MEDISPA APPLICATION

Applicant Name: _____ Phone Number: _____

Business Name: _____

Email Address: _____ Website: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Business Address (1): _____

City: _____ State: _____ Zip code: _____

Type of Facility: _____ Square Footage: _____

Business Address (2): _____

City: _____ State: _____ Zip code: _____

Type of Facility: _____ Square Footage: _____

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

Business Operated as a Medispa? ☐ Yes ☐ No If Not, other: _____

How long in business? _____ Annual gross receipts from all operations? _____

Are you in compliance with all City, County and/or State Ordinances? ☐ Yes ☐ No

Do all professionals have licenses? ☐ Yes ☐ No

Are you teaching and/or offering in-house training? *(if yes, separate application required)* ☐ Yes ☐ No

Will you have other operations you do not wish to cover on this policy? ☐ Yes ☐ No

If Yes, provide details: _____

Do you need General Liability? ☐ Yes ☐ No If no, what Company insures your General Liability coverage? _____

If Yes, Answer Below

Are you required to name any other person or entity as an Additional Insured on your Policy? ☐ Yes ☐ No

a. If Yes, please provide Name and Address: _____

_____

b. What is the interest of the Additional Insured? ☐ Landlord ☐ City or Government Agency ☐ Lessor ☐ Franchisor ☐ Other: _____

c. Does the additional Insured require the following: ☐ Primary/ Non Contributory Wording ☐ Waiver of Subrogation

Products Liability needed for take home products sold by you ☐ Yes ☐ No Gross receipts (excluding private label): _____

Do you private label products for sale? ☐ Yes ☐ No *If Yes, requires separate application*

BEAUTY SERVICES: Pick the best ONE for each technician	**Number to be Insured**
Beauticians: *Hair, Nails, Eyelash & Brow Enhancements, Sugaring, Waxing, Threading, Topical Makeup Application*	
Massage Therapist: *Massage, Body Wraps, Endermologie, Reiki*	
Aesthetician: *All Beautician services AND Facials, Aesthetic Peels, Body Wraps, Massage, Electrology, Microdermabrasion, Ear Piercing, Ear Candling, Airbrush Tanning, Aesthetic Body Treatments, Needling/Collagen Induction Therapy*	
Medical Aesthetician: *All Beautician, Aesthetics AND Medical Grade Peels, Cosmetic Ultrasound, LED/Microcurrent, Aesthetic Radio Frequency, Demaplaning, Wart Removal, Skin Tag Removal and Cryo Spot Treatments*	
Total Number of Operators:	0

Do you use a consent form for Medical Grade Peels? ☐ Yes ☐ No Do you use Levulan? ☐ Yes ☐ No

If you provide any of the following, please indicate how many operators – *may require separate application*

☐ Tattooing/ Body Piercing: _____ ☐ Permanent Makeup: _____ ☐ Personal Trainers: _____ ☐ Acupuncture: _____

☐ Removal of Warts: _____ ☐ Removal of Moles: _____ ☐ Colon Hydrotherapy: ____ ☐ Acne Subcisions: _____
(NP/MD Only)

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SECION I: LIGHT/ENERGY **If this Section does not apply, Check Here** ☐

Includes IPL, Laser, Medical and/or High Heat Radio Frequency, Ultrasound, High Frequency (not listed on page 1)

	Name of Operator	Medical Designation (if any)	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	
4.	

Indicate Service (s) being performed with Light/Energy Devices

☐ Hair Removal ☐ Photo Rejuvenation ☐ Skin Tag Removal ☐ Acne Treatments

☐ Rosacea ☐ Tattoo Removal ☐ Body Contouring/Cellulite Reduction ☐ Pain Therapy

☐ Age/Sun Spots ☐ Nail/Toe Fungus ☐ Wrinkle Reduction ☐ Psoriasis

☐ Acupuncture for Smoking Cessation and/or Allergy Testing ☐ Veins (Up to 3.0mm, Spider Veins) ☐ Vitiligo

☐ Vaginal Rejuvenation ☐ Intra Oral Tightening ☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

☐ I am submitting my own consent and medical history form ☐ I will use PPIB consent and medical history approved forms

Do you provide goggles or eye shields to clients for all Laser/IPL work on faces? ☐ Yes ☐ No ☐ N/A

Are you in compliance with all FDA and State laws as to use Light/Energy Devices? ☐ Yes ☐ No

On Behalf of ALL Light/Energy Operators endorsed herein, I understand:

1. The Fitzpatrick Scale. I will not be insured to work on Skin Types V & VI unless I have 6 months of experience with Laser/IPLs
2. It is warranted that for Class III & IV devices googles must be worn by all people in the room at all times while the laser is in use. All reflective surfaces will be covered.
3. Every Client must sign a consent and medical history form. No coverage will apply if there is not a signed form on file.
4. For Class IV laser use, the room door will stay locked at all times while the laser is in use or a sign must be posted on door: LASER IN USE, DO NOT ENTER.
5. I understand there is no coverage for EMLA anesthetic use with laser/IPL.
6. No insurance will be offered for the following treatments
   I. Any raised tissue with its own blood supple (such as moles).
   II. Skin that is unclerated, broken (not Intact) blistered or has open sores.
   III. Bulging veins, veins or cherry hemangiomas over 3.0mm.
7. I understand coverage for laser hair removal work on individuals under the age of 14 is excluded.
8. I understand all new Laser/IPL technicians must have 6 months' experience or 30 hours of training to be eligible for Laser/IPL use.
9. If I use Class III & IV Device (s), I will only use those that have been approved for sale by the FDA

Signature of Applicant: _____ Date: _____

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SECTION II: INJECTABLE PROFESSIONAL **If this Section does not apply, Check Here** ☐

	Name of Operator	Medical Designation (if any)	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	
4.	

Indicate Service (s) being performed

☐ Botox/Dysport/Xeomin ☐ Botox for Hyperhidrosis ☐ Botox for Platysmal Bands ☐ Botox for Masseters

☐ FDA Approved Dermal Fillers ☐ Dermal Fillers on Hands ☐ Dermal Fillers on Ear Lobes ☐ Carboxy Therapy

☐ Mesotherapy ☐ Sclerotherapy ☐ Blood Draws ☐ IV Therapy

☐ Flu Shots ☐ Chelation Therapy ☐ Kybella

☐ Vitamins/Supplements - *includes injection of Vitamin A, B, C, D, E, and K, Amino Acids and other Dietary Supplements*

☐ Allergy Immunotherapy (describe): _____

☐ Other: _____

Do you perform PRP Injections? ☐ Yes ☐ No If yes, indicate what PRP is used for below

☐ Vampire Face Lift ☐ Breasts Enhancements ☐ Hair Stimulation ☐ Vitiligo

☐ Wound Healing ☐ Joint Pain Reduction ☐ O Shot ☐ Priapus Shot

☐ Prolotherapy (describe): _____

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Are you in compliance with all AMA and/or State Laws as to use of Injectable Products? ☐ Yes ☐ No

On Behalf of ALL Injectable Operators endorsed herein, I understand:

1. I will only have coverage in specified facilities unless the no location limitation endorsement is purchased.
2. I will only buy injectables from Manufacturer directly or their approved wholesalers.
3. In regards to Mesotherapy, products must be purchased from licensed compounding pharmacies (acceptable ingredients only).
4. Botox, Dysport, Xeomin is only provided for work on patients over 18.
5. Every client must sign a consent form and no coverage will apply if there is not a signed form on file.
6. There is no coverage for prescription medications, except for anesthetics used with injectables, unless endorsed on.
7. In regards to Sclerotherapy, there is no coverage for work on veins over 3.00mm in diameter and products must be used that are exclusively for treatment of spider or varicose veins.
8. I understand each technician must have specific training or 6 months experience to be eligible for injectable coverage.

Signature of Applicant: _____ Date: _____

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SECTION III: WELLNESS PROFESSIONAL **If this Section does not apply, Check Here** ☐

	Name of Operator	Medical Designation (if any)	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	
4.	

Indicate Service (s) being performed

☐ hCG ☐ Phentermine ☐ Tenuate/Diethylpropion ☐ Didrex

☐ Phendimetrazine ☐ Belviq/Qsymia ☐ Nutritional/Diet Counseling ☐ Wellness Analysis

☐ Orlistat ☐ Bioidentical Hormones ☐ Ingestible Vitamins/Supplements ☐ Contrave

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Are you in compliance with all FDA and State Laws as to Weight Loss/ Hormone Services? ☐ Yes ☐ No

On Behalf of ALL Wellness Professionals, I confirm that my medical history and/or consent forms address the following:

1. No Guarantee of Results
2. There is a question regarding if client is pregnant, nursing or trying to get pregnant

Signature of Applicant: _____ Date: _____

SECTION IV: UNITS/DEVICES **If this Section does not apply, Check Here** ☐

Indicate Number of Units for each

Showers #: _____ Saunas/Steam Rooms #: _____ Soaking Pools #: _____

Oxygen Devices #: _____ UV Tanning #: _____ Foot Detox Units #: _____

Salt Caves #: _____ Hyperbaric Oxygen Chambers #: _____ Flotation Devices #: _____

LED Teeth Whitening #: _____

Do you provide customers with home whitening products? ☐ Yes ☐ No

If Yes, do you provide written instructions for home use? ☐ Yes ☐ No

On Behalf of all LED Teeth Whitening Technicians, I Understand:

1. Ever client must sign a consent and dental history form. No coverage will apply if there is not a signed form on file
2. There is no coverage for any prescription anesthetic use
3. A written doctor's approval will be on file for treatment on pregnant women

Signature: _____ Date: _____

LED Hair Stimulation #: _____

Have all operators been trained in LED Hair Stimulation? ☐ Yes ☐ No

On Behalf of all LED Hair Stimulation Technicians, I understand:

1. Coverage is excluded for any guarantees of hair growth
2. Coverage is available only for units designed specifically for hair stimulation
3. For Coverage to apply, only trained technicians will turn on or operate the device
4. A signed consent & medical history form must be on file

Signature: _____ Date: _____

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SECTION V: CRYOTHERAPY

If this Section does not apply, Check Here ☐

Total Number of Units excluding cryo pens: _____

Manufacturer of each Cryotherapy Unit: _____

Does your Liquid Nitrogen provider has specific limit requirements? ☐ Yes ☐ No

If Yes, please describe limits: _____

_____

Are you required to name them as an Additional Insured? ☐ Yes ☐ No

If Yes, please provide Name and Address: _____

_____

Do they require the following? ☐ Primary/ Non Contributory Wording ☐ Waiver of Subrogation

On Behalf of ALL Cryotherapy Operators, I understand:

1. That all cryotherapy units are single person booths, no multi – person "walk – in" booths are being used
2. The patients head must be elevated outside the chamber at room temperature at all times
3. Patients are provided with appropriate protective clothing to prevent rapid freezing
4. Waivers/ Consent Forms including possible side effects are used and signed by the patient before every Cryotherapy procedure
5. Cryotherapy Services are only available to patients age 18 and older
6. Cryotherapy Sessions are no longer than 3 mins at temperatures no lower than -200°F
7. Patients are supervised at all times while undergoing Cryotherapy
8. All technicians have been property trained

Signature of Applicant: _____ **Date:** _____

SECTION VI: MEDICAL DIRECTOR SECTION

If this Section does not apply, Check Here ☐

Is there a Medical Director on your staff? ☐ Yes ☐ No

Do they work out of your office? ☐ Yes ☐ No

Name and Degree of your supporting Doctor? _____

Do you want to cover the doctor as Medical Director on the policy? ☐ Yes ☐ No

If yes, indicate any claims they have had in their medical career: _____

Is the doctor a medical director for other facilities? ☐ Yes ☐ No

If so, should coverage be extended? ☐ Yes ☐ No

Number of Facilities: _____ For what Services: _____

Does your Medical Director offer Direct Patient Care for services no otherwise listed on the application? ☐ Yes ☐ No

If Yes, Describe Services: _____

Does your Medical Director offer prescriptions not otherwise listed herein? ☐ Yes ☐ No

If Yes, List : _____

Will there be any Medical Assistants on staff? (If yes, answer below) ☐ Yes ☐ No

	Name	Services assisting with
1.		
2.		
3.		

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SECTION VII: INVASIVE PROCEDURES **If this Section does not apply, Check Here** ☐

	Name of Operator	Medical Designation	Years of Experience
1.			
2.			
3.			
4.			

If Less than 1 year of experience, provide training detail for each technician

1.	
2.	
3.	

Indicate Service (s) being performed ***Additional Premium May Apply***

☐ Neograft Hair Transplant ☐ Fue/Strip Hair Transplant ☐ Upper Blepharoplasty ☐ Fat Transfers

☐ Silhouette Face Lift ☐ PDO Threading ☐ Mini Tummy Tucks ☐ Tickle/Smart Lipo

☐ Tumescent Liposuction ☐ Laser/Ultrasound Assisted Lipolysis

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Advise what kind of anesthetics, if any, do you use? _____

Devices being used for procedures: _____

If you are doing Fat Transfers Answer the following?

A. Indicate Method of Removal: _____

B. Indicate the areas you re-inject: _____

C. Do you use the Brava System or something similar for injections in the breasts? ☐ Yes ☐ No ☐ N/A

D. Do you reinject fat into the person that is was removed from? ☐ Yes ☐ No

Signature of Applicant: _____ Date: _____

SECTION VIII: OTHER COVERAGE OPTIONS **If this Section does not apply, Check Here** ☐

Do you want coverage for Defense Outside the Limit? ☐ Yes ☐ No

Do you want coverage for HIPAA Reimbursement? ☐ Yes ☐ No

Do you want coverage for Sexual Abuse? ☐ Yes ☐ No

If Yes, what limit ☐ $25k/$50k ☐ $50K/$100k ☐ $100/$200K ☐ Other: _____

Do you want coverage for Property? *(separate application required)* ☐ Yes ☐ No

Do you want coverage for Cyber Protection? ☐ Yes ☐ No

What other services not listed already do you want coverage for? _____

_____

_____

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SECTION IX: HISTORY

Note – ALL questions must be answered. Failure to disclose claims history could invalidate coverage

Do you Currently have Insurance coverage ☐ Yes ☐ No

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

If Claims Made, most Recent Retroactive Date: _____

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

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

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? *If yes, describe details on a separate sheet* ☐ Yes ☐ No

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 regulatory agency? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

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

ATTESTATION

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 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 is not 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 BE COMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY.

By signing below, I confirm on behalf of all technicians covered under this policy:

1. Technicians are licensed as necessary for all services being provided.
2. Technicians do not use any product that contains more than 2% formaldehyde.
3. I understand that no service or individual is covered unless listed and a premium paid.
4. That all technicians have been trained for the service they are performing or on the device they are using.
5. I understand that no coverage is provided under this policy for invasive or surgical procedures unless specifically listed

_____ _____

APPLICANT SIGNATURE **TITLE**

_____ _____ _____

DATE SIGNED **REQUESTED EFFECTIVE DATE** **LIABILITY LIMIT REQUESTED**

Can we Email your policy? (usually within 2-3 weeks) ☐ Yes ☐ No _____@_____

One box below must be checked:

☐ I ELECT TO PURCHASE TERRORISM COVERAGE AT AN ADDITIONAL PREMIUM

☐ I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT AN ADDITIONAL PREMIUM