

$\frac{\textbf{PROFESSIONAL AND GENERAL LIABILITY APPLICATION}}{\textbf{FOR MEDICAL SPAS}}$

1. Name of Applicant:				-
2. Mailing Address:				-
3. Location Address:	(If multiple nam	ne and locations, please	ottach lict)	_
	(II munipie nam	ie and locations, please	attach list)	
4. Telephone Number:	Fax Nu	ımber:	Website Address:	
5. a) Date Established:				
b) Entity Type: Corp	Partnership	Prof. Assoc	Individual	
6. a) Desired Effective Date:				
b) Desired Limits of Liabil	lity: \$/	\$		
c) Desired Deductible: \$				
7. a) Gross Receipts for the F	Past 12 Months: \$			
b) Estimated Gross Receip	ts for the Next 12 Mor	nths: \$		
c) Payroll for the Past 12 M	Months: \$			
d) Estimated Payroll for th	e Next 12 Months: \$_			
8. Does the applicant have an	y ancillary operations?	Yes No		
If yes, please provide details:				
9. Is the firm engaged in, own	ned by, associated with	or controlled by any of	her business? If yes, please provide det	ails:
10. a) What was your total nu	mber of patient/client	visits last year?		
b) Estimated next year?	most of patient entitle			
DELINITIATED HEAT VEAL!				



11. Are any of the following procedures performed and if so, by whom:

Acne Treatment?	Yes	No	Qualification of Person:
Acupuncture?	Yes	No	Qualification of Person:
Botox & Dermal Filler Injections?	Yes	No	Qualification of Person:
Brown Spot Removal?	Yes	No	Qualification of Person:
Dermaplaning?	Yes	No	Qualification of Person:
Electrolysis?	Yes	No	Qualification of Person:
Facials, Chemical Peels & Microdermabrasion?	Yes	No	Qualification of Person:
HCG?	Yes	No	Qualification of Person:
Hormone Therapy?	Yes	No	Qualification of Person:
IPL & Photofacial Rejuvenation?	Yes	No	Qualification of Person:
Laser Cellulite Treatment?	Yes	No	Qualification of Person:
Laser Hair Removal?	Yes	No	Qualification of Person:
Laser Skin Resurfacing?	Yes	No	Qualification of Person:
Any other Laser Procedures?	Yes	No	Qualification of Person:
If yes to the above, please provide	a detailed descript	tion of procedures	performed:
Lipodissolve?	Yes	No	Qualification of Person:
Massage Therapy?	Yes	No	Qualification of Person:
Mesotherapy?	Yes	No	Qualification of Person:
Permanent Make-Up?	Yes	No	Qualification of Person:
Pigmented Lesion Removal?	Yes	No	Qualification of Person:
Sclerotherapy?	Yes	No	Qualification of Person:
Skin Tag Removal?	Yes	No	Qualification of Person:
Tattoo Removal?	Yes	No	Qualification of Person:
Teeth Whitening?	Yes	No	Qualification of Person:
Vein Treatment?	Yes	No	Qualification of Person:



Wart Removal?	Yes	No	Qualification of Perso	n:	
Waxing?	Yes	No	Qualification of Perso	n:	
Weight Loss Services?	Yes	No	Qualification of Perso	n:	
If yes to the above, please p	rovide a detailed descrip	ption of procedures	performed:		
Any surgical and/or invasive procedure? Yes No					
If yes to the above, please p	rovide a detailed descrip	ption of procedures	s performed:		
Any other procedures?	Yes	No			
If yes to the above, please p	rovide a detailed descrip	otion of procedures	performed:		
12. a) List the number and t state none. Profession	ype of applicant's emplo		luding estimated over the n	ext 12 months. If none, <u>Number</u>	
Registered Nurse Licensed Practical Nurse Aesthetician Nurse Practitioner Physician Assistant Medical Assistant Other (please describe)		Physici Laser T CRNA Massag Chiropi	an (patient contact) an (medical director only) Technician /Surgical Technician ge Therapist ractor 1/Admin		
b) List the number and type of independent contractors estimated over the next 12 months. If none, state none.					
<u>Profession</u>	Number	Prof	<u>Cession</u>	<u>Number</u>	
Registered Nurse Licensed Practical Nurse Aesthetician Nurse Practitioner Physician Assistant Medical Assistant Other (please describe) c. Are all the above individ	uals listed in response to	Physici Laser T CRNA Massag Chiropi Clerica	l/Admin	th applicable state and	
federal regulations	vo	If no, attach exp		ii applicavie state allu	



	•		ch coverage?	iranee & so	cure certificates of
Yes		No			
If no, i	s coverag	ge desired wi	th shared limits on this policy? Yes No		
			d physicians, surgeons, nurse anesthetists, dentists, podiatris nsurance and secure Certificates of Insurance as evidence of		
Yes		No	If yes, at what limits? \$ / \$		
15 a) V	Who is the	e Medical D	irector?		
b) I	s coverag	ge desired for	r:		
	(i)	The Med	ical Director's administrative duties only?	Yes	No
	(ii)	The Med	ical Director's administrative duties & good faith exams only	y? Yes _	No
	(iii)	The Medi	cal Director's administrative duties & direct patient care?	Yes	No
	If yes t	o part (iii), p	please provide a list of all procedures/services provided by th	e Medical	Director:
If r	no, please	provide det	ails of any off-site exposure including what procedures are p what % this is of total procedures performed:	performed,	at what types of
	•		as ever used for "off-label" purposes? Yes tails of the drugs and the off-label purposes for which they a		
18.			pre-employment screening and investigation? prospects about previous claims or suits?	Yes	
	•	-	equired to actively participate in continuing education?		No
			job descriptions and instructional manuals for your staff?	Yes	No
			ritten incident/occurrence reporting policy and procedures?		No



19. Check all t process:	the following that app	ly if obtained, verified	& kept on file as pa	rt of the employee hirin	g & screening			
Applications Criminal Background Checks								
Drug / HIV/ H	lepatitis Testing							
Education/Train	gistry							
20. Is the appli	icant a member of any	association or certified	d or accredited by a	ny governing body? If y	ves, give details:			
21. ATTACH	DETAILED EXPLAI	NATION FOR ANY "'	'YES"" ANSWERS	k:				
Has the applica	ant or have any of the	above employees:		YES	NO			
	a) Ever been the subject of disciplinary or investigative proceedings or reprimandby a governmental or administrative agency, hospital or professional association?							
b) Ever been c other than traff		mmitted in violation of	any law or ordinan					
c) Ever been tr	reated for alcoholism	or drug addiction?						
dispense narco	otics refused, suspende	cense or license to presed, revoked, renewal rever voluntarily surrende	fused or					
	pplicant own (wholly I services are customa		administer any hosp No	oital, nursing home or o	ther institution			
If yes, give det	tails, including name,	location size and numb	per of beds:					
23. Give Profe	essional Liability cove	rage for last five years	for the firm:					
Carrier	Limit	Deductible	Premium	Expiration (Mo/I	Day/Yr)			
								
If expiring inst	urance is a claims made	de policy, what is the re	etroactive date?					



Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
		de policy, what is the re		
ar only and		,		
		onal Liability Insurance or has the insurance evo		the firm, any predecessors in business or renewal refused?
YesNo_				
If yes, please g	give details			
26. Has any in	surer cancelled or ref	used to renew any simil	ar insurance during	the past five years?
YesNo_				
If yes, please g	give details			
27. Has any cla	aim ever been made a	against the firm or any o	of its employees?	
YesNo_				
				act giving rise to the claim was committed; eserves; and 6) final disposition.
		cumstances which may st Partners or Officers?		against him, the firm, his predecessors in
Yes No_	If yes, please	give full details.		



Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant	Please Print	Title	
Signature:			
	Name	Date	
	(NOTE: Application must be signed by the owner or president or principal)		