ADMIRAL INSURANCE COMPANY A Berkley Company®

PHYSICIAN'S MEDICAL SPA PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

PHYSICIAN'S PERSONAL INFORMATION

1) Full Name of Applicant:

2) Mailing Address:

3) Medical License # and State of Issuance:

4) Social Security #: 5) DEA#

6) Date of Birth: 7) Place of Birth:

8) Medical School & Year of Graduation:

9) Medical Specialty: Sub Specialty:

*Unless your specialty is Dermatology, Aesthetics, Anti-Aging or Plastic/Cosmetic Surgery, please attach Certificates of Training for the procedures you will be performing outside your specialty.

10) Are you American Board Certified? ◯ YES ◯ NO

If Yes, in what specialty? Year Certified:

MEDISPA INFORMATION

11) Name & Location of Medical Spa (s) where services will be performed:

12) Your relationship to this entity:

◯ Owner/Partner
◯ Independent Contractor
◯ Employee
◯ Other - Please Describe

13) When did you begin providing medical services at this facility?

14) 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		Injectable/Dermal Fillers *		Pigmented Lesion Removal	
Acne Treatment		IPL & Photofacial Rejuvenation		Sclerotherapy	
Acupuncture		Lipolysis - Laser (Smart Lipo)		Skin Tag Removal	
BHRT (Bioidentical Hormone Replacement Therapy)		Liposuction		Tattoo Removal	
Breast Augmentation		Laser Cellulite Treatment		Teeth Whitening	
Brown Spot Removal		Laser Hair Removal		Thermage	
Chemical Peels (Light)		Laser Skin Resurfacing		Vein Treatment	
Chemical Peels (Medium to Heavy)		Lipodissolve		Wart Removal	
Contour Thread Lifts		Liposelection		Waxing	
Dermaplaning		Lipolysis - Injection		Weight Loss Mgmt	
Ear Candling		Massage		Other	
Electrolysis		Mesoderm		Other	
Hair Transplants		Mesotherapy		Other	
HCG		Microdermabraison		Total of Procedures	
Hyperbaric Treatment		Permanent Makeup			

* Injectable/Dermal Fillers: Include Artefill, Botox, Captique, Collagen, Hylaform, Juvederm, Radiesse, Restylane, Sculptra

* 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.

PRIOR INSURANCE AND CLAIM INFORMATION

15) Do you currently carry Professional Liability Insurance for your medical services provided outside of this facility? If Yes, please provide details for the past 5 years: ◯ YES ◯ NO

Company	Policy Term	Limits of Liability	Retro Date	Premium

16) Has any claim ever been made against you for Medical Malpractice? Form Link ◯ YES ◯ NO

17) Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? Form Link ◯ YES ◯ NO

18) Are you aware of any circumstances which may result in a claim against you for medical malpractice? ◯ YES ◯ NO

19) Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? If Yes, please provide a written explanation below and attach a copy of the Complaint, Consent Order document if applicable. ◯ YES ◯ NO

20) Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ◯ YES ◯ NO
If Yes, please provide a written explanation below.

21) Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you to be evaluated for an alleged mental condition and/or alcohol or drug addiction? ◯ YES ◯ NO
If Yes, please provide a written explanation below.

22) Have you 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? ◯ YES ◯ NO
If Yes, please provide a written explanation below.

23) Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? ◯ YES ◯ NO
If Yes, please provide a written explanation below.

MEDICAL DIRECTOR INFORMATION

24) Do you also provide Medical Director Services for this Medical Spa? ◯ YES ◯ NO
If Yes, please complete Questions # 25-30 below.

25) How many hours per week are dedicated to medical director services only?

26) How long have you worked as medical director at this facility?

27) Please describe your duties as medical director:

28) List the number and type of employees that you supervise at this facility:

Type of Professional	#	Type of Professional	#	Type of Professional	#
Physician(s)		Registered Nurse(s)		Laser Technicians	
Physician's Assistant(s)		LPN's		Other	
Nurse Practitioner (s)		Medical Aesthetician(s)		Other	

29) Has any claim ever been made against you solely as respects your duties as a medical director. If Yes, complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs. ◯ YES ◯ NO

30) Are you aware of any circumstances, solely as respect your duties as a medical director, which may result in a claim against you? If Yes, please provide a written explanation below. ◯ YES ◯ NO

☑ 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:

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.

Type or print your name & title

Type or print your phone number

Type or print your e-mail address

Current Date:

Please attach copies of the following documents:

* A minimum of five years of currently valued company loss runs.

* CV or Resume

* Unless your specialty is Dermatology, Aesthetics, Anti-Aging or Plastic/Cosmetic Surgery, please attach Certificates of Training for the procedures you will be performing outside your specialty.

Additional Comments or Details: