MEDICAL SPA – APPLICATION

The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

Instructions:
1) Please type or print clearly.
2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Appropriate).
3) If the applicant needs more space for responses, continue on a separate sheet with letterhead and indicate question number.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED:

LOSS HISTORY – Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.

Copies of all marketing materials/brochures.

Current financial statements (audited if available).

Copies of most recent inspection reports within the past three years.

Copy of Informed Consent.

GENERAL/OVERVIEW INFORMATION

Applicant Name

Business Address

Mailing Address

Website

Date Business Established

Is business a Start-Up?

Requested effective date

Retroactive date:

Applicant is a

Applicant operates

Reporting/Fiscal Year Start Date:

Current Form of Insurance		Retro Date for Claims Made

Requested Coverage		Retro Date for Claims Made

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Limits of Liability*

**Professional Liability and General Liability Limits must be the same, but apply separately*.

Deductible (*applies separately to Professional Liability and General Liability*)

Revenue					
				Current Year	**12 Month Projected**

Number of Locations: _____

If more than one location, list all locations: _____

_____

_____

PROFESSIONAL LIABILITY EXPOSURE INFORMATION

1) What is the professional specialty of the clinic? _____

_____

2) Indicate the total number of annual procedures/visits per type for each of the Applicant's services:

Surgery Procedures	Performed By	Current Year Total Procedures	12 Month Projected Total Procedures
Non-Surgical Procedures			
Total			

3) For those services in the prior Question that are performed by Physicians or Dentists:

(a) Do they carry their own Professional Liability coverage?

(b) If yes, list the minimum limits required:

(c) Is coverage requested for any Physicians or Dentist list above?

4) What type of anesthesia is administered to patients?

5) Client/Patient Age Breakdown by percentage, must total 100%:

Less than 21 years old
21 to 50 years old
50+ years old
Total

6) If the Applicant plans to expand locations offered, services and/or number of personnel, give details:

7) If a physician does not perform the "good faith" initial exam, explain why not in detail

PRODUCTS LIABILITY

8) Complete the following:

Products Sold	Current Year Revenue	Projected 12 Months Revenue	Is this product FDA approved?	If FDA approved, is it used in an 'off-label' manner?

If a product is FDA approved and is it used in an 'off-label' manner, describe details here:

STAFF

9) Professional Employees/Independent Contractors – list each physician providing services at the applicant's facility.

Medical Director - Name	Specialty	Insurance Carrier & Policy Number	Employee or Contractor	Hours per Month

10) Will the Medical Director have any direct patient contact or work in an administrative capacity only?

11) Other Health Care Professionals – Indicate the number in each category, full-time and part-time.

Profession	# of Employees		# of Contractors	
	Full Time	Part Time	Full Time	Part Time

12) For those health care professionals that are considered Independent Contractors:

(a) Do they carry their own Professional Liability coverage?

(b) If yes, list the minimum limits required:

(c) Does the applicant request proof of coverage for Independent Contractors?

RISK MANAGEMENT

13) Has any outside organization conducted an inspection of the applicant's facility in the past 3 years?

If yes, please indicate the name of the organization and the type of inspection:

14) Is this facility licensed by the state?

If yes, list the type of licensing and list the state(s).

15) Do any of the employees require licensing by the state?

If yes, list the employee name, type of licensing and the state(s).

16) Has the applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any state/federal licensing board or regulatory agency?
If yes, give details.

17) If the facility is accredited and/or inspected by any governmental body or other organization indicate below:

Number of Facilities	Organization	Status	Date of Last Inspection

Describe the type(s) of inspections (physical plant, nursing protocols) and include a copy of any accreditation report(s).

18) List all associations that the applicant is a member of:

19) Does the applicant's facility have a formalized Risk Management Program?

20) Who coordinates the applicant's Risk Management Program?

Name

Title Phone Number

21) Is parental consent obtained for all minors treated at the applicant's facility?

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22) Does the Applicant take before and after photographs of every patient?

If no, give details.

23) Does the applicant have any contractual agreements with independent contractors/providers to provide services at the applicant's facility?

If yes, give details and provide a copy of a sample contract.

Are certificates of insurance obtained from all contracted providers?

24) Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at the applicant's facility:

Check of educational background, or residency program, when applicable.
Check of previous employers
Check of personal references
Check on hospital privileges for physicians, oral surgeons and dentists.
How often doe the applicant update their list of specific privileges?
Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
Require information on any professional liability or work-related claim that has previously been made against any individual.

25) Does the applicant's facility have written job descriptions?

COMMERCIAL GENERAL LIABILITY INFORMATION (Complete This Section If Requesting GL Coverage)

26) Please provide physical plant information as requested (use additional sheet if necessary):

Address / Occupancy	Square Footage	Age	Type of Construction	# Floors	Type of Fire Protection*	Designed for Patient Care?	Designed for Overnight Guests?	Number of Exits per Floor

27) Please indicate any additional insureds to be included under the applicant's facility General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

28) Does the applicant own or lease equipment?

29) Who is responsible for the inspection and maintenance of the equipment?

30) Are policies/procedures established to respond to/address patient medical emergencies while at the facility?

31) Are the electrical, heating and plumbing systems up to code and regularly inspected?

If yes, then inspected by whom and what date?

Is the building completely sprinklered?

If partially sprinklered, identify those areas that are sprinklered.

32) Are the fire alarms connected to a local fire station?

If yes, what was the date of the last fire alarm inspection?

HISTORICAL CARRIER INFORMATION

33) Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

Type	Insurer	Policy Period	Premium	Limits	Deductible/SIR	CM (w/ Retro) Or Occurrence	If CM. Retro Date

34) Has the applicant ever had any insurance company decline, cancel, rescind or non-renew Professional Liability coverage? If provide details.

LOSS HISTORY

35) Large Loss Description – Attach 5 years Loss Runs. On a separate sheet of paper list any liability claims or suits made or brought against the applicant's facility during the past five years for amounts incurred greater than $50,000. If no claims or suits greater than $50,000 then check the box:

□ Submitted on Separate Sheet of Paper
□ None Greater than $50,000

36) Is the applicant aware of any circumstances, accidents or losses (occurring after the retroactive date) that have not yet been reported but which may result in a claim?

If yes, give dates, allegations and disposition of each claim or suit in the comments section.

37) Give the valuation date:

OTHER

38) Does the applicant offer day care services?

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THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE PART OF THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THIS APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

NOTICE TO KENTUCKY APPLICANTS: "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 INSURANCE ACT, WHICH IS A CRIME."

NOTICE TO LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

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NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "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, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____

Producer Name: _____

Address: _____

Telephone: _____

Fax: _____