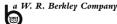


1. Full Name of Applicant: (Include all DBA's and subsidiaries seeking coverage under the policy for which you are applying.)



MEDICAL SPA PROFESSIONAL LIABILITY INSURANCE APPLICATION (CLAIMS MADE)

2. Mailing Address:						
3. Other Locations:						
4. Web Site Address:						
5. Date Established:	(mm/dd/yy)					
6. Type of Entity: Corporation P	Partnership Ir	ndividual LLC	Other (Specify) :			
7. Is this entity owned by, associated wit	h or controlled by	any other entity?	Yes No			
If Yes, please explain:						
	ge* for their service	es on behalf of this	entity:		n	
8. Please provide the <u>number</u> of the emp				y carry their ow <u>Insured</u> <u>Limits</u>	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery)	ge* for their service	es on behalf of this Independent	Insured on Own Med Mal Policy O Yes O No	Insured	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery) Physicians (surgical)	ge* for their service	es on behalf of this Independent	Insured on Own Med Mal Policy O Yes O No O Yes O No	Insured	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery)	ge* for their service	es on behalf of this Independent	Insured on Own Med Mal Policy O Yes O No	Insured	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery) Physicians (surgical) CRNA's	ge* for their service	es on behalf of this Independent	Insured on Own Med Mal Policy O Yes O No O Yes O No O Yes O No	Insured	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery) Physicians (surgical) CRNA's Physician Assistants Nurses (RN/LPN/LVN) Aestheticians	ge* for their service	es on behalf of this Independent	Insured on Own Med Mal Policy O Yes O No	Insured	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery) Physicians (surgical) CRNA's Physician Assistants Nurses (RN/LPN/LVN) Aestheticians Laser Techs Medical	ge* for their service	es on behalf of this Independent	entity: Insured on Own Med Mal Policy O Yes O No	Insured	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery) Physicians (surgical) CRNA's Physician Assistants Nurses (RN/LPN/LVN) Aestheticians Laser Techs Medical Assistants Massage	ge* for their service	es on behalf of this Independent	Insured on Own Med Mal Policy O Yes O No	Insured	n	
8. Please provide the <u>number</u> of the emp individual medical malpractice coverag Physicians (no surgery) Physicians (surgical) CRNA's Physician Assistants Nurses (RN/LPN/LVN) Aestheticians Laser Techs Medical	e* for their service Employee	es on behalf of this Independent	entity: Insured on Own Med Mal Policy O Yes O No	Insured	n	

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10.	Who Is your Medical Director?			_		
	Medical Specialty:					
	Please indicate below which coverage option you	want, or if no coverage is desired for Medical Director, check None:				
	a. Would you like to include coverage for the Medical Director's administrative duties only? Yes					
	b. Would you like to include coverage for the Mo (If Yes, please attach a completed Medispa Phys	edical Director's administrative duties & good faith exams only?	Yes	No		
	c. Would you like to include coverage for the Mo (If Yes, please attach a completed Medispa Phys	edical Director's administrative duties & direct patient care? icians application.)	Yes	No		
	d. None					
11.	. Has the applicant or any of the above employees a (If the answer to any of the following questions is	•				
	a. Ever been the subject of disciplinary or investige governmental or Administrative agency, hos	gative proceedings or been reprimanded by a spital or professional association?	Yes	No		
	b. Ever been convicted of a criminal act other th	antraffic offenses?	Yes	No		
	c. Ever been treated for alcoholism or drug addic	ction?	Yes	No		
d. Ever had any state professional license or license to prescribe narcotics suspended, revoked, renewal refused or restricted, or ever voluntarily surrendered same? Yes						
12.	(If you offer a procedure that is not shown below,	es to be performed over the next 12 months in all of the following callistit in the box marked OTHER and provide the # of estimated procedureS. JECTABLE, NON ABRASIVE SKIN CARE & DAY SPA TYPE PROCEDURES	_			
	# Of Procedure		lures			
	Body & Facial Waxing Manicures/Pedicures Ear Candling Facials	Hyperbaric Treatment Massage Weight Loss – Non Surgical and No HCG Other:	in the second			
	CATEGORY II - NON-INVASIVE PROCEDURES, I	NJECTABLES, ABRASIVE SKIN CARE & NON-LASER REMOVAL PROCEDU	RES			
	# Of Proced	-	Of cedures			
	Acupuncture BHRT (no pellet insertion) Brown Spot Removal – Non Laser Chemical Peels (Light) Fillers/Injectables Dermaplaning Electrolysis HCG Injections or Liquid Drops	Microdermabrasion Permanent Make Up Platelet Rich Plasma Therapy (PRP) Mesotherapy (No PC/DC) Skin Tag Removal Stem Cell Therapy (Blood Based Stem Cell Harvesting Only) Wart Removal Other:				

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CATEGORY III - LASER-BASED PROCEDURES, FAT EMULSION, NON-INVASIVE LIPO PROCEDURES (COLD LASER), ABRASIVE FACIAL PROCEDURES

Proced	<u>f</u> <u>ures</u> <u>P</u>	# Of Procedures
BHRT Pellet Insertion	Laser Hair Removal	
Brown Spot Removal	Laser Skin Resurfacing	
(Laser Based Treatments)	Liposonix	
Cavi-Lipo	Pigmented Lesion Removal	
Cold Laser for Fat Reduction	Sclerotherapy	
(No Incisions)	Tattoo Removal - Laser Based Treatment	
Fraxel Laser Procedures	Thermage	
Heavy Chemical Peels	Vein Treatments	
IPL ,	Velashape	
Laser Cellulite Treatment	Other:	
CATEGORY IV - MINOR FACIAL	COSMETIC SURGERY, NON-LIPOSUCTION BASED COSMETIC SURGER	<u>Y</u>
	# Of	# Of
	<u>Procedures</u>	<u>Procedures</u>
Blepharoplasty	Threadlifts	
Ear Pinning	Other:	
Hair Restoration/Hair Transplant Surge		
CATEGORY V - COSMET	IC SURGERY PROCEDURES AND INVASIVE LIPO PROCEDURES	<u>s</u>
<u>CATEGORY V - COSMET</u>	IC SURGERY PROCEDURES AND INVASIVE LIPO PROCEDURES # Of	<u># Of</u>
		_
	<u># Of</u>	# Of
<u>P</u> i	<u># Of</u> rocedures	# Of
Position Abdominoplasty/Tummy Tucks	# Of rocedures Mesotherapy with PC/DC Smart Lipo	# Of Procedures
Abdominoplasty/Tummy Tucks Butt Lift or Augmentation	# Of rocedures Mesotherapy with PC/DC Smart Lipo Face Lifts —	# Of Procedures
Abdominoplasty/Tummy Tucks Butt Lift or Augmentation Breast Augmentation	# Of rocedures Mesotherapy with PC/DC Smart Lipo Face Lifts — Full Face Laser Lipolysis Lipodissolve	# Of Procedures
Abdominoplasty/Tummy Tucks Butt Lift or Augmentation Breast Augmentation Lipolysis	# Of rocedures Mesotherapy with PC/DC Smart Lipo Face Lifts — Full Face Laser Lipolysis Lipodissolve Stem Cell Therapy	# Of Procedures

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Of Procedures

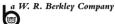
Type of Surgeries

14. What	ttype of anesthesia care is used at the medical spa & who is it ad	ministered by?	Administered by:	
	Local Anesthesia Only			
	Conscious Sedation			
	General Anesthesia			
	Other:			
15. Are	FDA Approved Drugs ever used for "off-label" purposes? Yes		Yes	No
If Ye	s, by whom and what is their medical designation. Need a list o	f the drugs and the "off-label" p	urposes for which they are	used?
16. Do y	ou ever provide any services at locations other than your medic	cal spa?	Yes	No
	If Yes, please provide the following details: What Services?			
b. <i>A</i>	At what locations?			
c. \	Who performs the services & what is their medical designat	ion?		
d.	How many off-site procedures do you estimate over the nex	xt 12 months?		
e.	Will alcohol be served to these off-site patients?		Yes	No
	es this applicant sell any products? The answer to any of the following questions is YES, please include B	prochures.	Yes	No
a.	What kind of products?			
b. I	Do any of these products require a physician's prescription?		O Yes	O No
c. [Do you label these products in your own name?		O Yes	O No
d. I	Does all labeling and use of drugs have FDA approval?		O Yes	O No
If N	o, Please provide details:			
18. State	e sources and amounts of total revenue:	<u>Last 12 months</u>	Estimate for next 12 n	<u>nonths</u>
a. F	ee for service:			
b. F	Product Sales			
c. (Other income:			
d. T	Total Gross Revenues			

	Profession for which students are being trained	Max#of students per session	# of sessions per year	% of time in clinical setting		tion of Faculty RN, PHD)	
	e provide the following information as ent coverage: (If none, state NONE.)	respects the las	t five years of p	rofessional liabili	ty coverage beginning	with the most	
	<u>Carrier</u>	<u>Lir</u>	<u>nit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Policy Term</u>	
21. What	is the retroactive date on your current	policy?					
	e applicant currently insured under a y? If Yes, please attach copy of declar		General Liabili	:y		Yes	No
	the applicant own, operate or manage ying for coverage?	any business o	ther than the	one(s) described i	n this application for	which you are	No
	s, please provide complete details, inc information on their insurance progra	_	of entity, your	ownership inter	est or contractual rela	ationship	
	ny application for professional liability ent partners ever been declined, cancell			the applicant, any	predecessors in busing	ess or Yes	No
If Ye	s, please provide details including nar	me of carrier a	nd dates.				
	any claim ever been made against thes, please complete the Supplemental			•	ink	Yes	No
	e applicant aware of any circumstance					? Yes	No
	s, please provide full details on each i us of incident.	ncident includ	ing name of p	arties involved, o	date of treatment an	d current	

19. If the applicant has a training school, please provide the following: (provide details on last page if more room is needed)





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 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 statement and representations made in this application. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Electronic Signature of Applicant of Authorized Representative:	Current Date:
Title	
If you prefer not to return Application with an electronic sign	gnature, please print and sign below.
Signature of Applicant of Authorized Representative	Current Date:
Title	

<u>ADDITIONAL INFORMATION</u> - Please provide the following information with this application:

- a. Advertisements, brochures, descriptive literature
- b. Informed consent document

Please provide any additional details in the space provided:

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