

Salon & Spa Association

Membership Application

Provided by Alternative Balance LLC

Po Box 450 Hillsboro, NH 03244 • Voice/Fax: 800-871-3848 • Email: SalonSpa@mail.com • Website: SalonSpaAssociation.com

1 Contact Information

Name: _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
Date of Birth ____-____-____ Sex ____ Male ____ Female

2 Therapies & License

Please check all that apply

____ Massage ____ Esthetician
____ Bodywork ____ Cosmetology
____ Energy Work ____ Nail Technician
____ Animal Therapies ____ Yoga Teacher

License # (if applicable) _____

3 Membership Options

Membership Levels (with Insurance)

Insurance includes both professional (malpractice) liability and general (premises, or 'slip & fall') Liability coverage: \$2 million of protection per year / \$3 million aggregate. \$5k limit for Animal Therapies. Pricing is in U.S. Funds

Professional\$179yr \$ _____
Pro. Part-time (less than 6hrs week)...\$159yr \$ _____
Student\$119yr \$ _____

Additional Insured Option.....\$10 each \$ _____
See page 2 for details

4 Processing Options

E-Standard Processing –No Extra Charge

(E-mail Confirmation, custom certificate & policy
Please allow 2-3 Business Days) _____

Rush Mail Processing\$20 \$ _____
(2-3 Business Days includes Certificate Only)

Rush Processing (Email or Fax)

24hrs ____ Email OR ____ Fax Service\$20
(Your email or fax number is required)
Have your proof of insurance e-mailed or faxed to you in 24hrs of receipt of your application.

E-mail: _____ OR
FAX#: (____) _____
Attn: _____ \$ _____

Total:..... \$ _____

For Alternative Balance Use Only

____ Standard Processing ____ Pr Mail Date: ____/____/____
____ Rush Processing ____ Email ____ Fax ____/____/____
Policy # _____ Active Date: ____/____/____
Rep _____ 3.10

5 Referral Credit

Did someone refer you to ATA ? You could earn them \$20!

*Referral credits are added to renewals notices for discounted renewal rates.

Member Policy # or Name _____

6 Payment Options

*A \$25 Charged will be assessed on all returned checks. Fee's must be paid in U.S. dollars. All fees paid to Alternative Balance are non-refundable once your application is accepted.

____ Check/Money Order ____ Visa/MasterCard ____ Discover ____ Amex

Name on Card: _____

Billing Address for Card: _____

City: _____ State: _____ Zip: _____

Card # _____

Exp. Date: ____/____/____ CVN (Required) _____

CVN is the last 3 Digits on the back of the card for Visa/MC/Disc & 4 Digits in the front of AMEX

7 Agreement & Signature

I represent that the statements are true and no material facts have been suppressed or misstated. I attest that, as of the date listed below.

I have no knowledge of any allegation, claim or suit or any act, error or omission, which might reasonably be expected to result in a claim or suit.

I also agree and understand that this insurance policy does not cover any claims or suits arising from work I may perform that is outside the scope of practice provided within any government regulations pertaining to my trade specialty and that any work performed by me in this regard that infringes upon the scope of practice of any other regulated trade specialty is not covered by this policy.

I understand that any false statements made in this application or subsequent renewals of this policy shall void this application and make my insurance null and void. I hereby understand that Alternative Balance LLC and its employees are not liable for any claims related or unrelated to this application and all claims will be submitted to the agent and its underwriter in a timely manner.

I understand all fees paid to Alternative Balance LLC are non-refundable after the approval and process of application.

Signature _____
Required _____ Date: _____

Salon & Spa Association

Po Box 450 Hillsboro, NH 03244 •Voice/Fax: 800-871-3848 • Email:SalonSpa@mail.com •Website: SalonSpaAssociation.com

Additional Benefit Holders

Your membership will provide you with insurance as an individual only.

Often your landlord or place of work such as a salon, spa healthcare center, hotel and or resort or tradeshow require that they be listed on your certificate of Insurance as an Additional Benefit Holder specifically for your work. If this is the case simple complete the detailed information below.

You may also choose to list your company name as the additional insured.

The Additional Benefit Holder is not for other professional providers as they must have their own individual policy.

There is a \$10 charge for each additional insured. After 10 Additional Benefit Holders, there is no charge for adding more.

Additional Insured Benefit Holder #1

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____

Additional Insured Benefit Holder #2

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____

Additional Insured Benefit Holder #3

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____

For Alternative Balance Use Only

____ Standard Processing ____ Pr Mail Date: ____/____/____
____ Rush Processing ____ Email ____ Fax ____/____/____
Policy # _____ Active Date: ____/____/____
Policy Holder: _____
Rep _____ 10.09

Additional Insured Benefit Holder #4

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____

Additional Insured Benefit Holder #5

Additional Insured : _____
Mailing Address: _____
City: _____ State: _____
Zip: _____ Country: _____
E-mail: _____
Website: _____
Phone (Home) (____) _____
Business: (____) _____
____ Landlord ____ Employer ____ Trade Show
____ Other please list _____