



8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-585-2853 • Fax 877-585-2854

HEALTH CLUBS APPLICATION

General Information

Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: () _____ Fax: () _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

Detailed description of business activities (specifically, and by location): _____

Is this a new business? Yes No If no, how many years have you been in business? _____

Applicant is: Individual Corporation Partnership Joint Venture

Other (please describe): _____

Annual Payroll: \$ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? Yes No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: () _____

Fax: () _____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor or related person or entity ever had a claim? Yes No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? Yes No

If yes, please explain: _____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? Yes No

If the standard markets are declining placement, please explain why: _____

2. Desired Insurance

Limit of Liability:

Per Act/Aggregate		OR	Per Person/Per Act/Aggregate	
<input type="checkbox"/>	\$50,000/\$100,000	<input type="checkbox"/>	\$25,000/\$50,000/\$100,000	
<input type="checkbox"/>	\$150,000/\$300,000	<input type="checkbox"/>	\$75,000/\$150,000/\$300,000	
<input type="checkbox"/>	\$250,000/\$1,000,000	<input type="checkbox"/>	\$100,000/\$250,000/\$1,000,000	
<input type="checkbox"/>	\$500,000/\$1,000,000	<input type="checkbox"/>	\$250,000/\$500,000/\$1,000,000	
<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____	

Self-Insured Retention (SIR): \$1,000 (Minimum) \$1,500 \$2,500 \$5,000 \$10,000

3. Business Activities

- Length of season: _____
- Describe Business Operations: _____

- Provide the total gross receipts and breakdown for all activities, operations and services provided. Give gross sales, commissions, fees, or other income. Identifying exposure separately will qualify the member for protection under the Group Liability Insurance Program.

Members/Customers/Patrons:

- Total number of current members: _____
- Total number of members last year at this time: _____
- Minimum age for members: _____ Maximum age for members: _____
- Average number of participants that use exercise equipment each day: _____
- Average total number of participants that are active in aerobics each day: _____

9. Average number of NEW guests visiting premises per day: _____
10. Average number of visits per day? _____
11. Maximum number of participants on premises at any one time: _____
12. Do guests sign a Release and Use form? Yes No
13. Are the health club facilities available to:

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Only women
<input type="checkbox"/>	<input type="checkbox"/>	Only men
<input type="checkbox"/>	<input type="checkbox"/>	Both sexes—mixed facility
<input type="checkbox"/>	<input type="checkbox"/>	Open certain days for women or men only
<input type="checkbox"/>	<input type="checkbox"/>	Other (please explain):

Operations:

14. Number of days you are open during the week: _____
15. Hours of operation each day: _____
16. Minimum age of instructors, supervisors, managers, or employees: _____
17. Owner or Location Manager
- a. Name: _____
- b. Age: _____
- c. Number of years experience: _____
- d. Number of years as owner or manager at this location: _____
- e. Is the owner of the business actively involved at least 40 hours a week at this location? Yes No
- f. Does owner(s) lease, operate, or participate in the operations of any other health club(s)? Yes No
- If yes, do you desire coverage for other facilities? Yes No
- g. Does owner(s) or applicant(s) lease, operate or are owner(s) or applicant(s) a subsidiary of any business(es) other than a health club(s)? Yes No
18. Are all participants, regardless if a registered member or a first time visitor, required to sign a disclosure, waiver, and/or Release of Liability PRIOR to participating in any physical activity? Yes No
- If no, would you be willing to effect such a measure as a precedent prior to insurance coverage being affected? Yes No
19. Is a general health questionnaire completed or health examination required on all new members? Yes No
20. Do your records of members contain medical information, including a medical history, the name and phone number of a physician to contact in case of emergency, and the name, address, and phone number of a nearest relative to contact in case of emergency? Yes No

21. What are the first aid and emergency procedures? _____

Finances:

22. Total Gross Receipts all operations: \$ _____
23. Total square footage of premises: _____ sq. ft.
24. Total square footage you sub-lease to others: _____ sq. ft.
- a. Do you desire coverage on sub-leased area? Yes No

Employees:

25. How many employees total? _____ Full-Time: _____ Part-Time: _____ Other: _____
26. How many employees are designated as: Managers: _____ Instructors: _____ Sales: _____
Office: _____ Other: _____
27. How many employees on duty during:
- a. Heavy Use: _____
- b. Low Use: _____
- c. Average use: _____
28. Is there a registered nurse or doctor on premises? Yes No
29. Is there professional advise, council, or direction given by a licensed professional which could cause for a medical malpractice lawsuit? Yes No
- If yes, please explain: _____

30. Is there a physical therapist on duty or contractually associated with your business? Yes No
- If yes, please give name and address
- Name: _____
- Address: _____

31. Is there a registered dietician on staff or under contract with your business? Yes No
32. Is staff required to have CPR and/or First Aid Training? Yes No
33. If club includes aerobics, are instructors and/or head instructors certified? Yes No

Facilities and Equipment

34. Are all emergency exits clearly marked? Yes No
35. Are lockers provided for members? Yes No
36. Are signs posted regarding responsibility for members' belongings? Yes No
37. Are the premises ever rented or loaned to outside organizations? Yes No
- If yes, please explain: _____
38. Do you sponsor competitions, exhibitions, or other organized and scheduled group activities, on or off the premises? Yes No
- If yes, please explain: _____

39. Is equipment on premises designated and designed for commercial use? Yes No

40. Number of Machine(s): _____ Brand(s) of Machine(s): _____

41. Number of Free Weights: _____ Brands of Weights: _____

42. Are spotters available? Yes No

43. Is there a formal schedule of inspection and maintenance of all apparatus exercise equipment and safety devices? Yes No

43. Are all walls, fixtures, and other building obstructions, with which participants might collide, padded? Yes No

44. Is safety glass used in windows, mirrors, and doors? Yes No

45. Are mats and safety devices appropriate for the needs of the exercise equipment used? Yes No

46. Is equipment replaced at least every 6 years? Yes No

a. If no, what is your rotation schedule? _____

47. Explain replacement and maintenance schedule, and program for ropes and cables: _____

48. Description of use and list of equipment: _____

49. For the following questions, please specify Yes or No, and include number of exposures where applicable.

YES	NO	TYPE	NUMBER	YES	NO	TYPE	NUMBER
<input type="checkbox"/>	<input type="checkbox"/>	Aerobics		<input type="checkbox"/>	<input type="checkbox"/>	Provide Physicals	
<input type="checkbox"/>	<input type="checkbox"/>	Body Toning Machines		<input type="checkbox"/>	<input type="checkbox"/>	Staff Medical Prof.	
<input type="checkbox"/>	<input type="checkbox"/>	Running Tracks		<input type="checkbox"/>	<input type="checkbox"/>	Blood Analysis	
<input type="checkbox"/>	<input type="checkbox"/>	Whirlpools		<input type="checkbox"/>	<input type="checkbox"/>	Stress Testing	
<input type="checkbox"/>	<input type="checkbox"/>	Steam-rooms		<input type="checkbox"/>	<input type="checkbox"/>	Kick-boxing	
<input type="checkbox"/>	<input type="checkbox"/>	Handball Courts		<input type="checkbox"/>	<input type="checkbox"/>	Karate Studios	
<input type="checkbox"/>	<input type="checkbox"/>	Ice Skating		<input type="checkbox"/>	<input type="checkbox"/>	Contact Karate	
<input type="checkbox"/>	<input type="checkbox"/>	Roller Skating		<input type="checkbox"/>	<input type="checkbox"/>	Trampolines	
<input type="checkbox"/>	<input type="checkbox"/>	Jacuzzis		<input type="checkbox"/>	<input type="checkbox"/>	Diet Centers	
<input type="checkbox"/>	<input type="checkbox"/>	Facial Tanning Machines		<input type="checkbox"/>	<input type="checkbox"/>	Gymnastic Classes	
<input type="checkbox"/>	<input type="checkbox"/>	Swimming Pools		<input type="checkbox"/>	<input type="checkbox"/>	Sports Medicine	
<input type="checkbox"/>	<input type="checkbox"/>	Diving Boards		<input type="checkbox"/>	<input type="checkbox"/>	Liquid Protein	
<input type="checkbox"/>	<input type="checkbox"/>	Racquetball Courts		<input type="checkbox"/>	<input type="checkbox"/>	Vitamin Injections	
<input type="checkbox"/>	<input type="checkbox"/>	Tennis Courts		<input type="checkbox"/>	<input type="checkbox"/>	Suntanning Units	

50. Is a Nursery available? Yes No

If yes, answer:

a. Number of exits: _____

b. Max number of children: _____ Age: _____ Group: _____

c. Number of Attendants: _____

d. Ages of Attendants: _____

e. Are attendants trained in childcare? Yes No

f. Are children allowed to stay if parents leave the center? Yes No

g. Describe method used for signing children in and out of the nursery. _____

h. Do you provide any type of exercise equipment or aerobics for children while in nursery? Yes No

If yes, please explain: _____

51. Is a swimming pool available to members and guests? Yes No

a. Average number of participants that use pool: _____

b. Please give dimensions, and maximum and minimum depth: _____

c. Is lifeguard on duty? Yes No

d. What signs are posted? _____

e. Is proper lifesaving equipment available? Yes No

If yes, please list type (i.e. Hook, Rope): _____

f. Are swimming pool rules posted? Yes No

g. Is there a Diving Board? Yes No

h. What is the height of the Diving Board? _____

52. Is there a professional shop? Yes No

a. Total Gross Receipts: \$ _____

b. What types of products are sold? _____

c. Are products sold that are not considered health/exercise related? Yes No

Are any products sold under you own label? Yes No

If yes, list products: _____

53. Are tanning beds available?

Yes No

a. Number of Units: _____

b. Manufacturer: _____

c. What type of bulbs are used? UVA caps UVB caps

Manufacturer: _____

d. Is it a: Bed Booth

e. Is there an attendant on duty?

Yes No

f. Is eye protection mandatory?

Yes No

g. Is it coin operated?

Yes No

h. Is a timer used?

Yes No

Where is the time control located? _____

i. Is release of risk signed?

Yes No

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____

Dated: _____

Applicant:

Agent/Broker:

Signature

Signature

Print Name

Print Name