ADMIRAL INSURANCE COMPANY a W. R. Berkley Company

MEDICAL SPA PROFESSIONAL INSURANCE APPLICATION (CLAIMS MADE)

1. Full Name of Applicant: (Include all DBA's and subsidiaries seeking coverage under the policy for which you are applying.)

2. Mailing Address: _____

3. Other Locations:

4. Web Site Address: _____

5. Date Established: _____ (mm/dd/yy)

6. Type of Entity: ◯ Corporation ◯ Partnership ◯ Individual ◯ LLC ◯ Other (Specify) : _____

7. Is this entity owned by, associated with or controlled by any other entity? ◯ Yes ◯ No

If Yes, please explain:

8. Please provide the **number** of the employees or Independent contractors and whether or not they carry their own individual medical malpractice coverage* for their services on behalf of this entity:

	Employee	Independent Contractor	Insured on Own Med Mal Policy	Insured Limits
Physicians (no surgery)			◯ Yes ◯ No	
Physicians (surgical)			◯ Yes ◯ No	
CRNA's			◯ Yes ◯ No	
Physician Assistants			◯ Yes ◯ No	
Nurses (RN/LPN/LVN)			◯ Yes ◯ No	
Aestheticians			◯ Yes ◯ No	
Laser Techs			◯ Yes ◯ No	
Medical Assistants			◯ Yes ◯ No	
Massage Therapists			◯ Yes ◯ No	
Other _____			◯ Yes ◯ No	

* Please attach copies of declaration pages on all individuals that carry their own medical malpractice.

9. Are all of the above individuals licensed in accordance with applicable State and Federal regulations? ◯ Yes ◯ No
If No, please provide a detailed explanation:

10. Who Is your Medical Director? _____

Medical Specialty: _____

Please indicate below which coverage option you want, or if no coverage is desired for Medical Director, check None:

a. Would you like to include coverage for the Medical Director's administrative duties only? ◯Yes ◯No

b. Would you like to include coverage for the Medical Director's administrative duties & good faith exams only? ◯Yes ◯No
(If Yes, please attach a completed Medispa Physicians application.)

c. Would you like to include coverage for the Medical Director's administrative duties & direct patient care? ◯Yes ◯No
(If Yes, please attach a completed Medispa Physicians application.)

d. ☐ None

11. Has the applicant or any of the above employees and/or independent contractors:
(If the answer to any of the following questions is YES, complete details are required.)

a. Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or Administrative agency, hospital or professional association? ◯Yes ◯No

b. Ever been convicted of a criminal act 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 narcotics suspended, revoked, renewal refused or restricted, or ever voluntarily surrendered same? ◯Yes ◯No

12. Please indicate the estimated number of procedures to be performed over the next 12 months in all of the following categories:
(If you offer a procedure that is not shown below, list it in the box marked OTHER and provide the # of estimated procedures)

CATEGORY I - NON-INVASIVE, NON-INJECTABLE, NON ABRASIVE SKIN CARE & DAY SPA TYPE PROCEDURES

	# Of Procedures		# Of Procedures
Body & Facial Waxing		Hyperbaric Treatment	
Manicures/Pedicures		Massage	
Ear Candling		Weight Loss – Non Surgical and No HCG	
Facials		Other: _____	

CATEGORY II - NON-INVASIVE PROCEDURES, INJECTABLES, ABRASIVE SKIN CARE & NON-LASER REMOVAL PROCEDURES

	# Of Procedures		# Of Procedures
Acupuncture		Microdermabrasion	
BHRT (no pellet insertion)		Permanent Make Up	
Brown Spot Removal – Non Laser		Platelet Rich Plasma Therapy (PRP)	
Chemical Peels (Light)		Mesotherapy (No PC/DC)	
Fillers/Injectables		Skin Tag Removal	
Dermaplaning		Stem Cell Therapy	
Electrolysis		(Blood Based Stem Cell Harvesting Only)	
HCG Injections or Liquid Drops		Wart Removal	
		Other: _____	

CATEGORY III – LASER-BASED PROCEDURES, FAT EMULSION, NON-INVASIVE LIPO PROCEDURES (COLD LASER), ABRASIVE FACIAL PROCEDURES

	# Of Procedures		# Of Procedures
BHRT Pellet Insertion		Laser Hair Removal	
Brown Spot Removal (Laser Based Treatments)		Laser Skin Resurfacing	
		Liposonix	
Cavi-Lipo		Pigmented Lesion Removal	
Cold Laser for Fat Reduction (No Incisions)		Sclerotherapy	
		Tattoo Removal - Laser Based Treatment	
Fraxel Laser Procedures		Thermage	
Heavy Chemical Peels		Vein Treatments	
IPL		Velashape	
Laser Cellulite Treatment		Other: _____	

CATEGORY IV - MINOR FACIAL COSMETIC SURGERY, NON-LIPOSUCTION BASED COSMETIC SURGERY

	# Of Procedures		# Of Procedures
Blepharoplasty		Threadlifts	
Ear Pinning		Other: _____	
Hair Restoration/Hair Transplant Surgery			

CATEGORY V - COSMETIC SURGERY PROCEDURES AND INVASIVE LIPO PROCEDURES

	# Of Procedures		# Of Procedures
Abdominoplasty/Tummy Tucks		Mesotherapy with PC/DC Smart Lipo	
Butt Lift or Augmentation		Face Lifts – Full Face Laser Lipolysis Lipodissolve	
Breast Augmentation			
Lipolysis		Stem Cell Therapy (Fat Based Stem Cell Harvesting)	
Liposelection			
Liposuction - Tumescent or Other		Other: _____	

13. Do you perform any surgery at this facility that you did not detail above? ◯ Yes ◯ No

If yes, please provide a list of these surgical procedures and the estimated # of surgeries for the next 12 months.

Type of Surgeries	# Of Procedures

14. What type of anesthesia care is used at the medical spa & who is it administered by?

Administered by:

- ◯ Local Anesthesia Only
- ◯ Conscious Sedation
- ◯ General Anesthesia
- ◯ Other: _____

15. Are FDA Approved Drugs ever used for "off-label" purposes? Yes ◯ Yes ◯ No

If Yes, by whom and what is their medical designation. Need a list of the drugs and the "off-label" purposes for which they are used?

16. Do you ever provide any services at locations other than your medical spa? ◯ Yes ◯ No

a. If Yes, please provide the following details:
What Services? _____

b. At what locations? _____

c. Who performs the services & what is their medical designation?

d. How many off-site procedures do you estimate over the next 12 months?

e. Will alcohol be served to these off-site patients? ◯ Yes ◯ No

17. Does this applicant sell any products? ◯ Yes ◯ No

If the answer to any of the following questions is YES, please include brochures.

a. What kind of products? _____

b. Do any of these products require a physician's prescription? ◯ Yes ◯ No

c. Do you label these products in your own name? ◯ Yes ◯ No

d. Does all labeling and use of drugs have FDA approval? ◯ Yes ◯ No

If No, Please provide details: _____

18. State sources and amounts of total revenue:

		Last 12 months	Estimate for next 12 months
a. Fee for service:			
b. Product Sales			
c. Other income:			
d. Total Gross Revenues			

19. If the applicant has a training school, please provide the following: (provide details on last page if more room is needed)

Profession for which students are being trained	Max # of students per session	# of sessions per year	% of time in clinical setting	Qualification of Faculty (MD, RN, PHD)

20. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If none, state NONE.)

Carrier	Limit	Deductible	Premium	Policy Term

21. What is the retroactive date on your current policy?

22. Is the applicant currently insured under a Commercial General Liability policy? If Yes, please attach copy of declarations page. ○ Yes ○ No

23. Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? ○ Yes ○ No

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

24. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? ○ Yes ○ No

If Yes, please provide details including name of carrier and dates.

25. Has any claim ever been made against the applicant or any of its employees? ○ Yes ○ No

If Yes, please complete the Supplemental claim form for each and every claim. Form Link

26. Is the applicant aware of any circumstances which may result in any claim against them or their employees? ○ Yes ○ No

If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.

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☐ The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application and this application will be made a pert of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Electronic Signature of Applicant of Authorized Representative: _____ Current Date: _____

Title _____

If you prefer not to return Application with an electronic signature, please print and sign below.

Signature of Applicant of Authorized Representative _____ Current Date: _____

Title _____

ADDITIONAL INFORMATION - Please provide the following information with this application:

a. Advertisements, brochures, descriptive literature
b. Sample contract between you and the clinical trial investigator, if the investigator is not your employee or enployee of the test site facility.
c. Informed consent document

Please provide any additional details in the space provided:

RESET SAVE AS PRINT EMAIL