



Fitness & Wellness Instructors Application

Cossio Insurance Agency • 864-688-0121 • Fax: 864-603-2348 • P.O. Box 5987, Greenville, SC 29606

- DIRECTIONS:** 1. Fill in the application by filling in the blue fields on all pages.
 2. Please fill in all the fields with the correct information.
 3. Email the application to apps@cossioinsurance.com or Fax to 864-603-2348

Section 1: General Information

How did you hear about us?

Your Coverage: \$1,000,000 per occurrence / \$3,000,000 aggregate limit

Are you an IDEA Member? Yes No

If no, are you interested in becoming an IDEA member? Yes No

IDEA Membership Status: Current Member Non-Member

Requested Policy Effective Date:

Policy Effective date must be greater than the current date and within 60 days of the current date.
Policy Expiration date defaults to (1) year following effective date.

Do you sell ingestible and/or topical products (ex: vitamins, supplements, lotions) manufactured under your company's label? Yes No

Have there been claims made against you in the last 3 years? Yes No

Do you require signed waivers from all clients? Yes No

Did your previous insurance provider cancel your policy or not allow you to renew? Yes No

If yes, explain:

Previous Insurance Provider:

Expiration Date:

Ineligible individuals/operations that may not be referred to Fitness & Wellness

Acupuncturists, Any applicant that does not have a license as required by state and/or local jurisdictions., Aerial or Acro Yoga, Cheerleading, Chiropractors, Dentists, Equestrian Yoga, Estheticians, Extreme sports, Freerunning Instructors, Health Care Providers, Martial Arts Weapon training, Massage Therapists, Naturopaths, Nutritionists who provide prescriptions, medical advices, and supply or sell clients medicinal supplements or steroids. Osteopaths, Parkour Instructors, Physical Therapists, Physicians, Pole Dancing, Scuba Instructors, Surgeons, Trapeze, bungee jumping or any aerial activity, Wilderness hiking, Wrestling or boxing (professional or amateur)

I have read and understood the list of ineligible operations and declare I do not participate in any of the mentioned operations. Yes No

Have you ever had an incident or been convicted of any crime, including sex related or child abuse related offenses? Yes No

Style/Profession:

Certification:



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Section 2: General Information

Name:

Email:

Retype Email:

Please ensure the email address you are entering is valid. All policy communication such as renewal notification and policy delivery will be handled via email. Your policy will not be delivered by mail.

Phone:

Cell Phone:

Home Address:

City:

State:

Municipality:

Zip:

*Louisiana locations are not eligible for this program

Mailing Address (If different):

Does the facility where you conduct business require you to list them as an Additional Insured on your policy and provide them with a Certificate of Insurance (COI)? Yes No

If yes, Name:

Email:

Phone:

Fax:

Street Address:

City:

State:

Zip:



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Section 3: Cyber Liability

1. Do you process payment cards? Yes No

2. Estimated annual number of payment card transactions

Section 4: Warranty

(Applies to all parts of this application and attachments submitted)

It is hereby understood and agreed that if insurance is issued by virtue of completing this application and any applicable supplemental applications, the Insurance is only issued on the reliance on the applicant's warranty of answers to the questions above and on any such supplemental applications. If, at the time a certificate/policy is issued and ANY OF THE ABOVE WARRANTIES IS IN ANY RESPECT INCORRECT, INCLUDING CLAIMS OR GROSS RECEIPTS, THE COVERAGE AFFORDED UNDER THE CERTIFICATE/POLICY shall, without notice to the applicant, immediately and automatically cease, & the certificate/policy shall BECOME NULL AND VOID. Warranties will survive a certificate/policy if issued.

Section 5: Signature

Print Name of Applicant

Title:

Signature of Applicant (Mandatory)

Date:



FRAUD NOTICE

GENERAL STATEMENT: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim 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 the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN, and VA, insurance benefits may also be denied)

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORDIA: 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 of the third degree.

APPLICABLE IN HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN MINNESOTA: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN 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 include imprisonment, fines, and denial of insurance benefits.

I understand that the insurance company, in determining in whether to provide insurance coverage, will rely on the information contained in this form and all other information submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

Insured Signature:

Date: