MEDI SPA APPLICATION

1.1 Applicant Name:____Phone:_______________________

Business Name:____Website:______________________

Mailing Address:_____________________________City:_________________State:______Zip:_______

Business Address:____

1.2 Business operated as: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Individual ☐ Independent Contractor

1.3 Business operated as Medi-spa?__________ If not, other:____

1.4 How long in business?________________________Do all professionals have licenses?______________

1.5 If business operated as a medi-spa, annual gross receipts from all operations:________________________

1.6 Do you have operations not listed on the below schedule?____If yes, provide details: _________________

____

Do you have insurance for these operations?________Name of insurance company:___________________

1.7 Products liability needed for products sold by you?_____Gross receipts (excluding private label):_________

Do you private-label products for sale?____________ (No coverage is provided for private label products)

SCHEDULE OF SERVICES

Indicate which services you provide, number of operators who do the service and if we are to insure them.

INSURE?

MANICURISTS YES/NO NUMBER_______ _______

BEAUTICIANS YES/NO NUMBER_______ _______

FACIALS YES/NO NUMBER_______ _______

List products you use and percentage of acids:____

Have you had training on the peels you are using?____

Do you perform Medical Strength peels? YES/NO NUMBER________ _______
If so, a separate application is required

MICRODERMABRASION
Have you been trained in microdermabrasion? YES/NO
Do you use a consent form for microdermabrasion? YES/NO (If yes, attach copy)

WAX REMOVAL YES/NO NUMBER_______ _______
Are all the facialists doing wax removal as well? YES/NO

BODY WRAPS YES/NO NUMBER_______ _______
List the type of wraps you use:____

MASSAGE YES/NO NUMBER_______ _______
Have you been trained in massage? YES/NO (If yes, attach copy)

ELECTROLOGY YES/NO NUMBER_______ _______

FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED

PERMANENT MAKEUP YES/NO NUMBER_______ _______

LEDs – CLASS II YES/NO NUMBER_______ _______

LASER / INTENSE PULSED LIGHT YES/NO NUMBER_______ _______

DERMAL FILLERS and/or BOTOX YES/NO NUMBER_______ _______

SCLEROTHERAPY YES/NO NUMBER_______ _______

PART IV. HISTORY All questions must be answered. Failure to disclose claims history could invalidate coverage

4.1 Do you currently have insurance coverage? ☐ Yes ☐ No If yes, indicate the following:

Insurer *Policy #* *Liability Limits* *Premium* *Exp. Date*

____

If claims made, most recent retroactive date: _______________

4.2 Have you ever had professional liability insured refused, declined, cancelled or accepted on special terms? ☐ Yes ☐ No
If yes, provide details on a separate sheet

4.3 Has any liability suit, arbitration or other claim proceeding been brought against you, your business or any applicant for any alleged malpractice? ☐ Yes ☐ No If yes, provide details on a separate sheet

4.4 Do you, or any applicant, have knowledge of an event, circumstance or occurrence prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No
If yes, describe details on a separate sheet

4.5 Has any applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by, or to, any state or federal licensing board or regulartory agency? ☐ Yes ☐ No
If yes, provide details on a separate sheet

4.6 Have you ever or any applicant ever been charged or convicted of a criminal offense? ☐ Yes ☐ No
If yes, provide details on a separate sheet

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

____ ____________________
APPLICANT SIGNATURE TITLE

_______________ __________________________ ____________________
DATE REQUESTED EFFECTIVE DATE LIABILITY LIMIT REQUESTED

One box below must be checked:

☐ I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

☐ I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

ADDITIONAL INSURED: Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME:____

ADDRESS:____

BOTOX/DERMAL FILLER OPERATOR APPLICATION

1.1 Applicant name:____Phone:________________

Business name:____

Mailing Address:_____________________________________City_______________State_______Zip____

1.2 Business structure: ☐ Corporation ☐ LLC ☐ Partnership ☐ Individual ☐ Independent Cont.

1.3 What percentage of your work is done in each of the following: Medi-Spas?_____Medical Center?_______

List other facility types & percentage:____

Business Address #1:____Type of Facility?_______________

City, State & Zip:____

Business Address #2:____Type of Facility?_______________

City, State & Zip:____

Do you operate out of only professional offices in the above facilities?_______________________________

1.4 If you are not an MD., is there a medical doctor on your staff?____Do they work out of your office?______

If in your office, give name and professional degree:____

If no, give name, degree and address of your supporting doctor:____________________________________

____

1.5 Are you in compliance with all AMA and state laws as to use of Botox & Fillers?______________________

1.6 Do you have everyone sign a consent form?________ We must receive a copy of the form(s) you use.

1.7 Do you use a medical history form on everyone?____ We must receive a copy of the form(s) you use.

OPERATOR INFORMATION

2.1. OPERATOR TO BE NAMED:____

2.2. Licenses you hold & license numbers:____

2.3. How long have you worked with Botox?______Do you offer off-label Botox (brows and crows feet)?_____

Education in Botox: List all information as requested and include certificates of completion

Date	Class Title	Number of Hours

2.4 Estimated Annual Gross Receipts from Botox services:____

2.5 How long have you been working with Dermal Fillers?____

2.6 What dermal fillers do you offer? Restylane ☐ Captique ☐ Hylaform ☐ Zyplast ☐ Sculptra ☐ Juvederm ☐

Other____

Education in Dermal Fillers: List all information as requested and include certificates of completion

Date	Class Title	Number of Hours

2.7 Estimated Annual gross receipts from dermal fillers:____

2.8 What type of services, not listed above, do you offer?____

____

2.9 What anesthetics do you use prior or during the filler procedure? ___________________________________

____

3.0 If you are a doctor, or want to cover a doctor, is their other medical malpractice coverage? yes ☐ no ☐

If yes, attach a copy of the malpractice declarations page.

I understand:

1. I will only have coverage in specified facilities.
2. I will only buy Botox in the United States from Allergan or from an approved Allergan wholesaler.
3. No insurance will be offered for any Botox area except as approved by the FDA, which currently is for glabella only unless limited off-label coverage for brows and crows feet at a $100,000 sub-limit is endorsed herein.
4. Botox coverage is only provided for work on patients from 18-65, per FDA guidelines.
5. I will only be covered for dermal fillers as approved by the FDA and endorsed on the policy applied for herein.
6. Every client must sign a consent and medical history form and no coverage will apply if there is not a signed form on file. If I change a form, it must be approved by the insurance company.
7. No coverage is provided for work on pregnant or nursing women.
8. All other medical services are excluded except for those being listed and paid for under this policy.
9. There is no coverage for prescription medications or prescription anesthetics unless a local anesthetic is approved by the carrier and endorsed onto the policy.

HISTORY: NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

4.1 Do you currently have insurance coverage? ___Yes ___No If claims made, most recent retroactive date:_______________
If yes, please indicate the following:

Insurer *Policy #* *Liability Limits* *Premium* *Exp. Date*

____

4.2 List all claims history whether or not insured: If none, state so_____________.

YR/Claim *Nature of injuries* *Equip. Involved* *Details, if Pending* *Amt. if settled*

____

____

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence?
_______Yes _______No. If yes, describe details of the event:

____

____

I understand and agree this Application and any and all supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to all Lloyd's of London syndiciates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

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☐ I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

LANDLORD AS ADDITIONAL INSURED_______:____

ADDRESS:____________________________________CITY, STATE, ZIP_______________________

MESOTHERAPY SUPPLEMENT APPLICATION

INDIVIDUAL NAME:____

Note only ingredients approved by the company will be covered

1. How long have you been providing Mesotherapy services?__________________

2. List your training classes and or experience with Mesotherapy injections?
   ____
   ____

   Provide all certificates of training

4. List name and address of your supporting doctor:__________________________
   ____

6. What licenses do you hold?____

7. Do you understand for coverage to apply, a consent form must be on file? ______
   Provide copies of all consent forms used.

8. Are all products used from licensed, compounding pharmacy?________________

9. Do you understand that no more than 40ccs of product can be used at any one visit?_________ If using between 20ccs and 40ccs in one visit, clients must stay and relax and sign the dizziness section on the Mesotherapy consent form.
   __________Initial

10. I understand that Mesotherapy injections will only be offered for fat reduction, cellulite and wrinkles. ________ No coverage is provided for pain reduction or other Mesotherapy categories.

Coverage is available on this form for a liability limit of $100,000 and has a $5,000 deductible

I warrant the above information is true, I accept the policy terms, and I will have every client sign an approved consent form prior to their Mesotherapy procedure.

Signed____Date:______________

Application must be used with Medi-Spa application for any individual applicant