



Health club solutions application
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 Telephone: (678) 290-2100 Fax: (678) 290-2200
 Email applications to mscsubmissions@markelcorp.com
 Website: markelinsurance.com

BASIC INFORMATION

Proposed Effective Date: _____

Named Insured: _____

Club Name (DBA): _____

Mailing Address: _____

Primary Contact Name: _____ Business Phone: _____

Cell Phone: _____ Fax: _____ Email: _____

Secondary Contact Name: _____ Business Phone: _____

Website Address: _____ Email: _____

Are you a member of a franchise? Yes No

If so, which one? Club Metro Crossfit Curves Fitness Together Get In Shape for Women
 Gold's Lady of America Orange Theory Express Planet Fitness
 Powerhouse Gym Pure Barre Retro Fitness SuiteSweat World Gym
 Work Out World Other: _____

How did you hear about our program? Email Internet Mailing Referral
 Seminar Other _____

Current Carrier & Limits of Liability: _____

Is this policy being non-renewed? Yes No Expiring Premium: _____

If so, why? Carrier no longer writing this coverage Loss History Other _____

Do you currently have Workers' Comp insurance ? Yes No

If yes, is the coverage with First Comp? Yes No

LIABILITY LIMITS & COVERAGE

General Liability (Including Professional Liability) Limit (choose one):

\$500,000/ \$1,000,000 \$1,000,000/ \$2,000,000 \$1,000,000/ \$3,000,000 \$2,000,000 / \$4,000,000

Abuse Liability Limit :

\$100,000/ \$300,000 \$500,000/ \$1,000,000 \$1,000,000 / \$2,000,000 \$1,000,000 / \$3,000,000

Fire Damage Legal Liability Coverage is provided at limits equal to the General Liability Occurrence Limit

Medical Payments Coverage:

\$0 \$5,000 \$10,000

Stop Gap Limit (Available in ND, OH, WA, WY only)(choose one):

\$100,000 / \$500,000 / \$100,000 \$500,000 / \$500,000 / \$500,000 \$1,000,000 / \$1,000,000 / \$1,000,000

Employee Benefits Liability: _____ Retroactive Date _____ Number of employees per location

Limit (choose one): N/A \$500,000 / \$1,000,000 \$500,000 / \$ 1,500,000 \$1,000,000 / \$1,000,000
 \$1,000,000 / \$ 2,000,000 \$1,000,000 / \$ 3,000,000

Hired Non-Owned Auto Liability: (Only available if you do not have any owned autos)

No Coverage Both Hired and Non-Owned Hired Coverage Only Non-Owned Coverage Only

BUSINESS INFORMATION

Form of Business: Corporation Individual Partnership Joint Venture LLC

Year business started under current ownership: _____

Submission # _____

Health & Fitness Application

(A Copy of this Page is Required for Each Additional Location)

SERVICES

Location # _____

Address: _____

What services do you provide at this location?

- Group Exercise Classes/ Spinning Classes/ Aerobics Classes
- Dance Classes
- Free weights/ Selectorized Equipment
- Martial Arts*
- Boot Camps**
- Children's Parties**
- Children Summer Camp Programs**
- Massage Therapy
- How many treatment rooms? _____
- Estimated Number of Therapists: _____
- Soccer - How many leagues? _____
- Physical Therapy
 - Employee How many? _____
 - 1099 Contractor How many? _____
- Nutritionist
 - Employee How many? _____
 - 1099 Contractor How many? _____
- Hypnotherapist
 - Employee How many? _____
 - 1099 Contractor How many? _____
- Chiropractor
 - Employee How many? _____
 - 1099 Contractor How many? _____
- Child Sitting - Are parents/guardians required to be on premises while the child is in your care? Yes No
- Bounce House - How many inflatables? _____
 - Are there signs clearly marking age, height or size limitations? Yes No
 - Are they inspected by the state and/or you and your employees? Yes No If yes, how often? _____
 - Do you use the manufacturer's checklist for the set up & use of the equipment? Yes No

- Kick Boxing Classes
- Yoga Classes
- Rock Walls*
- Zip Line*
- Tumbling Classes
- Personal Training
- Outdoor Cycling**
- Cross Country Skiing**
- Internet Counseling**
- Indoor Golf**- How Many Courses: _____
- Batting Cages - How Many: _____
- Tanning Beds / Booths* - How Many: _____
- Tennis -How Many Courts: _____
- Racquetball/Squash - How Many Courts: _____
- Basketball -How Many Courts: _____
- Cross Fit - Light Military Combative Other
- Other (including outside activities): _____

- Saunas
- Steam Room
- Day Spa*
- Hiking**
- Water Parks*
- Ropes Course*

(Services with an * require the completion of a supplemental application)

Services with ** require an explanation Please explain: _____

Please advise if any spaces in your facility are dedicated to the following activities:

- Video Sales or Retail Sales Laundry Facility Warehouse - Square Feet of the Warehouse: _____
- Liquor Sales - Percentage of receipts from food/liquor service: _____
- Food Service - Type of Services: Full-service Restaurant Snack/Juice Bar Vending Machines
- Do you have any of the following: Deep Fryer Grill Ansul System

Annual receipts from Food/Liquor Service: _____

Submission #

Health & Fitness Application
(A Copy of this Page is Required for Each Additional Location)

Location # _____

Address: _____

OPERATIONS

Which best describes the operations at this location:

- 24/7 Fitness Center Athletic Club Barber Shop Beauty Salon Corporate Fitness Center
- Day Spa Dance Studio Fitness / Studio Full Service Health/Fitness/Spa
- Health/Fitness Club/Spa Martial Arts Studio Massage Center Nail Salon
- Personal Trainer Studio Pre-sales / Office Yoga, Pilates or Aerobic Studio
- Non Profit Community Center

Annual Revenue (excluding Food Services): _____ Square Footage: _____

Number of Active Members: _____

Do you have a liquor license? Yes No If yes, do you want Liquor Liability Coverage? Yes No

Does this location have any pools, spas, whirlpools, jacuzzi's or hot tubs? Yes No
(If yes, complete pool supplemental)

Do you have any office space at this location? Yes No Square Footage: _____

Do you lease space to others at this location? Yes No Total Square Footage: _____

Tenant: _____ Square Footage: _____ Tenant: _____ Square Footage: _____

Tenant: _____ Square Footage: _____ Tenant: _____ Square Footage: _____

Are Employees/Owners present during all hours of operation? Yes No
(If no, complete 24 hour access supplemental)

Are the clientele at this facility primarily children under the age of 18? Yes No

Digital surveillance is in place and operational at all times? Yes No

Do you have Automatic External Defibrillators on site? Yes No

ADDITIONAL INSURED

List all additional insureds that need to be listed on the policy:

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Submission #

Health & Fitness Application

(A Copy of this Page is Required for Each Location for which property coverage is desired)

BASIC PROPERTY INFORMATION

Location #: _____ Building #: _____

Address: _____

Property Deductible (choose one): \$500 \$1,000 \$2,500 \$5,000 \$10,000 \$25,000
 \$50,000 \$75,000

Wind/Hail Deductible (choose one): Same as all other property Exclude
 Percent - 2% 5%
 Flat - \$1,000 \$2,500 \$5,000 \$10,000 \$25,000
 \$50,000 \$75,000

Property Coinsurance Percentage (choose one): 80% 90% 100%

Construction Type (choose one): Frame Joisted Masonry Masonry Non-Combustible
 Non-Combustible Semi-Fire Resistive Fire Resistive

Is your building sprinklered? Yes No

In what year was the building constructed? _____

If the building is more than 20 years old, insert the year of the latest building updates completed for each category:

Plumbing: _____ Heating: _____ Roof: _____ Electrical: _____

What type of Alarm system is in the building? None Burglar Alarm Fire Alarm Both

Number of Stories: _____

COVERAGES AND LIMITS

Choose the coverages desired or are required to carry:

Building \$ _____ Replacement Cost ACV Inflation Guard _____

Business Personal Property \$ _____ Replacement Cost ACV

Tenant Improvements & Betterments \$ _____ Replacement Cost ACV

Signs (\$1,000 Deductible) \$ _____

Description of sign(s): Attached Free Standing Both

Type of sign(s): Entirely Metal Other

Business Income (72 Hr Wait Period) \$ _____

Does a separate business income coinsurance apply? Yes No

If so, please choose one: 50% 60% 70% 80% 90% 100% 125%

Select the monthly limit of indemnity: 1/3 1/4 1/6 None

PROPERTY ADDITIONAL INTERESTS

List all property additional interest that need to be listed on the policy:

Name: _____

Address: _____

Insured Type: Mortgagee Building Owner Loss Payee Lender's Loss Payee

Name: _____

Address: _____

Insured Type: Mortgagee Building Owner Loss Payee Lender's Loss Payee

For Inland Marine or Crime Coverages, please complete the appropriate Accord application and submit with the completed Health & Fitness Application

Submission #

Health & Fitness Application

QUALIFICATION

Do you have a formal safety program? No Yes

Any policy or coverage declined, cancelled or non-renewed during the prior 3 years? N/A in Missouri. No Yes

Have any crimes occurred or been attempted on your premises within the last 3 years? No Yes

Are you currently in bankruptcy? No Yes

Are any of your employees trained in CPR or First Aid? No Yes

Do you conduct orientation for all new members? No Yes

Do you require signed waivers from all clients? No Yes

Is safety signage used throughout the facility? No Yes

Do you have non-slip surfaces in ALL wet areas? No Yes

Do you have showers in your facility? No Yes

Do you keep equipment maintenance logs? No Yes

Do you manufacture, formulate, private label your own products?(lotions, supplements, equipment, etc.) No Yes

****Coverage is only provided for skin care products. no coverage is provided for any ingested products.**

Any products sold under the insured's name? No Yes

****We do not provide coverage for products sold under your insured's name. You must provide proof of other insurance coverage for products sold under your insured's name.**

Do you use independent contractors? No Yes

If so, do you require proof of independent contractor's insurance? No Yes

LOSS HISTORY

List all losses in the past 3 years whether or not insured(Attach additional sheet if necessary):

Date of Claim	Type of Claim	Description of Claim	Open/Closed	Paid

I AM AWARE THAT THE COMPANY MAY ORDER AN INSPECTION FOR MY PLACE OF BUSINESS AND I AGREE TO COOPERATE WITH THE INSPECTOR(S).

Submission #

Health & Fitness Application Tanning Supplement

How is tanning exposure time controlled? User Operator Token

Is protective eye wear provided for customers? No Yes

If yes, is it sanitized after each use? No Yes

Are the tanning beds sanitized after each use? No Yes

Is the maximum exposure time for tanning within manufacturer guidelines? No Yes

Is a drug reaction list posted in your club? No Yes

Do you manufacture your own tanning beds? No Yes

Are all beds UL listed? No Yes

Are customers required to read & sign an acknowledgement of the risks involved with the tanning exposure? No Yes

Applicant's Signature: _____

Date: _____

Submission #

Health & Fitness Application
24 Hour Access Supplement
(A Copy of this Page is Required for Each Location)

Location #: _____

Address: _____

Do members have key/swipe cards access to facility? No Yes

Do you have a panic system that is monitored by an outside source and was installed as recommended by the vendor? No Yes

If yes, which type of panic system do you have? Hardwired and wall mounted Emergency Necklaces

Are all unauthorized areas of the club locked off with only access to those areas during normal business hours? No Yes

Do you physically inspect the club several times a day to verify unsafe conditions have not developed? No Yes

Do you prohibit the use of the facility from any uninsured personal trainer? No Yes

Do you have specific separate waivers? No Yes

Applicant's Signature: _____

Date: _____

FRAUD WARNINGS

GENERAL STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation). (Not applicable in AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PR, RI, TN, VA, VT, WA and WV).

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI and WV

Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

APPLICABLE IN COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

APPLICABLE IN FLORIDA and OKLAHOMA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (In FL, a person is guilty of a felony of the third degree).

APPLICABLE IN KANSAS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA and WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: _____ Date: _____