SUPPLEMENT FOR MEDICAL SPA/ANTI-AGING CLINICS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. Full name of Applicant: _____

2. Date continuous operations began: _____

   If the Applicant is a start-up operation, attach a copy of the Applicant's' business plan.

3. Website: _____

II. OPERATIONS

1. What is the professional specialty of the clinic? _____

   _____

2. (a) Provide a list of the Applicant's Medical Director(s): _____

   _____

   (b) Attach a CV for each of the Applicant's Medical Directors and a description of their duties.

3. Provide the percentage of the Applicant's patients/clients in the following categories:

(a)		(b)	
Beauty Shop (nails, hair, facials)	_____%	<u>Patient/Client Ages:</u>	
Dental	_____%	Less than 12 years old	_____%
Massage	_____%	12 to 18 years old	_____%
Medical Spa/Anti-Aging	_____%	Greater than 18 years old	_____%
Research or Experimental	_____%	TOTAL	100%
Surgical	_____%		
Weight Control	_____%		
Other (specify) _____	_____%		
TOTAL	100%		

III. PROFESSIONAL SERVICES

1. List all manufactured equipment used in the Applicant's practice and the purpose for which each is used:

   _____

   _____

   _____

2. Does all labeling of and use of drugs have FDA approval?..... [ ] Yes [ ] No
   If No, explain. _____

3. Does the Applicant take before and after pictures of every patient?..... [ ] Yes [ ] No
   If No, explain. _____

   _____

4. Provide the following information for each type of procedure that is performed and attach a Training Certificate, CV, Client Selection Protocol and Informed Consent for each procedure:

Procedure	Performed By (include name of all individuals performing each procedure)	Is Training Certificate Attached? (Yes/No)	Is CV Attached? (Yes/No)	Is Client Selection Protocol Attached? (Yes/No)	Is Informed Consent Attached? (Yes/No)	Number of Procedures
Acne Blue Light Treatment						
Botox Injections						
Chemical Peels Specify Solution Strength_____						
Electrolysis						
Hair Transplants						
Laser Hair Removal						
Laser Skin Treatment Specify Type _____						
Massage						
Microdermabrasion						
Other Injections Specify Type (fat, collagen, silicone) _____						
Permanent Makeup/ Micropigmentation						
Other _____						

5. Are any of the procedures listed in question 4 above performed by a physician or dentist?*.....[ ] Yes [ ] No
If Yes, do all physicians and dentists carry Professional Liability Insurance? .....[ ] Yes [ ] No

* If coverage is requested for any physicians or dentists submit a separate Application for Physicians & Surgeons Professional Liability Insurance (MM-30000) for each physician or Application for Dentists Professional Liability Insurance (SM666) for each dentist.

IV. STAFF

1. Does the Applicant employ anyone? .....[ ] Yes [ ] No
If Yes, indicate by profession the number of individuals employed:

___ Aesthetician ___ Registered Nurse

___ Electrologist ____Technician (specify type) _____

___ Massage Therapist ____Other (describe) _____

2. Does the Applicant supervise anyone other that its own employees? .....[ ] Yes [ ] No
If Yes,

(a) Indicate by profession the number of individuals supervised:

____ Aesthetician ___ Registered Nurse

____ Electrologist ____Technician (specify type) _____

____ Massage Therapist ____Other (describe) _____

(b) Provide a detailed explanation of the responsibilities for each profession and specify the relationship to the Applicant.

V. HISTORY

1. List the Applicant's prior Professional Liability Insurance for each of the last three (3) years, including the current year: If none, check here [ ]

Insurance Company	Limits of Liability	Deductible (if any)	Premium	Inception/ Expiration Dates (MM/DD/YYYY)	Claims Made or Occurrence Form	Retroactive Date

2. List the Applicant's prior General Liability Insurance for each of the last three (3) years, including the current year: If none, check here [ ]

Insurance Company	Limits of Liability	Deductible (if any)	Premium	Inception/ Expiration Dates (MM/DD/YYYY)	Claims Made or Occurrence Form	Retroactive Date

V. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's locations:

(a)

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					
4					

(b)

	Location 1	Location 2	Location 3	Location 4
Square Footage				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

2. Are all of the Applicant's locations equipped with:
   (a) Complete Sprinkler System? ..... [ ] Yes [ ] No
   (b) At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
   (c) Self-closing fire doors on each floor? ..... [ ] Yes [ ] No
   (d) Automatic fire alarm system connected to a local fire department? ..... [ ] Yes [ ] No
   (e) Smoke detectors? ..... [ ] Yes [ ] No
   (f) Emergency electrical system? ..... [ ] Yes [ ] No
   (g) Heat sensors? ..... [ ] Yes [ ] No
   (h) Fire escape(s)? ..... [ ] Yes [ ] No
   (i) Posted emergency evacuation procedures? ..... [ ] Yes [ ] No
   (j) Properly maintained fire extinguishers? ..... [ ] Yes [ ] No

3. Does the Applicant have a written safety program in place? ..... [ ] Yes [ ] No
   If Yes, attach a copy of the written safety program.

4. Does the Applicant have written procedures for incident reporting? ..... [ ] Yes [ ] No

5. Do any of the Applicant's locations have any:
   (a) Exposure to flammables, explosive, chemicals? ..... [ ] Yes [ ] No
   (b) Catastrophe exposure? ..... [ ] Yes [ ] No
   (c) Exposure to radioactive materials? ..... [ ] Yes [ ] No

6. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? ..... [ ] Yes [ ] No

7. Does the Applicant:
   (a) Loan or rent machinery or equipment to others? ..... [ ] Yes [ ] No
   (b) Own any elevators or escalators? ..... [ ] Yes [ ] No
   If Yes,
   (i) Provide the model of the elevator(s) and/or escalator(s): _____
   _____
   (ii) Are the elevators and/or escalators serviced by the Applicant or under a maintenance contract? ..... [ ] Yes [ ] No
   (c) Own or rent any parking facility? ..... [ ] Yes [ ] No
   (d) Provide any recreational facility? ..... [ ] Yes [ ] No
   (e) Have a swimming pool on the premises? ..... [ ] Yes [ ] No
   (f) Sponsor any sporting or social events? ..... [ ] Yes [ ] No

8. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? ..... [ ] Yes [ ] No

9. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? ..... [ ] Yes [ ] No
   If Yes, provide details for each incident._____
   _____
   _____

NOTICE

I understand that the information submitted herein becomes a part of my professional liability application and is subject to the same warranty and conditions.
Must be signed and dated by an Owner, Partner or Principal as duly authorized on behalf of the Applicant.

_____

Signature of Owner, Partner or Principal | Title | Date

APPLICATION FOR MISCELLANEOUS MEDICAL LIABLITY INSURANCE (CLAIMS-MADE FORM)

General Applicant Information

1. Name of Applicant: _____

_____

2. Principal Address: _____

_____

3. City: _____ County: _____ State: _____ Zip Code: _____

4. Phone: _____ Website Address: _____

5. a. Does the Applicant practice as: ☐ Corporation ☐ Partnership ☐ Individual ☐ Prof. Association

☐ Other: _____

b. In what states is the applicant registered and licensed to practice? _____

6. Date Applicant was established: ____ / ____ / ____
MM DD YY

7. Is the firm engaged in, owned by, associated with or controlled by any other business? _____

If yes, give details _____

_____

8. PROFESSIONAL ACTIVITIES AND SPECIALTY (Attach narrative description if necessary)

☐ Health Maintenance Organization
☐ Home Healthcare Agency
☐ Medical/Testing Laboratory
☐ Nurse's Registry
☐ Out-Patient Clinic
☐ Residential Healthcare Facility
☐ Other (Specify) _____

9. State approximate division of applicant's patients among:

a. Alcoholics	(____)%	h. Holistic Medicine	(____)%	n. Research or Experimental	(____)%
b. Counseling / Family Planning	(____)%	i. Medical	(____)%	o. Senile or Aged	(____)%
c. Communicable	(____)%	j. Mentally Retarded	(____)%	p. Stress Testing	(____)%
d. Dental	(____)%	k. Obstetrical	(____)%	q. Surgical	(____)%
e. Drug Addicts	(____)%	l. Pediatric	(____)%	r. Tubercular	(____)%
f. General	(____)%	m. Psychiatric	(____)%	s. Other _____	(____)%
g. Hemodialysis	(____)%				

10. a. List the number and type of applicant's employees and volunteers: If None, State None. _____

Number	Type of Profession	Number	Type of Profession
1) _____	Inhalation Therapists	9) _____	Perfusionists
2) _____	Laboratory Technicians	10) _____	Pharmacists
3) _____	Nurse Anesthetists	11) _____	Physicians – Minor Surgery
4) _____	Nurses, Licensed Practical	12) _____	Physicians – No Surgery
5) _____	Nurse Practitioner	13) _____	Physiotherapists
6) _____	Nurses Registered	14) _____	Social Workers
7) _____	Opticians	15) _____	Speech Therapists
8) _____	Optometrists	16) _____	Other

b. List the number and type of independent contractors who provide professional services on behalf of the applicant.

If None, State None _____

_____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the above employees:

1) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

2) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

3) Ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

4) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

11. Does the applicant perform:

a. Acupuncture or acupuncture anesthesia? Explain: _____ Yes ☐ No ☐

b. Angiography/Arteriography/Venography? Describe: _____ Yes ☐ No ☐

c. Catheterization (other than urinary or umbilical)? Describe: _____ Yes ☐ No ☐

d. Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? Yes ☐ No ☐

e. Injection of radioisotopes and/or use of irradiated substances? Describe: _____ Yes ☐ No ☐

f. Radiation Therapy and/or Chemotherapy? Describe: _____ Yes ☐ No ☐

g. Psychiatric shock therapy? Yes ☐ No ☐

h. Silicone Injections? Describe: _____ Yes ☐ No ☐

i. Spinal Anesthesia (other than saddle blocks or caudals? _____ Yes ☐ No ☐

j. Laser Treatment? Describe: _____ Yes ☐ No ☐

12. Does the applicant perform any:

a. Surgery other than incision of superficial boils or suturing superficial fascia? Yes ☐ No ☐

b. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemarkers? Yes ☐ No ☐

c. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections? Yes ☐ No ☐

d. Cosmetic Plastic Surgery? Describe: _____ Yes ☐ No ☐

e. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? Yes ☐ No ☐

f. Hysterectomies? Yes ☐ No ☐

g. Open reduction of fractures? Describe: _____ Yes ☐ No ☐

h. Surgery for weight reduction of patients? Yes ☐ No ☐

i. Abortions and/or menstrual extractions? Describe (include trimester, method and number of Abortions performed per month): _____ Yes ☐ No ☐

j. Silicone Implants? Describe: _____ Yes ☐ No ☐

k. Sterilization Procedures? Describe: _____ Yes ☐ No ☐

l. Biopsies and/or endoscopies? List types performed: _____ Yes ☐ No ☐

m. Sex change operations? Describe and advise the number performed per year: Yes ☐ No ☐

_____

n. Other Surgery? Describe: _____ Yes ☐ No ☐

13. Does the applicant perform hospital emergency room care?

a. For its own regular patients? Yes ☐ No ☐

b. For patients not its own? Yes ☐ No ☐

c. If answer to b. is yes, please specify: the percentage of its time devoted to this work = (_____)%, the number of hours per month devoted to this work = (_____) hrs.

14. Does the applicant use drugs for weight reduction patients? Yes ☐ No ☐
If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant?

15. Does the applicant administer any methadone treatment? Yes ☐ No ☐
If yes, describe treatment and controls used and indicate number of treatments during last 12 months (_____), next 12 months ( ).

16. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes ☐ No ☐

If yes, attached detailed explanation.

17. Does the applicant maintain any beds for overnight occupancy? Yes ☐ No ☐

If yes, total number: _____

18. State number of X-ray machines owned or operated and whether they are used fro diagnosis or treatment or both.

State by whom treatment is given and number of procedures: _____

19. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes ☐ No ☐

If yes, give details, including name, location, size and number of beds. _____

20. State sources and amounts of total revenue:

	Source	Amount Last Policy Year	Ext. Amount This Policy Year
a.	Charitable Contributions	$ _____	$ _____
b.	Government Funding	$ _____	$ _____
c.	Fee for Services	$ _____	$ _____
d.	_____	$ _____	$ _____
e.	_____	$ _____	$ _____
	TOTAL GROSS REVENUE:	$ _____	$ _____

21. Number of patient encounters last 12 months (_____) and/or patient test carried out (_____).

(NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

22. Number of estimated patient encounters next 12 months (_____) and/or patient test carried out (_____).

(NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

23. If applicant has a training school, complete the following.

Specify profession for which students are being trained	Max. No. of students per session	No. of sessions per year	% of Time involved in clinical setting	Number of students	Qualifications of faculty (eg. MD, RN, PhD)

24. If applicant is an ambulance services, please complete the following.

Number of Ground Ambulances _____ Number of Emergency Calls (per year) _____

Number of Air Ambulances _____ Number of non-Emergency Calls (per year) _____

Radius of Services _____

25. Give Professional Liability Coverage for last five years for the firm:

Carrier	Limit	Deducible	Premium	Expiration (Mo/Day/Yr)

If expiring insurance is a claims made policy, what is the retroactive date? _____

26. Is the applicant currently insured under a Commercial General Liability Policy? Yes ☐ No ☐

If yes, please give details:

Insurance Company	Type of Coverage	Limits BI	Limits PD	From	To

27. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present partners ever been declined or has the insurance ever been cancelled or renewal refused? Yes ☐ No ☐

If yes, please give details: _____

28. Has any claim ever been made against the applicant or any persons named in question 1? Yes ☐ No ☐

If yes, how many? _____

Please attach currently valued company loss runs for the past 5 years and details stating:

1) Date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition

29. Is the applicant aware of any circumstances which may result in any claim against the applicant or any persons named in question 1? Yes ☐ No ☐

If yes, how many? _____

Please attach currently valued company loss runs for the past 5 years and details stating:

1) Date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition

30. Has any insurer cancelled or refused to renew any similar insurance during the past five years? _____

31. Limits of Liability requested _____ Deductible _____

32. Desired term of policy: From _____ To _____

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the dates of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signature of the Applicant | Title | Date

Producer