ALLIED HEALTHCARE MED SPA APPLICATION

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Applicant Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. Date Established:_____

5. The applicant is:
   [ ] Sole Practitioner
   [ ] Sole Proprietorship
   [ ] Partnership
   [ ] Corporation
   [ ] Other; Describe:_____

6. Gross Annual Receipts: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

PART II. EXPOSURES

1. Provide the percentage of the applicant's patients/clients in the following categories:

_____ % Beauty Shop (nails, hair, etc.)
_____ % Dental
_____ % Massage
_____ % Medical Spa/Anti-Aging
_____ % Research/Experimental
_____ % Holistic
_____ % Substance Abuse
_____ % Surgical
_____ % Weight Control
_____ % Other;(Describe)_____
_____ % **Total (should equal 100%)**

Age of Patients/Clients
_____ % Under 12 Years Old
_____ % 12–18 Years Old
_____ % Greater Than 18 Years Old
_____ % **Total (should equal 100%)**

2 Below, Indicate the estimated annual number for each procedure that is performed and **attach a training certificate, Curriculum Vitae, client selection protocol, and informed consent** for each procedure performed.

Procedure	Name and qualification of the person performing the procedure	Is Training Certificate attached? (Yes/No)	Is CV attached? (Yes/No)	Is Client Selection Protocol attached? (Yes/No)	Is Informed Consent attached? (Yes/No)	Estimated annual number of procedures
Acne Blue Light Treatment						
Botox Injections						
Chemical Peels (specify solution strength)						
Electrolysis						
Hair Transplants						
Laser Hair Removal						
Laser Skin Treatment (specify type)						
Massage						
Microdermabrasion						
Other Injections (specify type)						
Permanent Make-Up						
Other (please describe)						

3. Do you use weight reduction drugs for patients? [ ] Yes [ ] No

If yes, list the drugs used and percentage devoted to weight reduction, the frequency and duration of prescriptions of weight loss drugs, and quantity dispensed.

_____

_____

4. If x-ray treatment is given, what qualifications are required of the staff performing this procedure?

_____

_____

5. Have you or any of your employees:

a) Ever been treated for alcoholism or drug addiction? [ ] Yes [ ] No

b) Ever had any state professional 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

c) Ever had any insurance company or Lloyds's cancel, decline, or refuse to renew or accept only on special terms their malpractice insurance? [ ] Yes [ ] No

6. Do you supervise any individual other than your own employees? [ ] Yes [ ] No

If yes, please provide explanation of responsibilities and relationships to the entity which employs these individuals.

_____

_____

_____

_____

_____

7. List memberships in professional organizations: _____

PART III. RISK MANAGEMENT

1. Total number of staff: _____

2. Total payroll last year: _____

Total payroll next year: _____

3. Do you desire coverage for independent contractor(s) as additional insured(s) on your policy while working on your behalf? [ ] Yes [ ] No

Do you require:

a) contracted staff to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

If yes, indicate minimum limits required: _____

b) employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

If yes, indicate minimum limits required: _____

4. Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? [ ] Yes [ ] No

5. Do you conduct pre-employment screening and investigation? [ ] Yes [ ] No

6. Do you prepare job descriptions and instructional manuals for your staff? [ ] Yes [ ] No

7. Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? [ ] Yes [ ] No

8. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? [ ] Yes [ ] No

Explain any exceptions: _____

_____

_____

_____

9. Are you equipped with an emergency 24-hour telephone call line for all of staff and patients: [ ] Yes [ ] No

10. Do you enter into any contractual agreements (other than lease of premises agreements)? [ ] Yes [ ] No

If yes, attach explanation.

11. Number of **Professional Staff**: (**E = Employed; C = Contract**)

E	C		E	C	
_____	_____	Case Managers	_____	_____	Psychiatrists*
_____	_____	Dieticians/Nutritionists	_____	_____	Psychologists/Psychotherapists
_____	_____	Marriage/Family Counselors	_____	_____	Respiratory Therapists
_____	_____	Nurse Practitioners	_____	_____	RNs/LVNs/LPNs
_____	_____	Occupational Therapists	_____	_____	School Counselors
_____	_____	Pharmacists	_____	_____	Social Workers
_____	_____	Physician Assistants	_____	_____	Speech Therapists
_____	_____	Physicians*/Dentists	_____	_____	Teachers
_____	_____	Physiotherapists/Physical Therapists	_____	_____	Other:_____

12. Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, and Physician Assistants:

* Complete Physician Supplement when applicable.

Name	Professional Status	E, C, or I (E = Employee C = Contract I = Independent)	Maintains malpractice insurance	Limit of Liability	Certificate of Insurance Obtained

13. Has the applicant or have any of the above employees:

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

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

c. ever been treated for alcoholism or drug addiction? [ ] Yes [ ] No

d. 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 to any of the above, please explain.

14. Name, qualification, and number of years of experience of the Medical Director, all managers, and supervisors:

Name Title Experience/Training Association Membership

_____

_____

_____

PART IV. HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

2. List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

3. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] Yes [ ] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

4. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [ ] Yes [ ] No

If yes, describe the event and indicate the reason for anticipation of a claim:

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. 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 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 the company providing insurance coverage and JaVA Underwriting, LLC, 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.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

Applicant Signature

Title

Date