☐ **Deerfield Insurance Company**
☐ **Evanston Insurance Company**
☐ **Essex Insurance Company**
☐ **Markel American Insurance Company**
☐ **Markel Insurance Company**
☐ **Associated International Insurance Company**

APPLICATION FOR MICROPIGMENT IMPLANTATION, TATTOO, BODY PIERCING PROFESSIONAL LIABILITY INSURANCE (Claims Made)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full Name of Applicant: _____

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

c. Business Phone: ( ) _____

Home Address: _____ Home Phone: ( ) _____

d. E-mail Address: _____

e. Website Address: _____

f. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____

g. Number of Independent Contractors: Full Time _____ Part Time _____ Seasonal _____ Total _____

h. Date Established: _____

i. [ ] Sole Proprietor [ ] Corporation [ ] Partnership [ ] Professional Association

[ ] Employee of (specify) _____

2. BUSINESS OPERATIONS

a. The business, corporate or partnership name is: _____

b. Please list names of all partners/members of the firm who provide professional services: _____

_____

c. Annual number of client encounters: _____

d. Total Gross Revenues: This fiscal year: _____ Estimated next fiscal year: _____

If you answer Yes to any of questions e. through i. below, please attach a detailed explanation and copies of all pertinent advertisements.

e. Do you own or operate any business other than that shown in Question 2(a) above? ..... [ ] Yes [ ] No

f. Are you employed by any individual or entity other than that shown in Question 1(a) above? ..... [ ] Yes [ ] No

g. Are you under contract to any individual or entity? ..... [ ] Yes [ ] No

h. Do you advertise professional services in any manner? ..... [ ] Yes [ ] No

i. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? ..... [ ] Yes [ ] No

j. Do you use a collection agency? ..... [ ] Yes [ ] No

If Yes, please give name of agency: _____

3. YOUR PRACTICE

a. Please provide a description of professional services: _____

_____

b. Does your practice include piercings of the following:

Head? ..... [ ] Yes [ ] No
Torso? ..... [ ] Yes [ ] No
Hands/Feet? ..... [ ] Yes [ ] No
Genitalia? ..... [ ] Yes [ ] No

c. Please describe the nature and duration of your professional training: _____

Institution Name, if applicable: _____

Years of Training: _____

Certification Attained, if applicable: _____

d. Have you received training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? ..... [ ] Yes [ ] No

If No, explain: _____

e. Have you received training pertaining to the safe handling of blood-borne pathogens? ..... [ ] Yes [ ] No

f. Are you certified in cardio-pulmonary resuscitation (CPR)? ..... [ ] Yes [ ] No

g. In what states are you licensed, certified or registered as a practitioner? _____

h. Do you practice as an independent contractor? ..... [ ] Yes [ ] No

If Yes, where do you practice? _____

i. Are you a member of:

American Academy of Micropigmentation? ..... [ ] Yes [ ] No
Society of Permanent Cosmetic Professionals? ..... [ ] Yes [ ] No
Alliance of Professional Tattooists? ..... [ ] Yes [ ] No
Association of Professional Piercers? ..... [ ] Yes [ ] No

Other (Specify): _____

j. In what setting(s) do you provide professional services:

Store/Kiosk/Mall? ..... [ ] Yes [ ] No
Private Office? ..... [ ] Yes [ ] No
Spa/Salon? ..... [ ] Yes [ ] No
Medical/Dental Office? ..... [ ] Yes [ ] No
Home/Home Office? ..... [ ] Yes [ ] No

Other (Specify): _____

k. Indicate professional societies or associations in which you are a member: _____

_____

l. Are you employed by, associated with or do you work for a physician or surgeon? ..... [ ] Yes [ ] No

If Yes, give details including name and specialty of physicians you work for: _____

_____

m. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ..... [ ] Yes [ ] No

If Yes, please describe in detail: _____

_____

n. Are clients screened for existing and prior medical conditions prior to treatment? ..... [ ] Yes [ ] No

o. Is signed and dated informed consent obtained from all patients prior to commencing treatment? ..... [ ] Yes [ ] No

Please provide a copy of the informed consent form.

p. Are services performed on clients under the age of 18? ..... [ ] Yes [ ] No

If Yes, is written consent of the parent/legal guardian obtained before performing any procedure? ..... [ ] Yes [ ] No

q. Are clients provided with written aftercare instructions? ..... [ ] Yes [ ] No

Please provide a copy of the aftercare instructions.

r. Are patient treatment records kept? ..... [ ]Yes [ ] No

If Yes, how long are patient treatment records kept? _____

s. Are services performed on pregnant women? ..... [ ] Yes [ ] No

t. Are disposable needles and disposable gloves (latex or non-latex) used in your procedures? ..... [ ] Yes [ ] No

u. For the categories listed below, please identify the method(s) of cleaning, disinfection or sterilization employed in your practice:

	Sterilized*	Disinfected**	Cleaned***	Disposable
Needles	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
Equipment/Instruments/Articles intended to penetrate the skin	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
Jewelry/Ornaments	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
Patient Furniture/Floors	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
Other _____	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No

* Subjected to a process that eliminates all forms of microorganisms, e.g. autoclave

** Subjected to a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects, e,g. use of alcohol, peroxide, bleach, etc.

*** Subjected to manual or mechanical removal of visible soil using water and detergent or other enzymatic product.

v. Do any tattoo inks utilized in your practice contain paraphenylenediamine (**PPD**) or black henna? ..... [ ] Yes [ ] No

w. Is the ink utilized in your practice manufactured only with sterile water? ..... [ ] Yes [ ] No

x. Is only sterile water used for the purpose of diluting tattoo ink? ..... [ ] Yes [ ] No

y. Do you perform tattoo removal? ..... [ ] Yes [ ] No

z. Are piercing instruments and implant jewelry/ornaments used in your practice only made of non-toxic metals? ..... [ ] Yes [ ] No

aa. Are any piercings performed with a piercing gun? ..... [ ] Yes [ ] No

If Yes, what body parts are pierced? _____

bb. Do you use disposable sterile cassettes in your piercing gun? ..... [ ] Yes [ ] No

4. INSURANCE AND CLAIMS HISTORY

a. Limits of Liability for Professional Liability - Indicate the limits of liability requested:

Per Claim/Coverage Aggregate

[ ] $ 100,000 / $ 300,000 [ ] $ 500,000 / $1,500,000

[ ] $ 200,000 / $ 600,000 [ ] $1,000,000 / $3,000,000

[ ] $ 250,000 / $ 750,000 Other:_____

b. Deductible - Indicate deductible requested:

[ ] None [ ] $1,000 [ ] $2,500 [ ] $5,000

c. Retroactive Date on current “claims made” policy, if applicable? _____

THE COMPANY DOES NOT GUARANTEE TO OFFER ANY OF THE ABOVE LIMITS, DEDUCTIBLES AND/OR RETROACTIVE DATE.

d. List prior Professional Liability Insurance carried for each of the last five years, including the current year.
If None, check here. [ ]

Ins Company	Limits of Liability	Deductible	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

e. Is coverage requested for independent contractors? ..... [ ] Yes [ ] No
If "No", do independent contractors carry their own professional liability limits? ..... [ ] Yes [ ] No

If "Yes", what limits of liability are maintained? $_____/$_____

f. Has the Applicant or any employed or contracted healthcare providers:

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

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

iii. Even been treated for alcoholism or drug addiction? ..... [ ] Yes [ ] No

iv. 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

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

If Yes to i. – v., provide details by attachment.

g. Is the Applicant or any employed or contracted healthcare provider aware of any act, error, omission, fact, circumstance, situation or incident which may result in a disciplinary or investigative proceeding by a governmental or administrative agency? ..... [ ] Yes [ ] No

h. Has any claim or suit for alleged malpractice been brought against the Applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant? ..... [ ] Yes [ ] No

If Yes, provide currently valued 5-year company loss runs or complete a copy of our Supplemental Claim form for each claim or suit.

i. Has any claim or suit for alleged malpractice been made against the applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant that has not been reported to a prior insurer? ..... [ ] Yes [ ] No

If Yes, complete a copy of our Supplemental Claim Information form for each claim or suit.

j. Is the Applicant aware of any act, error, omission, fact, circumstance, situation or incident which may result in a malpractice claim or suit being made or brought against the Applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant organization? ..... [ ] Yes [ ] No

If Yes, complete a copy of our Medical Incident Form for each incident.

5. ADDITIONAL INFORMATION ON MEDICAL PRACTICE AND PROCEDURES

a. Please attach copies of the following:

i. Patch test consent forms.

ii. Procedural consent forms.

iii. Certificates of attendance/completion/graduation for all training programs.

iv. Your business letterhead.

6. GENERAL LIABILITY — Check if coverage Not Requested [ ]

a. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address of Facility	Description (Yes/No)	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					
4					

b. Does the Applicant maintain office space at a host facility? ..... [ ] Yes [ ] No

c. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

d. Are all of the Applicant's locations equipped with:

i. Complete Sprinkler System? ..... [ ] Yes [ ] No
ii. At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
iii. Smoke detectors? ..... [ ] Yes [ ] No
iv. Emergency electrical system? ..... [ ] Yes [ ] No
v. Heat sensors? ..... [ ] Yes [ ] No
vi. Fire escape(s)? ..... [ ] Yes [ ] No
vii. Posted emergency evacuation procedures? ..... [ ] Yes [ ] No
viii. Properly maintained fire extinguishers? ..... [ ] Yes [ ] No

If any of the above are answered No, provide details by attachment.

e. Does the Applicant have a written safety program in place? ..... [ ] Yes [ ] No

If Yes, attach a copy of the written safety program.

f. Does the Applicant have written procedures for incident reporting? ..... [ ] Yes [ ] No

g. Do any of the Applicant's locations have any:

i. Exposure to flammables, explosive, chemicals? ..... [ ] Yes [ ] No
ii. Catastrophe exposure? ..... [ ] Yes [ ] No
iii. Exposure to radioactive materials? ..... [ ] Yes [ ] No

h. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? ..... [ ] Yes [ ] No

i. Does the Applicant sell or lease any medical equipment or products to patients or others in connection with Applicant's operation? ..... [ ] Yes [ ] No

If Yes,

i. Total Annual Sales $_____

ii. Total Annual/Lease Rental Receipts $_____

j. Does the Applicant:

i. Loan or rent machinery or equipment to others? ..... [ ] Yes [ ] No

ii. Own any elevators or escalators? ..... [ ] Yes [ ] No

iii. Own or rent any parking facility? ..... [ ] Yes [ ] No

iv. Provide any recreational facility? ..... [ ] Yes [ ] No

v. Have a swimming pool on the premises? ..... [ ] Yes [ ] No

vi. Sponsor any sporting or social events? ..... [ ] Yes [ ] No

vii. Own or rent space used for housing for any healthcare provider? ..... [ ] Yes [ ] No

If Yes to i. – vii., provide details by attachment.

k. Limits of Liability for General Liability - Indicate the limits of liability requested:

Per Claim/Coverage Aggregate

[ ] $ 100,000 / $ 300,000 [ ] $ 500,000 / $1,500,000

[ ] $ 200,000 / $ 600,000 [ ] $1,000,000 / $3,000,000

[ ] $ 250,000 / $ 750,000 Other:_____

i. Deductible - Indicate deductible requested:

[ ] $5,000 [ ] $10,000 [ ] $15,0000 [ ] $25,000 [ ] $50,000 [ ] other _____

THE COMPANY DOES NOT GUARANTEE TO OFFER ANY OF THE ABOVE LIMITS, DEDUCTIBLES AND/OR RETROACTIVE DATE.

l. Type of coverage requested; [ ] Claims Made [ ] Occurrence

m. If claims made coverage requested, is coverage requested for prior acts? ..... [ ] Yes [ ] No

If Yes, requested Retroactive Date: _____

n. Does the Applicant currently have coverage for:

i. Hired and Non-Owned Auto Liability? ..... [ ] Yes [ ] No

If Yes, provide the limits of liability currently carried. $_____/$_____

If the Applicant wants coverage for Hired and Non-Owned Auto Liability, complete our Supplement for Hired and Non-Owned Auto Liability (SM-31003).

ii. Employee Benefits Liability? ..... [ ] Yes [ ] No

If Yes, provide the limits of liability, deductible and retroactive date currently carried.

Limits of Liability: $_____/$_____ Deductible: $_____ Retroactive Date:_____

If the Applicant wants coverage for Employee Benefits Liability, complete our Supplement for Employee Benefits Liability (ZZ-31002-01).

o. Does the Applicant want coverage for any additional insureds? ..... [ ] Yes [ ] No

If Yes, list any additional insureds that coverage is requested for and the relationship to the Applicant.

_____

p. List prior General Liability Insurance carried for each of the last five years, including the current year.

If None, check here. [ ]

Ins Company	Limits of Liability	Deductible	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

q. Has any claim for General Liability ever been made against any person(s) or organization(s) proposed for this insurance? ..... [ ] Yes [ ] No

If Yes, provide currently valued 5-year year loss runs or complete a copy of our Supplemental Claim Information form for each claim.

r. Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, circumstance, situation or incident which may result in a General Liability claim, such as would fall under the proposed insurance? ..... [ ] Yes [ ] No

If Yes, complete a copy of our Supplemental Claim Information form for each incident.

7. ALL APPLICANTS ATTACH THE FOLLOWING DOCUMENTS

a. Curriculum Vitae (CV) for the Applicant Organization's Medical Director, including specialty and board certification.
b. Risk Management protocols.
c. Most recent annual financial statements.
d. Sample contract for healthcare providers and facilities.

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

If the coverage for which application is made is for claims made coverage, the undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

i. The coverage for which application is made applies only to "Claims" first made during the "Policy Period."

ii. Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by "Claim Expenses" and, in such event, the Company will not be liable for "Claim Expenses" or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy; and

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant	Title
Signature of Applicant	Date

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 insurance act, which is a crime and subjects the person to criminal and civil penalties.