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

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full name of Applicant: ____________________

b. Date established: ____________________

Please attach proforma business plan if this is a start-up.

c. Website: ____________________

2. OPERATIONS

a. Clinics professional specialty: ____________________

____

b. Please identify Medical Director(s): ____________________

Attach CV for Medical Director(s) along with a description of duties.

c. Division of patients / clients:

Medical Spa / Anti-Aging	______%
Surgical	______%
Massage	______%
Weight Control	______%
Dental	______%
Research or Experimental	______%
Beauty Shop (nails, hair, facials)	______%
Other ____________	______%
____________	100%

Patient / client ages:

Less than 12 years old	______%
13 to 18 years old	______%
Greater than 18 years old	______%
Total	100%

3. PROFESSIONAL SERVICES

a. Do you perform:

Procedure	Performed by (include name of all individuals performing each procedure	Training Certificate and CV Attached	CV Attached	Client Selection Protocol Attached	Informed Consent Attached	Number c Procedure
Microdermabrasion	________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Laser Hair Removal	________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Electrolysis	________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Chemical Peels (solution strength?)	________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________

Massage	______________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Botox Injections						
Other Injections Please specify type. (collagen, fat, silicone)	______________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Laser Skin Treatment Please specify type	______________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Acne Blue Light Treatment	______________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Hair Transplants	______________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Permanent Makeup / Micropigmentation	______________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________
Other ______________	______________	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	________

NOTE: If you require any physician or dentist to be Named Insureds, please submit a separate application for each such individual. If any physician is providing services has separate coverage for his/her activities, please provide confirmation of such coverage.

b. Identify all Manufactured Equipment used in your practice along with the purpose for which each is used.

____

____

____

____

c. Is all labeling of Drugs and use of Devices with approval of the FDA? ....[ ] Yes [ ] No
If no, please explain____

d. Do you take before and after pictures of every patient? ....[ ] Yes [ ] No
If not, why?____

4. STAFF

a.

Number	Type of Profession	Number	Type of Profession
______	Aestheticians	______	Massage Therapist__________________________
______	Electrologist	______	Technician, please specify type__________________
______	Registered Nurse	______	Other, please specify type______________________

b. Do you supervise any individual other than your own employees?..[ ] Yes [ ] No
If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals. ____

____

Indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
______	Aestheticians	______	Massage Therapist__________________________
______	Electrologist	______	Technician, please specify type__________________
______	Registered Nurse	______	Other, please specify type______________________

5. HISTORY

Please list Professional Liability insurance carried for each of the past three years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes No	Retro Date
							[ ] [ ]	
							[ ] [ ]	
							[ ] [ ]	

Please list prior General Liability insurance carried for each of the past three years. If none, state "NONE".

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes No	Retro Date
							[ ] [ ]	
							[ ] [ ]	
							[ ] [ ]	

6. GENERAL LIABILITY

a. Please complete the following for each of your facilities if you desire General Liability insurance:

	Location Number	Parking Lot or Name and Location Address	Description of Type of Facility	Garage Maintained by Insured?	Adjacent Exposure?	Square Footage
(i)				[ ] Yes [ ] No	[ ] Yes [ ] No	
(ii)				[ ] Yes [ ] No	[ ] Yes [ ] No	
				[ ] Yes [ ] No	[ ] Yes [ ] No	

b. Please complete the following for each location:

(i)	Year built			
(ii)	Year Remodeled			
(iii)	Number of Stories			
(iv)	Construction: Frame, Brick, Concrete			
(v)	Percentage of Building Occupied by Insured			
(vi)	Other Occupancy			
(vii)	Location Number			

c. Is the Building Equipped with:

(i) Complete Sprinkler System? .... [ ] Yes [ ] No
(ii) At Least Two Clearly Marked Exits at Each Floor? .... [ ] Yes [ ] No
(iii) Self-Closing Fire Doors on Each Floor? .... [ ] Yes [ ] No
(iv) Automatic Fire Alarm System Connected to Local Fire Department? .... [ ] Yes [ ] No
(v) Smoke Detectors? .... [ ] Yes [ ] No
(vi) Emergency Electrical System? .... [ ] Yes [ ] No
(vii) Heat Sensors? .... [ ] Yes [ ] No
(viii) Fire Escape(s)? .... [ ] Yes [ ] No
(ix) Posted Emergency Evacuation Procedures? .... [ ] Yes [ ] No
(x) Properly Maintained Fire Extinguishers? [ ] Yes [ ] No

d. Is a formal written safety program in place? .... [ ] Yes [ ] No

(If Yes, please attach a copy of the safety program.)

e. Are written procedures in effect for incident reporting? .... [ ] Yes [ ] No

f. Any exposure to flammables, explosive, chemicals? .... [ ] Yes [ ] No

g. Any catastrophe exposure? .... [ ] Yes [ ] No

h. Any exposure to radioactive materials? .... [ ] Yes [ ] No

i. Do operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? .... [ ] Yes [ ] No

j Machinery or equipment loaned or rented to others? .... [ ] Yes [ ] No

k. Are there any elevators or escalators owned by you? .... [ ] Yes [ ] No
If Yes, please indicate model and if the elevator and/or escalator is serviced by you under a maintenance contract. ______________________________

l. Any parking facilities owned/rented? .... [ ] Yes [ ] No

m. Recreation facilities provided? .... [ ] Yes [ ] No

n. Is there a swimming pool on the premises? .... [ ] Yes [ ] No

o. Sporting or social events sponsored? .... [ ] Yes [ ] No

5 Year General Liability Loss History (attach further sheets if needed)
(10 Years for Claims $100,000 and Greater)

q.

Date of Occurrence	Date Claim Made	Amount Description of Loss	Amount of of Loss Reserved	Amount Expenses Paid	Amount of of Loss Reserved	Open (O) Expenses Reserved	or Closed (C)

r. (i) Is any claim above subject to a deductible or self-insured retention? .... [ ] Yes [ ] No

(ii) If Yes, are the amounts shown above inclusive or exclusive of the deductible or self-insured retention? ______________________________

(iii) If inclusive, the amount of the deductible or self-insured retention is $ ____________

s. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you? .... [ ] Yes [ ] No
If Yes, please attach an explanation.

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.

______________________________ ______________________________
Name of Applicant Title (Officer, partner, etc.)

______________________________ ______________________________
Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

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Over a Century of Service

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