

Laser Pacsm
Marine Agency Corporation
191 Maplewood Avenue
Maplewood NJ 07040
800-763-4775
facsimile 973-763-1635

Training Requirements

1. Basic Services: Skin & Photo Rejuvenation & wrinkle reduction. Treatment of rosacea, veins, and sun spots for lasers & IPL's using under 20 joules/cm squared at 10mm or greater spot size.

TRAINING REQUIRED: ONE YEAR EXPERIENCE AND/OR SPECIFIC TRAINING FOR EACH MACHINE AND TREATMENT

2. Laser / IPL hair removal only.

TRAINING REQUIRED: ONE YEAR EXPERIENCE AND/OR 30 HOURS SPECIFIC TRAINING FOR EACH MACHINE AND TREATMENT

3. Professional package coverage for all the above, without fluency or spot size restriction.

TRAINING REQUIRED: ONE YEAR EXPERIENCE AND/OR 30 HOURS SPECIFIC TRAINING FOR EACH MACHINE AND TREATMENT

4. Tattoo removal, and all above services. A \$5,000 deductible will apply for this level.

TRAINING REQUIRED: ONE YEAR EXPERIENCE AND/OR 30 HOURS SPECIFIC TRAINING FOR EACH MACHINE AND TREATMENT

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Program Guidelines & Checklist

- | TO CONSIDER BINDING WE MUST RECEIVE: | DONE? |
|---|--------------------------|
| I. Copy of your consent(s) | <input type="checkbox"/> |
| A. Must state that hyper- or hypo-pigmentation is possible | |
| B. Must state that it could take 3-6 months to heal | |
| C. Must release laser center, medical staff, and specific technician from liability associated with the above. | |
| D. Must state that compliance with recommended aftercare guidelines are crucial for healing, prevention of scarring, and hyperpigmentation. | |
| II. Medical history form that your clients sign | <input type="checkbox"/> |
| A. Must include question about 'are you currently on any mood altering or depression medication?' | |
| III. If covering tattoo removal, proof of medical malpractice insurance for the doctor and/or facility. | <input type="checkbox"/> |
| IV. If using a Class IV laser, we must receive: | |
| A. Picture of the goggles being used | <input type="checkbox"/> |
| B. Picture of the room where lasers used | <input type="checkbox"/> |
| C. Picture of the laser | <input type="checkbox"/> |
| V. Completed, signed application | <input type="checkbox"/> |
| VI. Either payment in full or deposit of 25% of premium plus taxes and fees
(If you send less than payment in full, we will finance your balance over nine installments) | <input type="checkbox"/> |

BE ADVISED THE FOLLOWING:

- A. Named individual if specifically underwritten
- B. We cover those services and lasers specifically listed and paid for
- C. Ruby laser is not insurable
- D. Q-Switched laser is not insurable for hair removal procedures
- E. To insure any laser, we require specific training in that laser
- F. Doctors are not covered unless specifically named and then only for Professional Services named in the policy endorsement
- G. This is a claims made policy form

COVERAGE EXCLUSIONS:

- A. Work in the eye area
- B. Lasers not specifically listed
- C. Technicians not specifically listed
- D. Laser services other than those specifically listed and paid for
- E. Laser eyeliner removal
- F. Work on Skin Types V and VI
- G. Prescription anesthetics

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LASER/IPL OPERATOR APPLICATION

THE APPLICATION MUST BE COMPLETED FOR EACH OPERATOR.

THE APPLICATION MUST ALSO BE COMPLETED FOR YOUR MEDICAL DIRECTOR IF THEY SHOULD BE COVERED.

COVERAGE CAN INCLUDE INDEPENDENT CONTRACTORS.

IF COVERING MORE THAN ONE OPERATOR ON A SINGLE POLICY FOR A BUSINESS, PLEASE RETURN ALL APPLICATION MATERIALS TOGETHER WITH A COVER LETTER THAT DESCRIBES BUSINESS NAME, BUSINESS OWNERSHIP, AND EMPLOYMENT STATUS OF ALL OPERATIONS (EMPLOYEE, INDEPENDENT CONTRACTOR, ETC.)

- 1.1 Applicant Name: _____
Phone: _____
Business Name: _____
Mailing Address: _____
Business Address: _____
- 1.2 Business Structure
- 1.3 Business operated as a salon? _____
.... Medical center? _____
.... Other? (describe) _____
- 1.4 Is there a medical doctor on your staff? YES NO
Do they work out of your office? YES NO
If no, give name, degree, and address of your supporting doctor: _____

- 1.5 Are you in compliance with all FDA and state laws as to use of lasers/IPL's? YES NO
- 1.6 Do you have everyone sign a consent form? YES NO
WE MUST RECEIVE A COPY OF THE FORM(S) YOU USE
- 1.7 Do you use a medical history form on everyone? YES NO
WE MUST RECEIVE A COPY OF THE FORM(S) YOU USE
- 1.8 Do you provide goggles for all laser/IPL work on faces? YES NO

OPERATOR INFORMATION

- 3.2 I understand it is warranted for Class III & IV devices goggles must be worn by all people in the room at all times the laser is in use.
- 3.3 I understand every client must sign a consent and medical history form and no coverage will apply if there is not a signed form on file.
- 3.4 I understand for Class IV laser use, the room door will stay locked at all times the laser is in use, if the laser is not actively using an ANSI compliant door-activated shut-off system.
- 3.5 I understand for Class III & IV laser use, all reflective surfaces will be covered.
- 3.6 I understand no insurance will be offered for any equipment that is not listed on the policy.
- 3.7 I understand when Class IV lasers are used, a sign must be posted on door: LASER IN USE, DO NOT ENTER
- 3.8 I understand no insurance will be offered for the following treatments:
 - i. any raised tissue with its own blood supply (such as moles)
 - ii. skin that is ulcerated, broken (not intact), blistered or has open sores
 - iii. bulging veins or veins over 1.5 millimeters

HISTORY

All questions must be answered. Failure to disclose claims history could invalidate coverage.

4.1 Do you currently have insurance coverage? YES NO

If claims made coverage form, most recent retroactive date: _____

If yes, please provide Insurer Name / Policy # / Liability Limits / Premium / Expiration Date

4.2 List all claims history whether or not insured: If none, so state. _____

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) 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? YES NO

If yes, please provide details of the event: _____

I understand and agree this Application and any and all supplements attached hereto will 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 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 to all Lloyd's of London 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 AND REPORTED 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 may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

<u>X</u> APPLICANT	_____	_____	_____
	TITLE		
_____	_____	_____	1,000,000 / 2,000,000
TODAY'S DATE	REQUESTED	LIABILITY LIMIT	
	EFFECTIVE DATE	REQUESTED	

NOTE: Coverage becomes effective only when accepted by the insurance company

LANDLORD AS ADDITIONAL INSURED: _____

LANDLORD ADDRESS: _____

