

## TONNING BED SUPPLEMENTAL APPLICATION

1. Applicant's Name: \_\_\_\_\_
2. Address of applicant: \_\_\_\_\_  
\_\_\_\_\_
3. Location of business? \_\_\_\_\_
4. Number of years in this business: \_\_\_\_\_
5. Number of years experience in other business: \_\_\_\_\_
6. Describe other business(es):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Effective date of policy: \_\_\_\_\_
8. Limits desired: \_\_\_\_\_
9. Previous carrier (last three years):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Previous premiums paid (last three years): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Any losses (last three years):    ☐ Yes    ☐ No
12. Describe losses if "yes" to Number 11: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Describe training given to new employees: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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14. Describe method used to determine length of time permitted on tables: \_\_\_\_\_

\_\_\_\_\_

15. Are timing controls on table or at front desk: \_\_\_\_\_

\_\_\_\_\_

16. Are any products of any type sold: ☐ Yes ☐ No

17. If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

18. Gross receipts: \_\_\_\_\_ Payroll: \_\_\_\_\_

19. Number of tables: \_\_\_\_\_

List manufacturer of tables: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Describe methods of evaluating medical history of participants:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

21. Are any babysitting or childcare services provided: ☐ Yes ☐ No

**NO COVERAGE IS BOUND UNTIL ACCEPTED AND APPROVED BY THE COMPANY OR ITS  
AGENT.**

\_\_\_\_\_  
PRODUCER'S SIGNATURE

\_\_\_\_\_  
DATE:

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE: