JM WILSON

800-666-5692

Agency: _____
Agency Code: _____
Contact: _____
Phone: _____
Email: _____
New ☐ Renewal ☐ Policy #: _____

PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR MEDICAL SPAS

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____ Website Address: _____

5. a) Date Established: _____

b) Entity Type: Corp. ☐ Partnership ☐ Prof. Assoc. ☐ Individual ☐

6. a) Desired Effective Date: _____

b) Desired Limits of Liability: $_____ / $_____

c) Desired Deductible: $_____

7. a) Gross Receipts for the Past 12 Months: $_____

b) Estimated Gross Receipts for the Next 12 Months: $_____

c) Payroll for the Past 12 Months: $_____

d) Estimated Payroll for the Next 12 Months: $_____

8. Does the applicant have any ancillary operations? Yes ☐ No ☐

If yes, please provide details: _____

9. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, please provide details:

_____

_____

10. a) What was your total number of patient/client visits last year? _____

b) Estimated next year? _____

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

					Qualification of Person:
Acne Treatment?	Yes	☐	No	☐	
Acupuncture?	Yes	☐	No	☐	
Botox & Dermal Filler Injections?	Yes	☐	No	☐	
Brown Spot Removal?	Yes	☐	No	☐	
Dermaplaning?	Yes	☐	No	☐	
Electrolysis?	Yes	☐	No	☐	
Facials, Chemical Peels & Microdermabrasion?	Yes	☐	No	☐	
HCG?	Yes	☐	No	☐	
Hormone Therapy?	Yes	☐	No	☐	
IPL & Photofacial Rejuvenation?	Yes	☐	No	☐	
Laser Cellulite Treatment?	Yes	☐	No	☐	
Laser Hair Removal?	Yes	☐	No	☐	
Laser Skin Resurfacing?	Yes	☐	No	☐	
Any other Laser Procedures?	Yes	☐	No	☐	

If yes to the above, please provide a detailed description of procedures performed: _____

_____

					Qualification of Person:
Lipodissolve?	Yes	☐	No	☐	
Massage Therapy?	Yes	☐	No	☐	
Mesotherapy?	Yes	☐	No	☐	
Permanent Make-Up?	Yes	☐	No	☐	
Pigmented Lesion Removal?	Yes	☐	No	☐	
Sclerotherapy?	Yes	☐	No	☐	
Skin Tag Removal?	Yes	☐	No	☐	
Tattoo Removal?	Yes	☐	No	☐	
Teeth Whitening?	Yes	☐	No	☐	
Vein Treatment?	Yes	☐	No	☐	

Wart Removal? Yes ☐ No ☐ Qualification of Person: _____

Waxing? Yes ☐ No ☐ Qualification of Person: _____

Weight Loss Services? Yes ☐ No ☐ Qualification of Person: _____

If yes to the above, please provide a detailed description of procedures performed: _____

Any surgical and/or invasive procedure? Yes ☐ No ☐

If yes to the above, please provide a detailed description of procedures performed: _____

Any other procedures? Yes ☐ No ☐

If yes to the above, please provide a detailed description of procedures performed: _____

12. a) List the number and type of applicant's employees currently including estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse		Physician (patient contact)	
Licensed Practical Nurse		Physician (medical director only)	
Aesthetician		Laser Technician	
Nurse Practitioner		CRNA/Surgical Technician	
Physician Assistant		Massage Therapist	
Medical Assistant		Chiropractor	
Other (please describe)		Clerical/Admin	

b) List the number and type of independent contractors estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse		Physician (patient contact)	
Licensed Practical Nurse		Physician (medical director only)	
Aesthetician		Laser Technician	
Nurse Practitioner		CRNA/Surgical Technician	
Physician Assistant		Massage Therapist	
Medical Assistant		Chiropractor	
Other (please describe)		Clerical/Admin	

c. Are all the above individuals listed in response to question 12a & b licensed in accordance with applicable state and federal regulations

Yes ☐ No ☐ If no, attach explanation.

13. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ If yes, at what limits? $_____ / S_____

If no, is coverage desired with shared limits on this policy? Yes ☐ No ☐

14. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ If yes, at what limits? $_____ / S_____

15 a) Who is the Medical Director? _____

b) Is coverage desired for:

(i) The Medical Director's administrative duties only? Yes ☐ No ☐

(ii) The Medical Director's administrative duties & good faith exams only? Yes ☐ No ☐

(iii) The Medical Director's administrative duties & direct patient care? Yes ☐ No ☐

If yes to part (iii), please provide a list of all procedures/services provided by the Medical Director:

_____

_____

16. Are all services provided at the applicant's location address(s)? Yes ☐ No ☐

If no, please provide details of any off-site exposure including what procedures are performed, at what types of locations, by whom and what % this is of total procedures performed: _____

_____

_____

17. Are FDA approved drugs ever used for "off-label" purposes? Yes ☐ No ☐

If yes, please provide details of the drugs and the off-label purposes for which they are used & by whom:

_____

_____

18. a) Do you conduct pre-employment screening and investigation? Yes ☐ No ☐

b) Do you question prospects about previous claims or suits? Yes ☐ No ☐

c) Are employees required to actively participate in continuing education? Yes ☐ No ☐

d) Do you prepare job descriptions and instructional manuals for your staff? Yes ☐ No ☐

e) Do you have a written incident/occurrence reporting policy and procedures? Yes ☐ No ☐

19. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	☐	Criminal Background Checks	☐
Drug / HIV/ Hepatitis Testing	☐	Licenses Held	☐
Education/Training/Competence	☐	Multi-State Registry	☐

20. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

21. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	☐	☐
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	☐	☐
c) Ever been treated for alcoholism or drug addiction?	☐	☐
d) 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?	☐	☐

22. 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:

_____

23. Give Professional Liability coverage for last five years for the firm:

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

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

24. Give General Liability coverage for last five years for the firm:

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

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

25. 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 _____

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

Yes ☐ No ☐

If yes, please give details _____

27. Has any claim ever been made against the firm or any of its employees?

Yes ☐ No ☐

If yes, please attach 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.

28. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

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)