HISCOX PRO™

# Anti-Aging Medical Spa Services Application

1. Name of applicant:

Principal business address (please attach a schedule of additional locations if needed):

2. Telephone:

3. Date established: mm/dd/yyyy

4. Applicant's practice is a:

- ☐ Solo practioner (unincorporated)
- ☐ Partnership
- ☐ Solo pracitioner (incorporated)
- ☐ Corporation (non-profit)
- ☐ Professional Association
- ☐ Corporation (for-profit)
- ☐ Other (describe):

5. Please state sources and amounts of total revenue:

| | Amount last 12 months | Estimated next 12 months |
|---|---|---|
| Fee for services | $ | $ |
| Other (explain) | $ | $ |
| | $ | $ |
| **TOTAL** Gross Revenue: | $ | $ |

6. a. If applicant has a training school, complete the following:

| Profession for which students are being trained | Max No. of students per session | No. of sessions per year | Number of faculty per session | Qualification of faculty (e.g. MD RN) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

6. b. What is the total number of faculty members?

7. List all manufactured equipment and drugs used in the applicant's practice and purpose for which each is used:

8. State approximate division of applicant's clients among the following categories:

| | | | | | |
|---|---|---|---|---|---|
| a. | Acupuncture | % | b. | Massage Therapy | % |
| c. | Ayurvedic Medicine | % | d. | Medical Spa | % |
| e. | Cosmetology-hair/nails/facial | % | f. | Plastic Surgery | % |
| g. | Dental | % | h. | Research/Experimental | % |
| i. | Dermatology | % | j. | Surgical | % |
| k. | Hormone Therapy | % | l. | Weight Management | % |
| m. | Other (please specify): | | | | % |

9. a. Indicate the number of applicant's staff:

| | Employed | Contracted |
|---|---|---|
| Aesthetician | | |
| Electologist | | |
| Laser Technician | | |
| Massage Therapist | | |
| Medical Assistant | | |
| Nurse Practitioner | | |
| Physician | | |
| Physician Assistant | | |
| Registered Nurse | | |
| Other (specify) | | |

b. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐
If No, please attach explanation.

c. i. Do you require contracted staff to carry their own Professional Liability Insurance? Yes ☐ No ☐

ii. If Yes, do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

d. Has the applicant or have any of the above employees:
(Attach detailed explanation for any 'Yes' answers)

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

iv. 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 ☐

10. a. Provide the following information for all procedures performed, include proof of training/certification, informed consent forms and client selection protocols:

| Procedures | Performed By: | Is training certificate attached? Yes/No | Is CV attached? Yes/No | Is client selection protocol attached? Yes/No | Is informed consent attached? Yes/No | Number of procedures per year? |
|---|---|---|---|---|---|---|
| Acne Blue Light Treatments | | | | | | |
| Botox Injections | | | | | | |
| Chemical peels | | | | | | |
| Colon Hydrotherapy | | | | | | |
| Cosmetology (hair/nails/facials) | | | | | | |
| Dermal fillers: Specify Type | | | | | | |
| Hormone Therapy (Specify Type and Method of Delivery) | | | | | | |
| Laser Hair Treatments | | | | | | |
| Laser Lipolysis / SmartLipo | | | | | | |
| Laser Skin Treatments: Specify Type | | | | | | |
| Massage Therapy | | | | | | |
| Mesotherapy | | | | | | |
| Microdermabrasion | | | | | | |
| Micropigmentation | | | | | | |
| Sclerotherapy | | | | | | |
| Tattoo Removal | | | | | | |
| Tooth Whitening | | | | | | |
| Waxing | | | | | | |
| Other: Describe: | | | | | | |

b. Are any of the above procedures performed by a physician or dentist? Yes ☐ No ☐

If Yes, does the physician(s) or dentist(s) have Medical Malpractice Liability Insurance for this activity? Yes ☐ No ☐

If No, please submit a Physician Supplemental application and C.V. for each physician or dentist to be included.

11. a. List prior professional liability insurers for the past 5 years (if none, state none):

| Insurer | Dates Covered (From-To) mm/dd/yyyy | Limits of Liability per Claim/Aggregate | Deductible | Premium | Coverage Type: Occurrence or Claims-Made |
|---|---|---|---|---|---|
| | - | $ /$ | $ | $ | |

| | | | | | |
|---|---|---|---|---|---|
| | - | $ /$ | $ | $ | |
| | - | $ /$ | $ | $ | |
| | - | $ /$ | $ | $ | |
| | - | $ /$ | $ | $ | |

11. b. If the current/expiring policy is on a Claims-Made form, what is the retroactive date? mm/dd/yyyy

12. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

If Yes, please list below:

| Insurer | Dates Covered: (From-To) mm/dd/yyyy | Limits of Liability per Claim/Aggregate | Deductible | Premium | Coverage Type: Occurrence or Claims-Made |
|---|---|---|---|---|---|
| | - | $ /$ | $ | $ | |
| | - | $ /$ | $ | $ | |
| | - | $ /$ | $ | $ | |
| | - | $ /$ | $ | $ | |
| | - | $ /$ | $ | $ | |

12. b. If the current/expiring policy is on a Claims-Made form, what is the retroactive date? mm/dd/yyyy

13. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐
If Yes, please attach an explanation.

14. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐
If Yes, please attach complete details including a description of the indicent(s).

15. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐
If Yes, please complete a Supplemental Claims Information Form for each claim.

How many claims have been made in the last five (5) years?

It is understood and agreed that with respect to questions 14 and 15, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

**Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.**

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

| | | |
|---|---|---|
| Name of applicant: | | |
| Signature of person authorized to execute on behalf of the applicant: | | Date: |

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated.
Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

**A copy of this application should be retained for your records.**