Weight Loss Supplement
(to be completed with the General Allied Health or Medical Spa Application)

1. Name of Applicant (as it should appear on the policy): _____

2. Please check all methods used for weight loss:

- ☐ Diet & Exercise
- ☐ Non-Prescription Vitamins/Supplements
- ☐ Prescription Medications
- ☐ Surgery/Surgical Procedures: (please provide details): _____
- ☐ Injections (please list type): _____
- ☐ Other (please list): _____

3. If medications are prescribed for weight loss, please answer the following:

i. Who is prescribing them (including professional designation): _____

ii. Provide a list of all medications prescribed:

_____

_____

_____

_____

iii. Is an in-person examination performed prior to the prescription of any medication?

Yes ☐ No ☐

If no, please provide details: _____

iv. Is blood work performed prior to treatment? Yes ☐ No ☐

How often is follow-up blood work required? _____

v. Are any medications prescribed for weight loss in an off-label/non-FDA approved manner (i.e. are any medications prescribed for weight loss that have not been approved by the FDA specifically for weight loss? Or are any medications prescribed for weight loss in a quantity, format, for a duration, or in a frequency other than that approved by the FDA?)

Yes ☐ No ☐

If yes, please provide details: _____

_____

vi. Are consent forms used and retained in the patient's file in all cases advising patients of the potential risks in taking medications that have not been approved by the FDA, or in taking medications in a quantity, format, for a duration, or in a frequency other than that approved by the FDA?

Yes ☐ No ☐

vii. Are any compounded weight loss medications prescribed? Yes ☐ No ☐

If yes, are they being compounded with sodium or acetate? Yes ☐ No ☐

viii. Do you ask all patients to fill their medications at a state licensed pharmacy, warning them in writing on a signed consent form kept in the patient's file of the dangers of filling medications using unapproved pharmacies?

Yes ☐ No ☐

ix. What steps are taken to prevent patients from measuring and self-administering incorrect doses of the medications prescribed? Please provide details: _____

_____

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.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Supplement must be signed by the owner or president or principal)