

Dear APAA Member

## **APAA Professional Indemnity/Public Liability Insurance**

As one of the many advantages of belonging to the professional organisation that is the Association of Professional Aestheticians of Australia (APAA), we are pleased to offer you the opportunity to take advantage of one of the broadest policy wordings for the above exposures available in Australia.

Having expressed great concern with the limitations offered by many existing insurance companies in the current difficult insurance market, and the ever increasing cost of premiums for this restricted cover, the APAA has spent considerable time and effort in conjunction with its insurance adviser of over ten years, Daniel Gumm, to obtain this coverage specifically tailored for the professional Beauty Therapist.

In order to finalize a quotation for your consideration, could you please complete and return the attached proposal form to the following address:

APAA National office  
P.O Box 96  
ROBINA QLD 4226

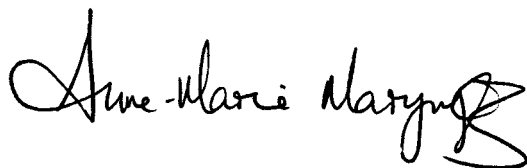
Should you require assistance with the completion of the attached, or require clarification on any aspect of this policy, please do not hesitate to contact the APAA National Office on:

(07) 5575 9364

or alternatively email:

[info@apaa.com.au](mailto:info@apaa.com.au)

Kind Regards

A handwritten signature in black ink that reads "Anne-Marie Marynycz". The signature is written in a cursive, flowing style.

Anne-Marie Marynycz  
APAA National President



# APAA Public Liability / Professional Indemnity Facility

APAA Member No: \_\_\_\_\_

1) Principal (s) or Firm(s):

\_\_\_\_\_

2) Postal Address

\_\_\_\_\_

\_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Phone:( ) \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

3) Situation of Salon(s): (If mobile, please note accordingly).

\_\_\_\_\_

\_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Phone:( ) \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

4) Business operated as:

Corporation	Partnership	Individual
Independent Contractor	Other (Specify)	

5) Please advise the number of staff

Principals / Partners / Directors:	
Full-time qualified staff:	
Part-time qualified staff:	
Other:	
Total:	

6) Qualifications and Experience of each Beauty Therapist:

Name	Qualifications	Years Qualified

7) Do you use a medical history / client information form on everyone?  
(If yes, please attach a sample copy). Yes / No

8) Do you use a hold harmless or informed consent form?  
(If yes, please attach a sample copy). Yes / No

9) Please list Machinery and Equipment Used in your Operations:

Type of Machine/Equipment	Quantity

**Insurance History**

10) Do you currently have Liability insurance coverage?  
If yes, please indicate the following: Yes / No

Insurer:	Policy No:	Liability Limits:	Premium:	Expiry:
		A\$	A\$	

11) Please list all past claims whether Insured or Not. If none, state so:

Yr/Claim	Nature of Injuries	Equipment Used	Amount	Finalised

12) Do you have any knowledge of any event, circumstance or occurrence (other than listed previously in this form) 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 of the event on a separate attachment. Yes / No

13) Please tell us which services you provide.

Type of Treatment	Yes / No
Body Wrapping	
Manicure	
Caci (Facial technique)	
Make-up	
Electrical Appellations (please note we do not cover this treatment when performed on Skin Types V & VI on the Fitzpatrick Scale).	
Nail Extensions	
Ear Piercing	
Pedicure	
Eyebrow Tinting	
Spa Treatments	
Facials	
Acid Peels – under 30%	
Sugaring	
Hairdressing	
St Tropez	
Lash tinting & Eyebrow Shaping	
Waxing	
Aromatherapy	
Lymphatic Massage	
Massage	
Reflexology	
Acupuncture	
Body Piercing (please note we do not cover piercing of genitalia or tongue)	
Electrolysis	
Cosmetic Tattoo/Micropigmentation	
Acid Peels – over 30% and Microdermabrasion	
Laser Therapy	
IPL/ VPL Treatment	
Red vein treatment/ Sclerotherapy	

- 14) Please state your gross turnover for the last 12 months A\$ \_\_\_\_\_
- 15) Approx what percentage of this is from sale of products? % \_\_\_\_\_
- 16) Do you provide private – label Products for sale? Yes / No
- Income from Private Label Products: A\$ \_\_\_\_\_  
 (NB. No coverage is provided for Private Label Products)

17) **FACIALS:**

List all products you use and their percentage of Acids:

Product	% Acid Content

Have you had specific training on the Peels you are using? Yes / No

18) **TANNING:**

Do you have sun beds or other tanning products? Yes / No  
 If Yes please describe below:

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19) Do you perform any activities other than those disclosed in this proposal? Yes / No  
 If Yes, provide details below.

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20) Combined Limit of Liability Requested:

A\$1,000,000	\$2,000,000
A\$5,000,000	\$10,000,000

I understand and agree this Application and any and all supplements attached hereto will be made part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. 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 a 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 the Company 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 AND REPORTED to the Company in writing within the period of coverage shown of the Certificate of Insurance issued with the Policy or Certificate on the date the Policy is cancelled or terminated, whichever comes first or as otherwise provided by the Policy.

***IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT.***

***SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.***

**Signature of Applicant:**

\_\_\_\_\_

**Print Name:**

\_\_\_\_\_

**Date:**

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