Professional & General Liability Application for Medical Spas

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

2. Mailing Address: _____

3. Location Address: _____
(If more than one location address, please provide a breakdown of the number and type of staff and procedures performed per location)

4. Telephone Number: _____ Website Address: _____

5. Exposure:

Gross Receipts for the Past 12 Months:	$
Estimated Gross Receipts for the Next 12 Months:	$
Payroll for the Past 12 Months:	$
Estimated Payroll for the Next 12 Months:	$
Number of Visits (not patients) for the Past 12 Months:	
Estimated Number of Visits (not patients) for the Next 12 Months:	

NOTE: Please provide # of visits, not the # of patients, in response to the above questions. Please count each time each client/patient has contact with a staff member, whether in person or via telehealth, as an individual visit.

6. Exposure: Please complete the table below showing all procedures/services performed.

NOTE: If this is a start-up business not yet in operation, please show estimated % exposures for the next 12 months in each of the areas listed.

Non-Medical Procedures:

Procedure/Service	Yes	No	Professional Designation/ Certification of person performing
Electrolysis	☐	☐	
Eyelash & Brow Procedures (Lifting, Tinting & Extensions)	☐	☐	

Procedure/Service	Yes	No	Professional Designation/ Certification of person performing
Non-Medical Grade Facials			
Dermaplaning			
Localized Cryotherapy, including Coolsculpting/Cryolipolysis and Cryo Facials			
Chemical Peels			
Microdermabrasion			
Microcurrent procedures			
Microneedling, including Radiofrequency Microneedling			
Permanent Make-Up & Microblading			
Saline Tattoo Removal			
Teeth Whitening			
Non-Laser Hair Removal (Waxing, Threading & Sugaring)			
Hair & Nail Services			
Make-Up Application			
Other (please describe):			

Injectables:

Procedure/Service	Yes	No	Professional Designation/ Certification of person performing
Neurotoxin Injections (e.g. Botox, Dysport, Xeomin, Jeuveau and Daxxify)			

Procedure/Service	Yes	No	Professional Designation/ Certification of person performing
Hyaluronic Acid Dermal Filler Injections (e.g. Juvederm and Restylane)			
Biostimulator Injections (e.g. Radiesse, Sculptra and Bellafill)			
Hyaluronidase Injections			
Kybella Injections			
Vitamin Injections			
Platelet-Rich Plasma and/or Platelet-Rich Fibrin Injections			
Sclerotherapy			
Other (please describe):			

Non-Laser Medical Procedures:

Procedure/Service	Yes	No	Professional Designation/ Certification of person performing
Elective IV Hydration Therapy			
Emsella			
Weight Loss			
Hormone Replacement Therapy			
Other (please describe):			

Light & Laser-Based Procedures:

Procedure/Service	Yes	No	Professional Designation/ Certification of person performing
Non-Invasive, Aesthetic Radiofrequency Skin & Body Procedures (e.g. Vanquish)			
Non-Invasive, Aesthetic Ultrasound Body Contouring and Skin Tightening (e.g. Ultherapy)			
Non-Invasive Aesthetic Light Skin Treatments (e.g. LED Skin Treatments & Photofacial Rejuvenation)			
Non-Invasive Aesthetic Thermal Skin Tightening			
Thermal, Radiofrequency, Ultrasound and/or Laser-Based Vaginal Rejuvenation			
Non-Invasive, Aesthetic Light & Laser Based Skin & Body Tightening, Resurfacing and/or Contouring (e.g. Sculpsure)			
Non-Invasive, Aesthetic Electromagnic Skin Tightening (e.g. Emsculpt, Emtone, Emface & Cooltone)			
Laser Mole, Skin Tag, Brown Spot, Pigmented Lesion & Wart Removal			
Laser Acne Treatment			
IPL Skin Procedures, including IPL Hair Removal			
Laser Hair Removal			
Laser Vein Treatment			
Laser Tattoo Removal			
Other (please describe):			

Other Procedures:

Procedure/Service	Yes	No	Professional Designation/ Certification of person performing	Number Performed Past 12 Months	Number Estimated Next 12 Months
Smart Lipo	☐	☐			
Plasma Fibroblast	☐	☐			
Other (please describe):	☐	☐			

7. Are any of the exposures listed in the above tables expected to change over the next 12 months?

Yes ☐ No ☐

If yes, please provide details: _____

_____

8. IV Therapy Exposure: Please answer the following questions if there is any current or anticipated IV therapy exposure

a) Professional designation/certification of person who pre-screens or will pre-screen all patients prior to IV therapy treatment being performed:

_____

b) Professional designation/certification of person who administers or will administer IV therapy treatment:

_____

c) Please list all substances administered, or that the applicant plans to administer, via IV: _____

_____

_____

9. Does the applicant, or any of their employees, independent contractors or volunteers, offer or plan to offer weight loss services over the next 12 months?

Yes ☐ No ☐ **If yes, please complete the Weight Loss Supplement.**

10. Does the applicant, or do any of their employees, independent contractors or volunteers, prescribe any medications for any reason other than weight loss as shown on the Weight Loss Supplement?

Yes ☐ No ☐ If yes, please answer the following:

a) Who is prescribing them (including professional designation): _____

b) Provide a list of all medications prescribed: _____

_____

c) Under what circumstances/for what reasons: _____

d) Is an in-person examination performed prior to the prescription of any medication?

Yes ☐ No ☐

If no, please provide details: _____

e) Are any medications prescribed for use in off-label/non-FDA approved manner (i.e. are any medications prescribed for a use or for a condition not approved by the FDA? Or are any medications prescribed in a quantity, format, or for a duration other than that approved by the FDA?)

Yes ☐ No ☐ If yes, please provide details:

_____

_____

11. a) List the number and type of employees/owners including any estimated over the next 12 months:

	Number		**Number**
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Laser Technician	
Aesthetician (medical)		Aesthetician (non-medical)	
Dentist		Paramedic/EMT	
Medical Assistant		Surgical Technician	
Massage Therapist		Pharmacist	
Chiropractor		Acupuncturist	
Admin/Clerical		Other (please describe)	

b) List the number and type of independent contractors including any estimated over the next 12 months:

	Number		**Number**
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Laser Technician	
Aesthetician (medical)		Aesthetician (non-medical)	
Dentist		Paramedic/EMT	
Medical Assistant		Surgical Technician	
Massage Therapist		Pharmacist	
Chiropractor		Acupuncturist	
Admin/Clerical		Other (please describe)	

c) Are all the individuals listed in response to Q17a & b licensed in accordance with applicable state and federal regulations?

Yes ☐ No ☐ **If no, attach explanation.**

12. 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? $_____ / $_____

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

13. Do you require employed, contracted or volunteer physicians, nurse anesthetists, dentists, acupuncturists and/or chiropractors to carry their own Professional Liability Insurance at a minimum of $1M/$3M limits and secure Certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ **Please attach proof of coverage.**

14. a) Name and professional designation of medical director (e.g. MD, DO, PA, NP): _____

b) Desired coverage for medical director:

	Yes	**No**
Administrative duties		
Good Faith Exams		
Direct Patient Care		

NOTE: If coverage is desired for direct patient care, please ensure that the procedure tables on the application are correctly completed showing all procedures the medical director performs.

15. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes ☐ No ☐

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of $1M/$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes ☐ No ☐

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

If no, please confirm what % of services are provided off-site _____ % and complete the table below:

Services Provided Off-Site	**Professional Designation/ Certification of person performing**	**Type of Location**	**% of Exposure**

17. Please confirm which of the following you obtain, review, verify and keep on file as part of the employee/ independent contractor hiring & screening process:

	Yes	**No**
Employment Application		
Criminal Background Checks		
Drug / HIV/ Hepatitis Testing		
Licenses Held		
Education/Training/Competence		

18. Additional employment related questions:

	Yes	No
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

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

_____

20. Do you sell, rent or otherwise provide any equipment to products or others? Yes ☐ No ☐

If yes, please complete the supplement for Durable Medical Equipment Sales/Rentals.

21. Please complete the table below showing the applicant's Professional Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

22. Please complete the table below showing the applicant's General Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

23. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	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 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?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

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

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

25. 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 attached a separate sheet with date(s) and 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.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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