkbox"/> Closed

41. During the past three years, has any company ever canceled, declined or refused to issue any similar insurance to the applicant? (Not applicable in Missouri) Yes No

If 'Yes", please explain: _____

This application shall not be binding unless and until confirmation by the Company or its duly appointed representatives has been given, and that a policy shall be issued and a payment shall be made, and then only as of the commencement date of said policy and in accordance with all terms thereof. The said applicant hereby covenants and agrees that the foregoing statements and answers are a full and true statement of all the facts and circumstances with regard to the risk to be insured, and the same are hereby made the basis and conditions for the insurance and a warranty on the part of the insured.

Signed: _____ Date: _____

(Applicant's Signature and Title)