WEIGHT LOSS CENTERS – SUPPLEMENTAL APPLICATION

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

Supplemental Questions

Applicant's Name: _____

1. Describe all the services offered:

	Revenues and Patients					
Service Type						$ Projected 12 Months
Total Revenues from Operations						
Total Patients						

2. List all products available at/from the weight loss center. For each product, provide a copy of ingredients.

3. Does your company use physicians? If so, complete the following:

Physician Name	Limits of Insurance Each Carries Per Claim/Aggregate	

4. Are blood tests taken for any reasons at any location? If so, complete the following:

Location	Details
Add More	

5. Does your company utilize other medical personnel such as nurses? Y/N
   If so provide details here.:

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6. Please complete to indicate growth:

						Projected 12 Months
Number of Locations						
Total Patients						

7. Please list the number of locations (corporate and franchisee) by state:

Corporate Locations		**Franchisee Locations**	
State	**Number of Locations**	**State**	**Number of Locations**

8. Please submit the following:
   (a) LOSS HISTORY – Submit company produced 5 year loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).
   (b) Provide list of all products sold with all ingredients clearly marked.
   (c) List of all locations and whether (1) franchised or (2) owned.
   (d) Copies of all marketing material.
   (e) Risk management guidelines.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS SUPPLEMENTAL APPLICATION CHANGES BETWEEN THE DATE OF THIS SUPPLEMENTAL 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 SUPPLEMENTAL APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS SUPPLEMENTAL APPLICATION SHALL BE PART OF THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THIS SUPPLEMENTAL APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

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

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____