

## Medical Spa Professional Liability Insurance Application (Claims Made)

1) Full Name of Applicant:

(Include all DBA's and subsidiaries seeking coverage under the policy for which you are applying.)

2) Mailing Address:

3) Other Locations:

4) Web site Address (If applicable)  5) Date Established

6) Type of Entity:     
 Corporation                       LLC  
 Partnership                               Other - Please Describe   
 Individual

7) Is this entity owned by, associated with, or controlled by any other entity?       YES     NO

If Yes, Please give details

8) Please provide the **number** of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

	<b><u>Employee or Volunteer</u></b>	<b><u>Independent Contractor</u></b>	<b><u>Insured On Own Med Mal Policy</u></b>	<b><u>Insured Limits</u></b>
Physicians (no surgery):	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Physicians (surgical):	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
CRNA's	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Physician Assistants:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Nurse Practitioners:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Registered Nurses:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
LPN's or Nurse Aides:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Aestheticians:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Laser Techs:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Medical Assistants:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Massage Therapists:	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>
Other: <input style="width: 100px;" type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>

\* Please attach copies of declarations pages on all individuals that carry their own medical malpractice.

\* Please note, basic policy does not cover independent contractors for their individual liability. If you are seeking coverage for independent contractors, please provide details on a separate attachment.

9) Are all of the above individuals licensed in accordance with applicable state and federal regulations.  YES  NO  
 If No, please attach a detailed explanation.

10) Who is your Medical Director?  Medical Specialty:   
 Please indicate below which coverage option you want, or if no coverage is desired for Medical Director, check None.

- (a) Would you like to include coverage for the Medical Director's administrative duties only?  YES  NO
- (b) Would you like to include coverage for the Medical Director's administrative duties & good faith exams only?  YES  NO  
 (If Yes, please attach a completed Medispa Physicians application.)
- (c) Would you like to include coverage for the Medical Director's administrative duties & direct patient care?  YES  NO  
 (If Yes, please attach a completed Medispa Physicians application.)
- (d)  None

11) Has the applicant or any of the above employees and/or independent contractors:  
 If the answer to any of the following questions is YES, complete details are required.

- (a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or Administrative agency, hospital or professional association?  YES  NO
- (b) Ever been convicted of a criminal act other than traffic offenses?  YES  NO
- (c) Ever been treated for alcoholism or drug addiction?  YES  NO
- (d) Ever had any state professional license or license to prescribe narcotics suspended, revoked, renewal refused, or restricted, or ever voluntarily surrendered same?  YES  NO

12) Please indicate the estimated number of procedures that will be performed over the next 12 months:

<b>PROCEDURE</b>	<b># Per Year</b>	<b>PROCEDURE</b>	<b># Per Year</b>	<b>PROCEDURE</b>	<b># Per Year</b>
Abdominoplasty	<input type="text"/>	Chemical Peels (Medium to Heavy)	<input type="text"/>	Injectable/Dermal Fillers *	<input type="text"/>
Acne Treatment	<input type="text"/>	Contour Thread Lifts	<input type="text"/>	IPL & Photofacial Rejuvenation	<input type="text"/>
Acupuncture	<input type="text"/>	Dermaplaning	<input type="text"/>	Lipolysis - Laser (Smart Lipo)	<input type="text"/>
BHRT (Bioidentical Hormone Replacement Therapy)	<input type="text"/>	Ear Candling	<input type="text"/>	Liposuction	<input type="text"/>
Breast Augmentation	<input type="text"/>	Electrolysis	<input type="text"/>		
Brown Spot Removal	<input type="text"/>	Hair Transplants	<input type="text"/>		
Chemical Peels (Light)	<input type="text"/>	HCG	<input type="text"/>		
		Hyperbaric Treatment	<input type="text"/>		

\* Injectable/Dermal Fillers: Include Artefill, Botox, Captique, Collagen, Hyiaform, Jurederm, Radiesse, Restylane, Sculptra

Question 12 continued:

Laser Cellulite Treatment	<input type="text"/>	Permanent Makeup	<input type="text"/>	Waxing	<input type="text"/>
Laser Hair Removal	<input type="text"/>	Pigmented Lesion Removal	<input type="text"/>	Weight Loss Mgmt	<input type="text"/>
Laser Skin Resurfacing	<input type="text"/>	Sclerotherapy	<input type="text"/>	Other	<input type="text"/>
Lipodissolve	<input type="text"/>	Skin Tag Removal	<input type="text"/>	Other	<input type="text"/>
Liposelection	<input type="text"/>	Tattoo Removal	<input type="text"/>	Other	<input type="text"/>
Lipolysis - Injection	<input type="text"/>	Teeth Whitening	<input type="text"/>	<b>Total of Procedures</b>	
Massage	<input type="text"/>	Thermage	<input type="text"/>		
Mesoderm	<input type="text"/>	Vein Treatment	<input type="text"/>		
Mesotherapy	<input type="text"/>	Wart Removal	<input type="text"/>		
Microdermabrasion	<input type="text"/>				

13) For the following procedures, please provide the additional information requested below.

<b>Yes/No</b>	<b>Procedure</b>	<b>Who performs the procedure?</b> <small>(Provide medical designation.)</small>	<b>On which parts of body?</b>
<input type="radio"/> YES <input type="radio"/> NO	Abdominoplasty	<input type="text"/>	<input type="text"/>
<input type="radio"/> YES <input type="radio"/> NO	Breast Augmentation	<input type="text"/>	<input type="text"/>
<input type="radio"/> YES <input type="radio"/> NO	Contour Thread Lift	<input type="text"/>	<input type="text"/>
<input type="radio"/> YES <input type="radio"/> NO	Lipodissolve	<input type="text"/>	<input type="text"/>
<input type="radio"/> YES <input type="radio"/> NO	Lipolysis - Injection	<input type="text"/>	<input type="text"/>
<input type="radio"/> YES <input type="radio"/> NO	Lipolysis - Laser (Smart-Lipo)	<input type="text"/>	<input type="text"/>
<input type="radio"/> YES <input type="radio"/> NO	Liposuction	<input type="text"/>	<input type="text"/>
<input type="radio"/> YES <input type="radio"/> NO	Hair Transplant	<input type="text"/>	<input type="text"/>

\* IF YOU PERFORM A PROCEDURE THAT IS CALLED BY A DIFFERENT NAME, BUT ESSENTIALLY THE SAME AS ANY OF THE ABOVE PROCEDURES, PLEASE ANSWER THE QUESTION ACCORDINGLY.

\*IF YOU PERFORM SURGICAL PROCEDURES OTHER THAN THOSE SHOWN ABOVE, PLEASE ATTACH A LIST OF THOSE PROCEDURES AND THE NUMBER OF ANTICIPATED PATIENT ENCOUNTERS FOR THE NEXT 12 MONTHS.

14) Are FDA Approved Drugs ever used for "off-label" purposes?  YES  NO

If Yes, by whom and what is their medical designation. Need a list of the drugs and the "off-label" purposes for which they are used?

15) Do you ever provide any services at locations other than your medical spa?  YES  NO

If Yes, please provide the following details:

(a) What services?

(b) At what locations?

(c) Who preforms the services & what is their medical designation?

(d) How many off-site procedures do you estimate over the next 12 months?

(e) Will alcohol be served to these off-site patients?  YES  NO

16) What type of anesthesia care is used at the medical spa & who is it administered by?

Administered by:

- |  |  |
|--|--|
| <input type="radio"/> Anesthesia Only  | <input style="width: 200px; height: 20px;" type="text"/> |
| <input type="radio"/> Conscious Sedation   | <input style="width: 200px; height: 20px;" type="text"/> |
| <input type="radio"/> General Anesthesia   | <input style="width: 200px; height: 20px;" type="text"/> |
| <input type="radio"/> Other <input style="width: 150px; height: 20px;" type="text"/> | <input style="width: 200px; height: 20px;" type="text"/> |

17) Does this applicant sell any products? If the answer to any of the following questions is YES, please include brochures.

(a) What kind of products?

(b) Do any of these products require a physician's prescription?  YES  NO

(c) Do you label these products in your own name?  YES  NO

(d) Does all labeling and use of drugs have FDA approval?  YES  NO

If No, Please provide details:

18) State sources and amounts of total revenue:

Last 12 months

Estimate for next 12 months

(a) Fee for service:

(b) Product Sales

(c) Other income:

(d) Total Gross Revenues

19) If the applicant has a training school, please provide the following: (provide details on last page if more room is needed)

<b>Profession for which students are being trained</b>	<b>Max # of students per session</b>	<b># of sessions per year</b>	<b>% of time in clinical setting</b>	<b>Qualification of Faculty (MD, RN, PHD)</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

20) Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If none, state NONE.)

<b>Carrier</b>	<b>Limit</b>	<b>Deductible</b>	<b>Premium</b>	<b>Policy Term</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

21) What is the retroactive date on your current policy?

22) Is the applicant currently insured under a Commercial General Liability policy?  YES  NO

If Yes, please attach copy of declarations page.

23) Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage?  YES  NO

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

24) Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed?  YES  NO

If Yes, please provide details including name of carrier and dates.

25) Has any claim ever been made against the applicant or any of its employees?  YES  NO

If Yes, please complete the Supplemental claim form for each and every claim. [Form Link](#)

26) Is the applicant aware of any circumstances which may result in any claim against them or their employees?  YES  NO

If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.

I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

Any person who knowingly and with intent to defraud any insurance company or other 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Current Date

Title

**If you prefer not to Return Application with an Electronic Signature, Please print and Sign Below:**

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this electronically submitted application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this electronic application and this application will be made part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

Please attach the following documents to this application:

- \* Certificates of training for Employees & Physicans
- \* Copies of brochures, marketing or advertising materials
- \* Five years of currently valued company loss runs.
- \* Information on disciplinary actions, license revocations, etc.
- \* Copy of most current declarations page

[Additional Comments or Details:](#)