MEDICAL SPA/ANTI-AGING CLINICS SUPPLEMENTAL APPLICATION
PROFESSIONAL LIABILITY INSURANCE

I. GENERAL INFORMATION

Attach a separate sheet of paper on your letterhead whenever additional space is needed.

1. Full Name of Applicant (Named Insured):

2. Indicate your facility’s core specialization:
   - Aesthetic/Cosmetic Practice
   - Preventative/Wellness/Mind-Body Medicine
   - Alternative/Complementary/Non-Western Medicine

3. List other business names your facility(ies) or its current principles(s) have used:

4. Date continuous operations began under current or previous business name(s):

5. Facility Licensure, if applicable:
   a. License/Registration Number:
   b. Regulating Body:
   c. Has any action ever been taken to remove, restrict, or has any disciplinary action been
      taken with respect to the current or past facility registration/license? Yes  [ ] No  [ ]
      If Yes, please explain:

6. Service Location(s) – Check all that apply and note percentage of receipts (total must equal 100%):
   - Alternative Treatment Centers __________ %
   - Beauty Salons/Aesthetic Salons __________ %
   - Doctor’s Office/Clinic/Freestanding Facility __________ %
   - Medical Centers/Hospitals __________ %
   - Private Home __________ %
   - Resorts __________ %
   - Therapeutic Centers __________ %
   - Other (specify): __________ %

II. POLICIES

1. Does Applicant utilize a formal written Quality Assurance & Risk Management Program? Yes  [ ] No  [ ]
   If No, please explain:

2. Is the overall responsibility for Risk Management assigned to one individual at your
   facility(ies)? Yes  [ ] No  [ ]
   If Yes, please provide name and title:

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

4. List name(s) and title(s) of person(s) who conduct good faith exams at your facility(ies):

5. Do you have overnight beds? Yes  [ ] No  [ ]
   If Yes, how many total persons can you accommodate at one time?

6. Do you perform procedures on patients younger than 16 years old? Yes  [ ] No  [ ]

7. Do you always require parental/guardian consent forms for be signed for patients aged 16 – 18 years old? Yes  [ ] No  [ ]

8. Do you provide daycare for patients’ children while at any of the locations noted above? Yes  [ ] No  [ ]
   If Yes, what is the staff to child ratio:
9. Do you require patients to sign liability waivers? □ Yes □ No
   If Yes, please attach your standard waiver to this application.

10. Are logs kept of all servicing, maintenance and calibration of precision instruments? □ Yes □ No

11. Please indicate the types of lasers used at your facility(ies) and the procedures in which they are used:

<table>
<thead>
<tr>
<th>Type of Laser</th>
<th>Procedures</th>
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<tbody>
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</table>

12. Do you sell or serve food or beverages? □ Yes □ No
   If Yes, please provide percentage to total annual revenues for each of the following:
   Food: ___________  Non-Alcoholic Beverages: ___________  Alcoholic Beverages: ___________

13. Is the food cooked/prepared on your premises or is it provided by a third party? □ Yes □ No

14. Are herbal supplements, homeopathic remedies, and/or nutraceuticals distributed or sold by your facility(ies)? □ Yes □ No
   If Yes, please provide a list on a separate sheet of paper the names of such supplements, remedies and/or nutraceuticals and the annual gross sales figures for each item sold.

15. Are any non-FDA approved treatments/procedures provided? □ Yes □ No
   If Yes, please explain:

16. Are each of the professionals performing procedures at your facility(ies) licensed/certified in accordance with applicable state and federal regulations? □ Yes □ No

17. Please indicate the name(s) and credentials of any individual who does or may perform injections (of any kind) on behalf of your facility(ies) and under what circumstances:

<table>
<thead>
<tr>
<th>Name</th>
<th>Credentials</th>
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</table>

18. Please provide the name(s) and credentials of any individual who does or may perform chemical peels on behalf of your facility(ies) and under what circumstances:

<table>
<thead>
<tr>
<th>Name</th>
<th>Credentials</th>
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<tbody>
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</table>
### III. OPERATIONS

1. For each of the following procedures, please indicate total number performed, receipts, and patient visits.

**NOTE:** (1) Only those procedures you indicate in this insurance application can be considered for coverage; and (2) Not all procedures indicated on this application will be covered. Ask your insurance broker to assist you with any questions relating to coverage.

<table>
<thead>
<tr>
<th>Procedure Name/Type</th>
<th>Total # Annual Procedures/Treatments</th>
<th>Total Annual Receipts</th>
<th>Total Annual Patient Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last 12 Months</td>
<td>Next 12 Months</td>
<td>Last 12 Months</td>
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<tr>
<td><strong>CLASS III</strong></td>
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<tr>
<td>Dermabrasion</td>
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<tr>
<td>Botox injections for cosmetic purposes only</td>
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<tr>
<td>Botox injections for purposes other than cosmetic only</td>
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<tr>
<td>Fat injections</td>
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<tr>
<td>Collagen injections</td>
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<tr>
<td>Silicone injections</td>
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<tr>
<td>Other injections (please specify): ____</td>
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<tr>
<td>Mesotherapy</td>
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<tr>
<td>Liposelection, Lipodissolve</td>
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<tr>
<td>Sclerotherapy</td>
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<tr>
<td>Moxibustion – direct</td>
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<tr>
<td>Chelation therapy: for purposes other than for heavy metal treatment</td>
<td></td>
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<tr>
<td>Weight management treatment involving injections and/or prescription drugs</td>
<td></td>
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<tr>
<td>Ultrasound</td>
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<tr>
<td>Mammography</td>
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<tr>
<td>Colonoscopy</td>
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<tr>
<td>Chiropractic or Traction Treatment</td>
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<tr>
<td>Hair Transplants/Implants</td>
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<tr>
<td>Any face lift including contour thread lifts, Aptos lifts and feather lifts or similar procedures</td>
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<tr>
<td>Other Surgical Procedures</td>
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<tr>
<td>Pigmented Lesion Removal</td>
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<tr>
<td><strong>CLASS II</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Microdermabrasion</td>
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<tr>
<td>Permanent Makeup/ Micropigmentation</td>
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<tr>
<td>Tattoo removal via laser</td>
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<tr>
<td>Chemical Peels - Specify Solution Strength: ____</td>
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<tr>
<td>Dental services: other than teeth whitening</td>
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<tr>
<td>Hyperbaric treatment for purposes other than for the aiding of wound healing</td>
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<tr>
<td>Acne Blue Light Treatment</td>
<td></td>
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<tr>
<td>Photo Rejuvenation/Fotofacial</td>
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<tr>
<td>Laser Hair Removal</td>
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<tr>
<td>Laser Skin Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure Name/Type</td>
<td>Total # Annual Procedures/Treatments</td>
<td>Total Annual Receipts</td>
<td>Total Annual Patient Visits</td>
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<tr>
<td>----------------------------------------------------------</td>
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<tr>
<td></td>
<td>Last 12 Months</td>
<td>Next 12 Months</td>
<td>Last 12 Months</td>
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<tr>
<td>Laser Cellulite Treatment</td>
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<tr>
<td>Thermal Wart Removal</td>
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<tr>
<td>Electrolysis</td>
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<tr>
<td>Addiction Treatment</td>
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<tr>
<td>Chelation therapy for heavy metal treatment only</td>
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<td>Colonic</td>
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<tr>
<td>Electrotherapy</td>
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</tbody>
</table>

**CLASS I**

- Tattoo removal not via laser or surgery
- Weight management treatment not involving injections and prescription drugs
- Cosmetology (nails, hair, facials)
- Biofeedback/Bone Density Scans
- Massage
- Tanning
- Ear Candling
- Hyperbaric treatment: for purpose of aiding wound healing only
- Physiocheneitherapy
- Ayurvedic Medicine
- Acupuncture
- Moxibustion – indirect only
- Dental services: teeth whitening only

2. For each of the following, please indicate number of each type of staff member, 1099s, and annual payroll.

<table>
<thead>
<tr>
<th>Personnel</th>
<th># Full-Time</th>
<th># Part-Time</th>
<th># of 1099s</th>
<th>Annual Payroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Licensed Nurses (RN/LPN/LVN)</td>
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<tr>
<td>Physician Assistants</td>
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<tr>
<td>Nurse Practitioners</td>
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<tr>
<td>Aestheticians</td>
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<tr>
<td>Electrologists</td>
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<tr>
<td>Massage Therapists</td>
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<tr>
<td>Student Interns</td>
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<tr>
<td>Other (describe):</td>
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</table>

**IV. MEDICAL DIRECTOR INFORMATION**

1. **Medical Director - Administrative Duties**
   a. Does your facility(ies) have a Medical Director? If No, skip this section completely.  
      □ Yes  □ No
      
      If Yes, please provide that person’s name: ____________________________

   b. Is the Medical Director a physician?  
      □ Yes  □ No
      
      If No, detail credentials of Medical Director: ____________________________

   c. Describe the duties of the Medical Director (attach additional sheets as necessary): ____________________________

Med Spa Application 6 12 08.doc 4
d. If not the Medical Director, who is responsible for the day to day operation of your facility(ies)?


e. Indicate days and hours when the Medical Director is present in the office:

f. Is the Applicant requesting coverage for its Medical Director’s administrative duties?  
   ☐ Yes ☐ No

   If Yes, please provide a copy of the contract(s).

g. Does the Medical Director have other professional liability coverage that will cover his or her administrative duties?  
   ☐ Yes ☐ No

h. Current Medical Director is:  ☐ Owner/Partner  ☐ Independent Contractor  
   ☐ Employee  ☐ Other (please provide details):

2. Medical Director – Patient Clinical Care

   a. Is the Applicant requesting coverage for the Medical Director’s clinical care at your facility(ies)?  
      ☐ Yes ☐ No

   b. Does the Medical Director have other professional liability coverage that will cover his/her clinical care at your facility(ies)? (If Yes, please provide a copy of that insurance policy.)  
      ☐ Yes ☐ No

   c. If the Medical Director is a physician, is he/she onsite during all procedures and/or readily available?  
      ☐ Yes ☐ No

   d. Please provide the following information for each Medical Director(s) for whom clinical care coverage is being requested (attach additional sheets as necessary):

      1) Medical Director-Physician’s full name:________________________

      2) Medical Director-Physician’s mailing address:______________________

      3) Medical license # and year and state of issuance:_________________ 4) DEA #:__________

      5) Date of Birth:_________________ 6) Place of Birth:__________________

      7) Medical School and Year of Graduation:__________________________

      8) Medical Specialty:________________ 9) Sub-Specialty:______________

      10) American Board Certified?  ☐ Yes ☐ No

          If Yes, in what specialty?________________ Year Certified:__________

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 fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

DECLARATION AND SIGNATURE:
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true and complete. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Authorized Signature on Behalf of Applicant

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be fully completed, signed and dated to be considered for quotation.
MEDICAL SPAS/ANTI-AGING CLINIC CHECKLIST

A complete submission contains the following supporting documents:

☐ Training Certificates for any Medical Director or Physician for whom coverage is being requested for any of the procedures indicated in Section III – Operations

☐ CV for any Physician for whom patient clinical care coverage is being requested

☐ List of herbal supplements, homeopathic remedies, and/or nutraceuticals distributed or sold at any location for which coverage is being requested, if applicable

☐ Copy of Medical Director’s contract(s) with the medical facility(ies) for which coverage is being requested

☐ Copy of Medical Director’s liability insurance policy indicating that professional liability coverage is provided for his/her patient clinical care performed on behalf of the facility(ies) for which coverage is being requested, if applicable

☐ Allied Medical General Application