



Medical Spa / Anti-Aging Clinics Application

1. Full Name of Applicant: _____
2. Mailing Address: _____
3. Other Locations: _____
4. Website Address: _____
5. Date Established: _____ (mm/dd/yy)
6. Type of Entity:
 Corporation Partnership Individual LLC
 Other(Specify): _____
7. Is this entity owned by, associated with or controlled by any other entity? Yes No
 If Yes, please explain: _____
8. Please provide the number of the employees or Independent contractors and whether or not they carry their own individual medical malpractice coverage* for their services on behalf of this entity:

	Employee	Independent Contractor	Shared Limits Coverage	
Physicians (no surgery)	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physicians (surgical)	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CRNA's	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician Assistants	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nurses (RN/LPN/LVN)	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aestheticians	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laser Techs	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Assistants	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Massage Therapists	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Please attach copies of declaration pages on all individuals that carry their own medical malpractice.
 If coverage is needed for employees or independent contractors on shared limits basis, please complete our one page application

9. Are all of the above individuals licensed in accordance with applicable State and Federal regulations? Yes No

If No, please provide 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? (If Yes, please attach a completed Medispa Physicians application.) Yes No
- 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 to be performed over the next 12 months in all of the following categories:

(If you offer a procedure that is not shown below, list it in the box marked OTHER and provide the # of estimated procedures along with the name of the procedure)

**CATEGORY I - NON-INVASIVE, NON-INJECTABLE, NON ABRASIVE SKIN CARE
& DAY SPA TYPE PROCEDURES**

	# Of Procedures		# Of Procedures
Body & Facial Waxing	_____	Hyperbaric Treatment	_____
Manicures/Pedicures	_____	Massage	_____
Ear Candling	_____	Weight Loss - Non Surgical	_____
Facials	_____	and No HCG	_____
		Other:	_____

**CATEGORY II - NON-INVASIVE PROCEDURES, INJECTABLES, ABRASIVE SKIN CARE &
NON-LASER REMOVAL PROCEDURES**

	# Of Procedures		# Of Procedures
Acupuncture	_____	Microdermabrasion	_____
BHRT(no pellet insertion)	_____	Permanent Make Up	_____
Brown Spot Removal - Non Laser	_____	Platelet Rich Plasma Therapy(PRP)	_____
Chemical Peels (Light)	_____	Mesotherapy (No PC/DC)	_____
Fillers/Injectables	_____	Skin Tag Removal	_____
Dermaplaning	_____	Stem Cell Therapy	_____
Electrolysis	_____	(Blood Based Stem Cell	_____
HCG Injections or Liquid Drops	_____	Harvesting Only)	_____
		Wart Removal	_____
		Other	_____

CATEGORY III – LASER-BASED PROCEDURES, FAT EMULSION, NON-INVASIVE LIPO PROCEDURES (COLD LASER), ABRASIVE FACIAL PROCEDURES

	# Of Procedures		# Of Procedures
BHRT Pellet Insertion	_____	Laser Hair Removal	_____
Brown Spot Removal	_____	Laser Skin Resurfacing	_____
(Laser Based Treatments)	_____	Liposonix	_____
Cavi-Lipo	_____	Pigmented Lesion Removal	_____
Cold Laser for Fat Reduction	_____	Sclerotherapy	_____
(No Incisions)	_____	Tattoo Removal -	_____
Fraxel Laser Procedures	_____	Laser Based Treatment	_____
Heavy Chemical Peels	_____	Harvesting Only)	_____
IPL	_____	Thermage	_____
Laser Cellulite Treatment	_____	Vein Treatments	_____
		Velashape	_____
		Other	_____

CATEGORY IV - MINOR FACIAL COSMETIC SURGERY, NON-LIPOSUCTION BASED COSMETIC SURGERY

	# Of Procedures		# Of Procedures
Blepharoplasty	_____	Threadlifts	_____
Ear Pinning	_____	Other	_____
Hair Restoration/			
Hair Transplant Surgery	_____		

CATEGORY V - COSMETIC SURGERY PROCEDURES AND INVASIVE LIPO PROCEDURES

	# Of Procedures		# Of Procedures
Abdominoplasty/Tummy Tucks	_____	Mesotherapy with PC/	
BBL, Butt Lift or Augmentation	_____	DC Smart Lipo	_____
Breast Augmentation	_____	Face Lifts	
Lipolysis	_____	Full Face Laser Lipolysis Lipodissolve	_____
Liposelection	_____	Stem Cell Therapy	
Liposuction-Tumescent or Other	_____	Fat Based Stem Cell Harvesting	_____

Other _____

13. Do you perform any surgery at this facility that you did not detail above? Yes No

If yes, please provide a list of these surgical procedures and the estimated # of surgeries for the next 12 months.

Type of Surgeries	# Of Procedures
_____	_____
_____	_____
_____	_____

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

Administered by:

- Local Anesthesia Only _____
- Conscious Sedation _____
- General Anesthesia _____
- Other: _____

15. 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? _____

16. Do you ever provide any services at locations other than your medical spa? Yes No

a. If Yes, please provide the following details:

What Services? _____

b. At what locations? _____

c. Who performs the services & what is their medical designation? _____

d. Will alcohol be served to these off-site patients? Yes No

17. Does this applicant sell any products? Yes No

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)

Profession for which students are being trained	Max # of students per session	# of sessions per year	% of time in clinical setting	Qualification of Faculty (MD, RN, PHD)

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.)

Carrier	Limit	Deductible	Premium	Policy Term

21. What is the retroactive date on your current policy? _____

22. Is the applicant currently insured under a Commercial General Liability policy? If Yes, please attach copy of declarations page. Yes No



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.

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.

ADDITIONAL INFORMATION: Please provide the following information with this application.

- A. Training certificates
- B. Informed patient consent forms

Please provide any additional details in the space provided:



NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a “CLAIMS MADE” basis for ONLY THOSE “CLAIMS” THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant

Title

Signature of Applicant

Date