Hull & Company
Lic. #0F60641

Southern California
P: (949) 477-5030
F: (949) 477-5040

Northern California
P: (209) 474-9100
F: (866) 217-1815

Pacific Islands
P: (808) 840-1980
F: (866) 859-8302

Medical Spa Professional Liability Insurance Application (Claims Made)

1) Full Name of Applicant:

(Include all DBA's and subsidiaries seeking coverage under the policy for which you are applying.)

2) Mailing Address:

3) Other Locations:

4) Web site Address (If applicable)

5) Date Established

6) Type of Entity:

- ◯ Corporation
- ◯ LLC
- ◯ Partnership
- ◯ Other - Please Describe
- ◯ Individual

7) Is this entity owned by, associated with, or controlled by any other entity? ◯ YES ◯ NO

If Yes, Please give details

8) Please provide the **number** of 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 or Volunteer	Independent Contractor	Insured On Own Med Mal Policy	Insured Limits
Physicians (no surgery):			◯ YES ◯ NO	
Physicians (surgical):			◯ YES ◯ NO	
CRNA's			◯ YES ◯ NO	
Physician Assistants:			◯ YES ◯ NO	
Nurse Practitioners:			◯ YES ◯ NO	
Registered Nurses:			◯ YES ◯ NO	
LPN's or Nurse Aides:			◯ YES ◯ NO	
Aestheticians:			◯ YES ◯ NO	
Laser Techs:			◯ YES ◯ NO	
Medical Assistants:			◯ YES ◯ NO	
Massage Therapists:			◯ YES ◯ NO	
Other:			◯ YES ◯ NO	

* Please attach copies of declarations pages on all individuals that carry their own medical malpractice.

* Please note, basic policy does not cover independent contractors for their individual liability. If you are seeking coverage for independent contractors, please provide details on a separate attachment.

9) Are all of the above individuals licensed in accordance with applicable state and federal regulations. ◯ YES ◯ NO

If No, please attach 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? ◯ YES ◯ NO (If Yes, please attach a completed Medispa Physicians application.)

(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 that will be preformed over the next 12 months:

PROCEDURE	# Per Year	PROCEDURE	# Per Year	PROCEDURE	# Per Year
Abdominoplasty		Chemical Peels (Medium to Heavy)		Injectable/Dermal Fillers *	
Acne Treatment		Contour Thread Lifts		IPL & Photofacial Rejuvenation	
Acupuncture		Dermaplaning		Lipolysis - Laser (Smart Lipo)	
BHRT (Bioidentical Hormone Replacement Therapy)		Ear Candling		Liposuction	
Breast Augmentation		Electrolysis			
Brown Spot Removal		Hair Transplants			
Chemical Peels (Light)		HCG			
		Hyperbaric Treatment			

* Injectable/Dermal Fillers: Include Artefill, Botox, Captique, Collagen, Hyiaform, Jurederm, Radiesse, Restylane, Sculptra

Question 12 continued:

Laser Cellulite Treatment		Permanent Makeup		Waxing	
Laser Hair Removal		Pigmented Lesion Removal		Weight Loss Mgmt	
Laser Skin Resurfacing		Sclerotherapy		Other	
Lipodissolve		Skin Tag Removal		Other	
Liposelection		Tattoo Removal		Other	
Lipolysis - Injection		Teeth Whitening		Total of Procedures	
Massage		Thermage			
Mesoderm		Vein Treatment			
Mesotherapy		Wart Removal			
Microdermabraison					

13) For the following procedures, please provide the additional information requested below.

Yes/No	Procedure	Who performs the procedure? (Provide medical designation.)	On which parts of body?
◯ YES ◯ NO	Abdominoplasty		
◯ YES ◯ NO	Breast Augmentation		
◯ YES ◯ NO	Contour Thread Lift		
◯ YES ◯ NO	Lipodissolve		
◯ YES ◯ NO	Lipolysis - Injection		
◯ YES ◯ NO	Lipolysis - Laser (Smart-Lipo)		
◯ YES ◯ NO	Liposuction		
◯ YES ◯ NO	Hair Transplant		

* IF YOU PERFORM A PROCEDURE THAT IS CALLED BY A DIFFERENT NAME, BUT ESSENTIALLY THE SAME AS ANY OF THE ABOVE PROCEDURES, PLEASE ANSWER THE QUESTION ACCORDINGLY.

*IF YOU PERFORM SURGICAL PROCEDURES OTHER THAN THOSE SHOWN ABOVE, PLEASE ATTACH A LIST OF THOSE PROCEDURES AND THE NUMBER OF ANTICIPATED PATIENT ENCOUNTERS FOR THE NEXT 12 MONTHS.

14) 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?

15) Do you ever provide any services at locations other than your medical spa? ◯ YES ◯ NO

If Yes, please provide the following details:

(a) What services?

(b) At what locations?

(c) Who preforms the services & what is their medical designation?

(d) How many off-site procedures do you estimate over the next 12 months?

(e) Will alcohol be served to these off-site patients? ◯ YES ◯ NO

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

	Administered by:
◯ Anesthesia Only	
◯ Conscious Sedation	
◯ General Anesthesia	
◯ Other	

17) Does this applicant sell any products? 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? ◯ YES ◯ NO

If Yes, please attach copy of declarations page.

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. Form Link

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.

☑ I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Current Date 09/30/2010

Title

If you prefer not to Return Application with an Electronic Signature, Please print and Sign Below:

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this electronically submitted application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this electronic application and this application will be made part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Signature of Applicant or Authorized Representative

Current Date:

Title

Type or print your name & title

Type or print your phone number

Type or print your e-mail address

Please attach the following documents to this application:

* Certificates of training for Employees & Physicans
* Copies of brochures, marketing or advertising materials
* Five years of currently valued company loss runs.
* Information on disciplinary actions, license revocations, etc.
* Copy of most current declarations page

Additional Comments or Details: