

Laser Pac *plus*sm MEDI SPA APPLICATION

- 1.1 Applicant Name: _____ Phone: _____
 Business Name: _____ Website: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Business Address: _____
- 1.2 Business operated as: Corporation LLC LLP Partnership Individual Independent Contractor
- 1.3 Business operated as Medi-spa? _____ If not, other: _____
- 1.4 How long in business? _____ Do all professionals have licenses? _____
- 1.5 If business operated as a medi-spa, annual gross receipts from all operations: _____
- 1.6 Do you have operations not listed on the below schedule? _____ If yes, provide details: _____

- Do you have insurance for these operations? _____ Name of insurance company: _____
- 1.7 Products liability needed for products sold by you? _____ Gross receipts (excluding private label): _____
 Do you private-label products for sale? _____ (No coverage is provided for private label products)

SCHEDULE OF SERVICES

Indicate which services you provide, number of operators who do the service and if we are to insure them.

INSURE?

MANICURISTS	YES/NO	NUMBER _____	
BEAUTICIANS	YES/NO	NUMBER _____	
FACIALS	YES/NO	NUMBER _____	
List products you use and percentage of acids: _____			
Have you had training on the peels you are using? _____			
Do you perform Medical Strength peels? If so, a separate application is required	YES/NO	NUMBER _____	
MICRODERMABRASION			
Have you been trained in microdermabrasion?			YES/NO
Do you use a consent form for microdermabrasion?			YES/NO (If yes, attach copy)
WAX REMOVAL	YES/NO	NUMBER _____	
Are all the facialists doing wax removal as well?			YES/NO
BODY WRAPS	YES/NO	NUMBER _____	
List the type of wraps you use: _____			
MASSAGE	YES/NO	NUMBER _____	
Have you been trained in massage?			YES/NO (If yes, attach copy)
ELECTROLOGY	YES/NO	NUMBER _____	
<u>FOLLOWING SERVICES REQUIRE SEPARATE APPLICATIONS IF COVERAGE IS NEEDED</u>			
PERMANENT MAKEUP	YES/NO	NUMBER _____	
LEDs – CLASS II	YES/NO	NUMBER _____	
LASER / INTENSE PULSED LIGHT	YES/NO	NUMBER _____	
DERMAL FILLERS and/or BOTOX	YES/NO	NUMBER _____	
SCLEROTHERAPY	YES/NO	NUMBER _____	

PART IV. 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 yes, indicate the following:

Insurer Policy # Liability Limits Premium Exp. Date

If claims made, most recent retroactive date: _____

4.2 Have you ever had professional liability insured refused, declined, cancelled or accepted on special terms? Yes No

If yes, provide details on a separate sheet

4.3 Has any liability suit, arbitration or other claim proceeding been brought against you, your business or any applicant for any

alleged malpractice? Yes No If yes, provide details on a separate sheet

4.4 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? Yes No

If yes, describe details on a separate sheet

4.5 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? Yes No

If yes, provide details on a separate sheet

4.6 Have you ever or any applicant ever been charged or convicted of a criminal offense? Yes No

If yes, provide details on a separate sheet

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 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.

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 BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

APPLICANT SIGNATURE

TITLE

DATE

REQUESTED EFFECTIVE DATE

LIABILITY LIMIT REQUESTED

One box below must be checked:

I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

ADDITIONAL INSURED: Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME: _____

ADDRESS: _____

BOTOX/DERMAL FILLER OPERATOR APPLICATION

- 1.1 Applicant name: _____ Phone: _____
Business name: _____
Mailing Address: _____ City _____ State _____ Zip _____
- 1.2 Business structure: Corporation LLC Partnership Individual Independent Cont.
- 1.3 What percentage of your work is done in each of the following: Medi-Spas? _____ Medical Center? _____
List other facility types & percentage: _____
Business Address #1: _____ Type of Facility? _____
City, State & Zip: _____
Business Address #2: _____ Type of Facility? _____
City, State & Zip: _____
Do you operate out of only professional offices in the above facilities? _____
- 1.4 If you are not an MD., is there a medical doctor on your staff? _____ Do they work out of your office? _____
If in your office, give name and professional degree: _____
If no, give name, degree and address of your supporting doctor: _____

- 1.5 Are you in compliance with all AMA and state laws as to use of Botox & Fillers? _____
- 1.6 Do you have everyone sign a consent form? _____ We must receive a copy of the form(s) you use.
- 1.7 Do you use a medical history form on everyone? _____ We must receive a copy of the form(s) you use.

OPERATOR INFORMATION

- 2.1 OPERATOR TO BE NAMED: _____
- 2.2 Licenses you hold & license numbers: _____
- 2.3 How long have you worked with Botox? _____ Do you offer off-label Botox (brows and crows feet)? _____

Education in Botox: List all information as requested and include certificates of completion

Date	Class Title	Number of Hours
_____	_____	_____
_____	_____	_____
_____	_____	_____

- 2.4 Annual Gross Receipts from Botox services: _____
- 2.5 How long have you been working with Dermal Fillers? _____
- 2.6 What dermal fillers do you offer? Restylane Hylaform Other _____

Education in Dermal Fillers: List all information as requested and include certificates of completion

Date	Class Title	Number of Hours
_____	_____	_____
_____	_____	_____
_____	_____	_____

- 2.7 Annual gross receipts from dermal fillers: _____
- 2.8 What type of services, not listed above, do you offer? _____

2.9 What anesthetics do you use prior or during the filler procedure? _____

- 3.0 If you are a doctor, or want to cover a doctor, is their other medical malpractice coverage? yes no
If yes, attach a copy of the malpractice declarations page.

I understand:

1. I will only have coverage in specified facilities.
2. I will only buy Botox in the United States from Allergan or from an approved Allergan wholesaler.
3. No insurance will be offered for any Botox area except as approved by the FDA, which currently is for glabella only unless limited off-label coverage for brows and crows feet at a \$50,000 sub-limit is endorsed herein.
4. Botox coverage is only provided for work on patients from 18-65, per FDA guidelines.
5. I will only buy Restylane or Hylaform as approved by the FDA.
6. Every client must sign a consent and medical history form and no coverage will apply if there is not a signed form on file. If I change a form, it must be approved by the insurance company.
7. No coverage is provided for work on pregnant or nursing women.
8. All other medical services are excluded except for those being listed and paid for under this policy.
9. There is no coverage for prescription medications or prescription anesthetics unless a local anesthetic is approved by the carrier and endorsed onto the policy.

HISTORY: NOTE: 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, most recent retroactive date: _____

If yes, please indicate the following:

<i>Insurer</i>	<i>Policy #</i>	<i>Liability Limits</i>	<i>Premium</i>	<i>Exp. Date</i>
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4.2 List all claims history whether or not insured: If none, state so _____.

<i>IR/Claim</i>	<i>Nature of injuries</i>	<i>Equip. Involved</i>	<i>Details, if Pending</i>	<i>Amt. if settled</i>
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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, describe details of the event:

I understand and agree this Application and any and all 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 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 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.

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 BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

APPLICANT SIGNATURE

TITLE

DATE

REQUESTED EFFECTIVE DATE

LIABILITY LIMIT REQUESTED

One box below must be checked:

I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

LANDLORD AS ADDITIONAL INSURED _____ :

ADDRESS: _____ CITY, STATE, ZIP _____

SCLEROTHERAPY SUPPLEMENT APPLICATION

INDIVIDUAL NAME: _____

1. List your sclerotherapy solution/products:

2. How long have you been doing sclerotherapy? _____
3. How many hours of training do you have in sclerotherapy? _____
Provide all certificates of training
4. What licenses do you hold? _____
5. Annual gross receipts from Sclerotherapy work: _____
6. List name and address of your supporting doctor if applicable: _____

7. Do you wish to insure your supporting doctor? ____ There is a 100% surcharge
8. Do you understand for coverage to apply, a consent form must be on file? _____
Provide copies of all consent forms used.
9. Do you work on veins larger than 1.5mm? _____
10. Do you give everyone aftercare instructions? _____
Provide copies of all aftercare forms used.

I warrant the above information is true and I will have every client sign an approved consent form prior to any sclerotherapy procedure on them.

Signed _____ Date: _____

MEDICAL PEEL SUPPLEMENT APPLICATION

INDIVIDUAL NAME: _____

1. What exact type of medical strength peels will you be using? List peel strengths

Note only peels listed above and approved by the company will be covered

2. How long have you been working with medical strength peels? _____

3. Have you had training in all the above indicated peels? _____

Provide all certificates of training

4. List name and address of your supporting doctor (mandatory): _____

5. Do you wish to insure your supporting doctor? _____ There is a 100% surcharge

6. What licenses do you hold? _____

7. Do you understand for coverage to apply, a consent form must be on file? _____

Provide copies of all consent forms used.

8. Do you understand there is no coverage for Skin Types V & VI? _____

Coverage is available on this form for a liability limit of \$100,000 only and for no more than 20 procedures/month.

I warrant the above information is true, I accept the policy terms, and I will have every client sign an approved consent form prior to their medical strength peel procedure.

Signed _____ Date: _____

COVERAGE DESIRED?

Rates: \$800/Technician Skin Types I-IV

Yes No

\$800/Doctor Supervisor

Yes No

LASER/IPL OPERATOR APPLICATION

- 1.1 Applicant name: _____ Phone: _____
Business name: _____
Mailing Address: _____ City _____ State _____ Zip _____
Business Address: _____
- 1.2 Business structure: Corporation LLC Partnership Individual Independent Cont.
- 1.3 Business operated as salon? _____ Medical Center? _____ Other: _____
- 1.4 Is there a medical doctor on your staff? _____ Do they work out of your office? _____
If in your office, give name and professional degree: _____
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/IPLs/Light devices? _____
- 1.6 Do you have everyone sign a consent form? _____ We must receive a copy of the form(s) you use.
- 1.7 Do you use a medical history form on everyone? _____ We must receive a copy of the form(s) you use.
- 1.8 Do you provide goggles for all laser/IPL work on faces? _____

OPERATOR INFORMATION

- 2.1. OPERATOR TO BE NAMED: _____
- 2.2. Licenses you hold & license numbers: _____
- 2.3. How long have you been working with lasers/IPLs/light devices? _____
- 2.4. What specific light source equipment do you want to insure?

- 2.5 What specific light source equipment have you been trained in? _____

- 2.6 What services do you offer: Laser Hair removal? _____ Photo Revjuventation? _____ Tattoo removal? _____
Veins (up to 1.5mm, spider veins) _____ Rosacea _____ Age/sun spots _____ Nonablative wrinkle reduction _____
If you checked Veins, please state the body areas (i.e. facial, leg, etc.) and maximum vein diameter (in millimeters):

- 2.7 What type of services, not listed above, do you offer? _____

- 2.8 Education in light source equipment: List all information as requested and include certificates of completion
- | <u>.Date</u> | <u>Class Title</u> | <u>Number of Hours</u> |
|--------------|--------------------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
- 2.9 Do you want coverage for Skin Types V & VI at an additional premium as noted? _____ (1 yr exp. Required)
- 3.0 Specific Light devices you want to be insured for (no coverage will be provided unless listed.)
- | <u>Laser /IPLType/Light devices (include wavelength
(specify "long-pulse" or "Q-switched, if applicable)</u> | <u>FDA
Class</u> | <u>Maximum Fluence (joules)
at Maximum Spot Size</u> |
|--|----------------------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I understand:

1. The Fitzpatrick Scale. I will not be insured to work on Skin Types V & VI unless specifically endorsed & paid for.
2. It is warranted that for Class III & IV devices goggles must be worn by all people in the room at all times the laser is in use. All reflective surfaces will & and medical history form. No coverage will apply if there is not a signed form on file.
3. 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 utilizing an ANSI compliant door-activated shut-off system. A sign must be posted on door: LASER IN USE, DO NOT ENTER
4. I understand there is no coverage for any prescription anesthetic use.
5. No insurance will be offered for any equipment that is not listed on the policy.
6. 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: NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

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If yes, please indicate the following:

<i>Insurer</i>	<i>Policy #</i>	<i>Liability Limits</i>	<i>Premium</i>	<i>Exp. Date</i>
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4.2 List all claims history whether or not insured: If none, state so _____.

<i>JR/Claim</i>	<i>Nature of injuries</i>	<i>Equip. Involved</i>	<i>Details, if Pending</i>	<i>Amt. if settled</i>
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_____Yes _____No. If yes, describe details of the event:

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APPLICANT

TITLE

TODAY'S DATE

REQUESTED EFFECTIVE DATE

LIABILITY LIMIT REQUESTED

One box below must be checked:

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LANDLORD AS ADDITIONAL INSURED _____ :

ADDRESS: _____ CITY, STATE, ZIP: _____