



REQUESTED COVERAGE – OUTPATIENT CLINIC / MEDICAL SPA COMBO

Requesting Professional Liability:

Requested Retro Date: _____

Professional Liability Limits

Professional Liability Deductible

- | | | | |
|--|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> \$100,000 / \$300,000 | <input type="checkbox"/> \$1,000,000 / \$1,000,000 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$15,000 |
| <input type="checkbox"/> \$200,000 / \$600,000 | <input type="checkbox"/> \$1,000,000 / \$2,000,000 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$20,000 |
| <input type="checkbox"/> \$250,000 / \$750,000 | <input type="checkbox"/> \$1,000,000 / \$3,000,000 | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$25,000 |
| <input type="checkbox"/> \$500,000 / \$1,500,000 | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Other: _____ |

Requesting General Liability:

Requested Retro Date: _____ or Occurrence Based Coverage

General Liability Limits

General Liability Deductible

- | | | | |
|--|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> \$100,000 / \$300,000 | <input type="checkbox"/> \$1,000,000 / \$1,000,000 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$15,000 |
| <input type="checkbox"/> \$200,000 / \$600,000 | <input type="checkbox"/> \$1,000,000 / \$2,000,000 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$20,000 |
| <input type="checkbox"/> \$250,000 / \$750,000 | <input type="checkbox"/> \$1,000,000 / \$3,000,000 | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$25,000 |
| <input type="checkbox"/> \$500,000 / \$1,500,000 | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Other: _____ |

Requesting Employee Benefits Liability (supplement required):

Requested Retro Date: _____

Employee Benefits Liability Limits

Employee Benefits Liability Deductible

- | | | | |
|--|--|----------------------------------|-----------------------------------|
| <input type="checkbox"/> \$100,000 / \$300,000 | <input type="checkbox"/> \$1,000,000 / \$1,000,000 | <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$10,000 |
| <input type="checkbox"/> \$200,000 / \$600,000 | <input type="checkbox"/> \$1,000,000 / \$2,000,000 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$15,000 |
| <input type="checkbox"/> \$250,000 / \$750,000 | <input type="checkbox"/> \$1,000,000 / \$3,000,000 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$20,000 |
| <input type="checkbox"/> \$500,000 / \$1,500,000 | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$25,000 |

Requesting Non-Owned Auto Liability (supplement required):

Non-Owned Auto Liability Limits

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$500,000 |
| <input type="checkbox"/> \$200,000 | <input type="checkbox"/> \$1,000,000 |
| <input type="checkbox"/> \$250,000 | <input type="checkbox"/> Other: _____ |

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.





Kinsale Insurance Company
 P. O. Box 17008
 Richmond, VA 23226
 (804) 289-1300
www.kinsaleins.com

APPLICATION FOR CLINICS (Medical, Dental, Public Health)

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
 - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
 - Copy of all advertising that you use
 - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) _____

2. Mailing Address: _____
STREET CITY COUNTY STATE ZIP

3. Location Address: Check here if same as mailing:

(1) _____
STREET CITY COUNTY STATE ZIP

(2) _____
STREET CITY COUNTY STATE ZIP

(3) _____
STREET CITY COUNTY STATE ZIP

(4) _____
STREET CITY COUNTY STATE ZIP

Attach Additional Pages as Needed

4. Website Address: www. _____ 5. Telephone: _____

6. Inspection contact: _____

7. Date Established _____ Years under current management _____

8. Applicant is a:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Professional Associations |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> LLC | <input type="checkbox"/> Joint Venture |
| <input type="checkbox"/> Other: _____ | |

9. Enterprise is: For Profit Not For Profit



10. Is this entity owned by, associated with or controlled by any other entity?

Yes No

If yes, please provide details:

OPERATIONS

11. Please check the category which best describes your organization

<input type="checkbox"/> Health and Wellness Center	Center or clinics established for primarily walk-in patients for basic health and health-related services. Primary care providers predominantly RNs or LPNs, NPs, and physician assistants. Facilities in this category would include free clinics open to the public or those provided for students/faculty of schools, colleges, universities.
<input type="checkbox"/> Primary Care Clinic	Majority of patient visits are scheduled preventative health services. This category can also include extended hours walk-in clinics where urgent care services are not the primary services provided by your organization. Your regular office hours have been extended to include the addition of walk-in care services. Primary care givers during these hours could include physicians or mid-level providers, although physicians are available during the extended hours.
<input type="checkbox"/> Urgent Care Center	Urgent care services are the primary activities performed by your organization. Physicians regularly staff your locations with the support of mid-level providers. Services provided are sometimes broader in scope than those typically found in a physician’s office. Locations may offer a range of services including physical therapy, occupational therapy, occupational health (Workers Compensation exams), on site x-ray and clinical lab.
<input type="checkbox"/> Emergi-Center	High level of acuity and may include minor invasive procedures such as those provided in emergency care centers/emergency rooms. Services would also include high level treatment for trauma or severe illness and crisis stabilization. Treatments may require moderate to high levels of anesthesia
<input type="checkbox"/> Other	Please provide a description of your organization if it does not readily reflect one of the above categories. <hr/> <hr/>

12. Please list all accreditations and association memberships held by the applicant’s facility (Joint Commission, AAAHC, etc):

13. Days and Hours of Operation: _____

14. Please state sources and amounts of total revenue:

<u>Source</u>	<u>Last 12 months</u>	<u>Next 12 months</u>
Charitable contributions	\$ _____	\$ _____
Government Funding	\$ _____	\$ _____
Fee for services	\$ _____	\$ _____
Other – specify:	\$ _____	\$ _____
TOTAL GROSS REVENUES	\$ _____	\$ _____



15. Please indicate number of patient visits:

	<u>Past 12 Months</u>	<u>Estimated Next 12 Months</u>
Emergency Visits	_____	_____
Urgent Care visits	_____	_____
Health/ Wellness Visits	_____	_____
Other: _____	_____	_____
TOTAL VISTS	_____	_____

16. If your facility offers any of the following services on site please provide the number of tests, prescriptions, or imaging studies respectively performed:

	<u>Past 12 Months</u>	<u>Estimated next 12 Months</u>
X-ray / Imaging	_____	_____
Pharmacy	_____	_____
Laboratory	_____	_____

Are any of these services offered to individuals who are not your facility's primary patient? YES NO N/A

17. Please indicate percentage of patients among the following:

- | | |
|--|---------------------------------------|
| _____ % Urgent Care | _____ % Alternative Medicine |
| _____ % Emergency Care | _____ % Women's Health/ Gynecological |
| _____ % General Practice / Family Practice | _____ % Sleep Studies |
| _____ % Dialysis | _____ % Psychiatric |
| _____ % Occupational health | _____ % Weight loss |
| _____ % Students | _____ % Crisis Stabilization |
| _____ % Surgical | |
| _____ % Other (please describe) _____ | |

18. Does the applicant maintain any beds for overnight occupancy? YES NO
If yes, please provide total number _____

19. Is anesthesia administered by the applicant, the applicant's employees or independent contractors other than topical or local? YES NO
If yes please provide a detail explanation on page 6

20. Does the applicant's employees or independent contractors perform any prenatal care or obstetrical procedures? YES NO
If yes, please provide details on page 6

21. Does the applicant, employees, or independent contractors use drugs for weight reduction? YES NO
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs and quantity dispensed.

22. Does the applicant perform laser hair removal, botox injections or dermal filler injections? YES NO
If yes, please complete medical spa supplement.

23. Does the applicant perform any psychiatric shock therapy? YES NO

24. Does the applicant perform any chelation therapy services? YES NO

25. Does the applicant administer any methadone treatment? YES NO
If yes, provide the number of treatments:

Last 12 Months _____ Next 12 Months _____

26. Does the applicant maintain written documentation of procedures for patient intake and follow-up? YES NO

27. Please provide name and location of any hospital or medical facility that the applicant refers in practice?



STAFF

28. Please indicate the number of employed and contracted staff:

	Number Employed?		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Acupuncturists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chiropractors*					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dentists*					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Inhalation/ Respiratory Therapists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Laboratory Technicians					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Licensed Practical Nurses					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nurse Anesthetists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nurse Midwives*					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nurse Practitioner					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Opticians					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Optometrists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Paramedics/ EMT's					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Perfusionists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pharmacists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physician Assistant					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physicians – Major Surgery*					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physicians – Minor surgery*					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physicians – No surgery*					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physicians – OBGYN*					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physiotherapists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Registered Nurses					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Social Workers					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Speech Therapists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
X-ray Technicians					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: Specify					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

* Additional applications required if coverage is desired

29. Please provide the name and specialty of the applicant's Medical Director: _____

Does the applicant's Medical Director have direct patient care? YES NO

Full Time or Part Time

30. Are all above individuals licensed in accordance with applicable state and federal regulations? YES NO

31. Do you require contracted staff to carry their own professional liability insurance? YES NO

If yes, what limits do they carry? _____

32. Do all physicians (employed and contracted) carry their own professional liability coverage? YES NO

If yes, what limits do they carry? _____

33. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:

- Check of educational background, or residency program, when applicable.
- Check of previous employers (In writing By Telephone)
- Criminal background check (STATE FEDERAL)
- Drug / Alcohol / Abuse Screening (circle all that are used)
- 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?

34. Does your facility have written job descriptions? YES NO



COVERAGE HISTORY AND LOSS HISTORY

35. Please list professional liability insurance carried for each of the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ Aggregate	Deductible	Premium	Retroactive date

36. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ Aggregate	Deductible	Premium	Occurrence or Claims Made

If the current expiring GL policy is claims- made what is the retroactive date? _____

Provide details for all "yes" answers to questions 37-42 on page 6 or attach additional pages as needed

- 37. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain on page 7 or attach additional pages as needed** YES NO
- 38. Has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain on page 7 or attach additional pages as needed** YES NO
- 39. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on page 7 or attach additional pages as needed** YES NO
- 40. Has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance? **How Many?** _____ **(Complete Supplemental Claims form for Each)** YES NO
- 41. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? **If yes, please explain in detail, completing a supplemental claim form for each.** YES NO
- 42. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.** YES NO



FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 denial of insurance benefits.

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 MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 \$5,000 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/she 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 a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 a 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.

NOTICE TO TENNESSEE 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 VIRGINIA 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.



The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent / Broker Name: _____



SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. **Attach additional sheets if necessary for adequate explanation.** All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: _____ Age: _____ Sex: _____

Incident Claim

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

Additional Defendants: _____

What is the present condition of the patient? _____

STATUS OF CLAIM

- Suit threatened, no action taken
- Suit filed but dropped by claimant
- Summary judgment in your favor

Court outcome in YOUR favor:

- Jury verdict
- Directed verdict

Unresolved/Open

- Awaiting mediation
- Awaiting court action

Reserve amount:
\$ _____

Suit settled out of court

- a. Date claim paid: _____
- b. Amount paid: \$ _____
- c. Did you want to settle?
 Yes No

Court outcome in favor of plaintiff:

- Jury verdict
 - Directed verdict
- Amount of loss payment:
\$ _____

Name and address of the attorney assigned to your case: _____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: No:

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

Signature: _____

Date: _____

Printed Name: _____



MEDICAL SPA SUPPLEMENT

Clinic Application **MUST** also be completed

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

GENERAL INFORMATION AND OPERATIONS

1. Full name of Applicant (Including DBA's) _____

2. Applicant's practice is run by:
 - Nurse Nurse Practitioner Physician Assistant Dentist Other Individual: _____
 - Physician (specify type)
 - Dermatologist
 - Plastic Surgeon
 - Other _____

3. Percentage of clients or patients within the following categories?

Beauty Shop (nails, hair, facial)	_____%	Weight Control	_____%
Massage	_____%	Dental (to include teeth whitening)	_____%
Hormone Therapy	_____%	Surgical /Plastic Surgery	_____%
Dermatology (to include acne treatment)	_____%	Medical Spa	_____%
Fitness Club / Yoga or Exercise Classes	_____%		

4. Age Range of Clients: _____% Under 18 _____% 18-39 _____% 40-65 _____% Over 65

5. Do you require **ALL** patients to sign an Informed Consent form prior to any procedure being performed? *If Yes, please attach copies of patient informed consents. If No, please explain.*

Yes No

6. If any clients are under the age of 18 – do you require parent/guardian signatures on Informed Consents? Please indicate all procedures performed on clients under the age of 18 if applicable:

Yes No N/A

7. Do you sell any products with the facility's name and/or label on them? *If yes, attach complete product list and indicate corresponding annual sales.*

Yes No

8. Do you sell **any** dietary supplements or prescribe any weight loss medication? If yes, identify brand names:

Yes No

9. Do you ever hold off-site events? *If yes, please describe:*

Yes No



10. Are any daycare or childcare services offered to your clients? Yes No

11. Are **any** alcoholic beverages sold and or served on premises? *Please elaborate if yes:* Yes No

12. Please indicate if any of the following are on your premises – indicate here if “none”

- Swimming Pool
- Sauna
- Steam Room
- Whirlpool Type Spa/Tub
- Tanning Booths (Number? _____)

13. SERVICES:

PROCEDURES PERFORMED AND PERFORMED BY:

(Check **All** that Apply also indicating any additional staff that may be performing the procedure)

Yes?	Procedures:	# Annually	LPN	RN	NP	PA	DDS/ DMD	MD / DO	OTHER (must specify name and designation)
<input type="checkbox"/>	ACUPUNCTURE		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	BOTOX		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	CHEMICAL PEELS UNDER 30% ACIDITY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	CHEMICAL PEELS OVER 30% ACIDITY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	DERMAL FILLERS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	FACIALS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HAIR TRANSPLANT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HORMONE THERAPY MEN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HORMONE THERAPY WOMEN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	INTENSE PULSE LIGHT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	LASER HAIR REMOVAL		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	LASER SKIN RESURFACING		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	LASER VEIN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	LASER TATTOO REMOVAL		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	LIPODISSOLVE		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	LIPOSUCTION: (type) _____ _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	MASSAGE THERAPY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	MESOTHERAPY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	MICRODERMABRASION		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	NUTRITIONAL COUNSELING		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	PERMANENT MAKEUP		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	SCLEROTHERAPY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	THERMAGE		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER PROCEDURES NOT NOTED ABOVE (Continue to specify individual performing)



14. Have all staff performing procedures noted on the previous page received a minimum of 8 hours training specific to the indicated procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? **Please attach evidence of training for aesthetic procedures noted.** Yes No

15. Does the applicant or staff utilize or perform any procedures, drugs, or equipment that is **not** approved for use by the FDA? **If yes, please explain:** Yes No

16. Does the applicant or staff **engage in any off label use** of otherwise FDA approved procedures, drugs, or equipment? **If yes, please explain:** Yes No

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 denial of insurance benefits.

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 MEXICO 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 civil fines and criminal penalties.



NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 \$5,000 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/she 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 a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 a 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.

NOTICE TO TENNESSEE 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 VIRGINIA 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent / Broker Name: _____

