



Coverage provided by

LANDMARK INSURANCE COMPANY

WILMINGTON, DELAWARE

ADMINISTRATIVE OFFICES: 100 SUMMER STREET, BOSTON, MA 02110-2103

(A Capital Stock Insurance Company)

MEDICAL SPA APPLICATION

NOTICE: THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED THEREIN, THE COVERAGE OF THIS POLICY IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST YOU AND REPORTED IN WRITING TO US DURING THE POLICY PERIOD. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

The Applicant represents that the statements and facts are true and no material facts have been omitted or misstated. If a policy is issued, this Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

Instructions:

- 1) Please type or print clearly.
- 2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Appropriate).
- 3) If you need more space for your responses, continue on a separate sheet with letterhead and indicate question number.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED:

- LOSS HISTORY – Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.
- Copies of all marketing materials/brochures.
- Current financial statements (audited if available).
- Copies of most recent inspection reports within the past three years.
- Copy of Informed Consent.

GENERAL/OVERVIEW INFORMATION

Applicant's Name: _____

Business Address: _____
Street City County State Zip

Mailing Address: _____

Website: _____ Telephone No.: _____

Date Business Established: _____ If start-up then check the box: Yes (start-up)

Requested effective date: _____ Retroactive date: _____

Current Coverage: Professional Liability: Claims-made Occurrence
Commercial General Liability: Claims-made Occurrence

Applicant is a:

- Corporation Partnership
- Partnership Association Sole Proprietorship
- Joint Venture Physician Owned
- Other (*Please Explain*) _____

Applicant Operates: For Profit Not for Profit

Total			
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- 3) For those services in the prior question that are performed by Physicians or Dentists:
- (a) Do they carry their own Professional Liability coverage? Yes No
- (b) If yes, list the minimum limits required: _____
- (c) **Is coverage requested** for any Physicians or Dentist list above? Yes No If yes, attach Physicians application.
- 4) What type of anesthesia is administered to patients?
- None General Local Conscious Sedation
- 5) Client/Patient Age Breakdown by percentage:
- | | |
|---|--------|
| <input type="checkbox"/> Less than 21 years old | _____% |
| <input type="checkbox"/> 21 to 50 years old | _____% |
| <input type="checkbox"/> 50+ years old | _____% |
| TOTAL | 100 % |
- 6) Do you plan to expand your locations offered, services and/or number of personnel? Yes No
- If yes, give details: _____
- _____
- 7) Does a physician perform the “good faith” initial exam? Yes No
- If no, then why not? (Give details): _____
- _____

PRODUCTS LIABILITY

- 8) Describe any products sold and their related \$ revenue for (1) Current Year and (2) Projected Next 12 Months:
- _____
- _____
- (a) Are any of these products FDA approved drugs? Yes No
- If yes, list each: _____
- _____
- (b) If yes, are any FDA approved drugs used in an “off-label” manner? Yes No
- If yes, give details: _____
- _____

STAFF

- 9) Professional Employees/Independent Contractors – List each physician providing services at your facility.

Medical Director - Name	Specialty	Insurance Carrier & Policy Number	Employee/ Contractor	Hours/Month

- 10) Will the Medical Director have any direct patient contact or work in an administrative capacity only? _____
- _____

11) Other Health Care Professionals – Indicate the number in each category, full-time and part-time.

	Employees		Contractors	
	Full Time	Part Time	Full Time	Part Time
Physicians				
Physician’s Assistants				
Dentists				
Aestheticians				
Electrologists				
Massage Therapists				
Registered Nurses				
Nurse Practitioners				
Medical Assistants				
Other (define)				
Other (define)				
Other (define)				

- 12) For those health care professionals that are considered Independent Contractors:
- (a) Do they carry their own Professional Liability coverage? Yes No
 - (b) If yes, list the minimum limits required: _____
 - (c) Do you request proof of coverage for Independent Contractors? Yes No

RISK MANAGEMENT

- 13) Has any outside organization conducted an inspection of your facility in the past 3 years? Yes No
 If yes, please indicate the name of the organization and the type of inspection: _____

- 14) Is this facility licensed by the state? Yes No
 If yes, list the type of licensing and list the state(s). _____

- 15) Do any of the employees require licensing by the state? Yes No
 If yes, list the employee(s) name, type of licensing and the state(s). _____

- 16) Has the applicant’s license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any state/federal licensing board or regulatory agency? Yes No

If yes, give details. _____

- 17) List other accreditation(s), if any: _____

- 18) List all associations that you are a member of: _____

- 19) Does your facility have a formalized Risk Management Program? Yes No

20) Who coordinates your Risk Management Program?

Name: _____

Title: _____ Telephone No.: _____

21) Is parental consent obtained for all minors treated at your facilities? Yes No

22) Does the Applicant take before and after photographs of every patient? Yes No

If no, give details. _____

23) Do you have any contractual agreements with independent contractors/providers to provide services at your facility?

Yes No If yes, give details and provide a copy of a sample contract. _____

Are certificates of insurance obtained from all contracted providers? Yes No

24) Please indicate all of the hiring/screening procedures used for professionals and others who provide services at your facility:

- Check of educational background, or residency program, when applicable.
- Check of previous employers In writing By telephone
- Check of personal references In writing By telephone
- Check on hospital privileges for physicians, oral surgeons and dentists.

How often do you update your list of specific privileges? _____

- Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
- Require information on any professional liability or work-related claim that has previously been made against any individual.

25) Does your facility have written job descriptions? Yes No

COMMERCIAL GENERAL LIABILITY INFORMATION (Complete This Section If Requesting GL Coverage)

26) Please provide physical plant information as requested (use additional sheet if necessary):

Address/Occupancy	Square Footage	Age	Type of Construction	# Floors	Type of Fire Protection*

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

27) Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

28) Was the facility designed for patients to stay overnight? Yes No

29) Does the applicant own or lease equipment? Own Lease

30) Who is responsible for the inspection and maintenance of the equipment? _____

31) Are policies/procedures established to respond to/address patient medical emergencies while at the facility? Yes No

32) What is the construction? _____ Fire Protection Class? _____ Number of Stories? _____

33) Are the electrical, heating and plumbing systems up to code and regularly inspected? Yes No
 If yes, then inspected by whom and what date? _____
 Is the building completely sprinklered? Yes No
 If partially sprinklered, identify those areas that are sprinklered. _____

34) Are the fire alarms connected to a local fire station? Yes No
 If yes, what was the date of the last fire alarm inspection? _____

HISTORICAL CARRIER INFORMATION

35) Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

PRIMARY	Insurer	Policy Period	Premium	Limits	Attachment	CM (w/ Retro) Or Occurrence
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						

36) Has the applicant ever had any insurance company decline, cancel, rescind or non-renew Professional Liability coverage? Yes No

If yes, provide details: _____

LOSS HISTORY

37) Summary of 5 Year Loss History - Please provide claims history as requested:

Year	# Open	Total Paid	# Closed	Total Paid	Total # of Claims	Total \$ Paid Expense	Total \$ Paid Indemnity	Total \$ Paid

38) If no claims have been reported to you, then initial here: _____

39) Large Loss Description – On a separate sheet of paper list any liability claims or suits made or brought against your facility during the past five years for amounts incurred greater than \$50,000. If no claims or suits greater than \$50,000 then check the box: Submitted on Separate Sheet of Paper None Greater than \$50,000

40) Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? Yes No
 If yes, give dates, allegations and disposition of each claim or suit in the comments section. _____

41) Give the valuation date: _____

OTHER

42) Does the applicant offer day care services? Yes No

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. ANY MATERIAL MISSTATEMENTS AND/OR OMISSIONS MAY RESULT IN RESCINDED COVERAGE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THE EARLIEST EFFECTIVE DATE FOR WHICH A POLICY MAY BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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 OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE

PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Applicant's Signature: _____
(MUST BE OFFICER OR PRINCIPAL OF BUSINESS)

Title: _____ Date: _____

Name of Agent: _____ Submitted by: _____

Date: _____ Address: _____

License #: _____