Commonwealth Underwriters Ltd.
P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
Fax: 888-359-6994
www.commund.com

MEDICAL SPA/ANTI-AGING CLINICS SUPPLEMENTAL APPLICATION
PROFESSIONAL LIABILITY INSURANCE

I. GENERAL INFORMATION

Attach a separate sheet of paper on your letterhead whenever additional space is needed.

1. Full Name of Applicant (Named Insured): _____

   Principle Address:
   (If multiple locations, please attach a list.) _____

2. Indicate your facility's core specialization:
   - ☐ Aesthetic/Cosmetic Practice
   - ☐ Preventative/Wellness/Mind-Body Medicine
   - ☐ Alternative/Complementary/Non-Western Medicine

3. List other business names your facility(ies) or its current principles(s) have used: _____

   _____

4. Date continuous operations began under current or previous business name(s): _____
5. Facility Licensure, if applicable:
   a. License/Registration Number: _____ b. Regulating Body: _____
   c. Has any action ever been taken to remove, restrict, or has any disciplinary action been taken with respect to the current or past facility registration/license? ☐ Yes ☐ No
   d. If Yes, please explain: _____
7. Service Location(s) – Check all that apply and note percentage of receipts (total must equal 100%):

☐ Alternative Treatment Centers	_____ %	☐ Private Home	_____ %
☐ Beauty Salons/Aesthetic Salons	_____ %	☐ Resorts	_____ %
☐ Doctor's Office/Clinic/Freestanding Facility	_____ %	☐ Therapeutic Centers	_____ %
☐ Medical Centers/Hospitals	_____ %	☐ Other (specify):	_____ %

II. POLICIES

1. Does Applicant utilize a formal written Quality Assurance & Risk Management Program? ☐ Yes ☐ No
   If No, please explain: _____
2. Is the overall responsibility for Risk Management assigned to one individual at your facility(ies)? ☐ Yes ☐ No
   If Yes, please provide name and title: _____
3. Does Applicant take before and after pictures of every patient? ☐ Yes ☐ No
   If No, please explain: _____
4. List name(s) and title(s) of person(s) who conduct good faith exams at your facility(ies): _____

   _____
5. Do you have overnight beds? ☐ Yes ☐ No
   If Yes, how many total persons can you accommodate at one time? _____
6. Do you perform procedures on patients younger than 16 years old? ☐ Yes ☐ No
7. Do you always require parental/guardian consent forms for be signed for patients aged 16 – 18 years old? ☐ Yes ☐ No
8. Do you provide daycare for patients' children while at any of the locations noted above? ☐ Yes ☐ No
   If Yes, what is the staff to child ratio: _____

9. Do you require patients to sign liability waivers? ☐ Yes ☐ No

   If Yes, please attach your standard waiver to this application. _____

10. Are logs kept of all servicing, maintenance and calibration of precision instruments? ☐ Yes ☐ No

11. Please indicate the types of lasers used at your facility(ies) and the procedures in which they are used:

Type of Laser	Procedures

12. Do you sell or serve food or beverages? ☐ Yes ☐ No

    If Yes, please provide percentage to total annual revenues for each of the following:

    Food: _____ Non-Alcoholic Beverages: _____ Alcoholic Beverages: _____

13. Is the food cooked/prepared on your premises or is it provided by a third party? ☐ Yes ☐ No

14. Are herbal supplements, homeopathic remedies, and/or nutraceuticals distributed or sold by your facility(ies)? ☐ Yes ☐ No

    If Yes, please provide a list on a separate sheet of paper the names of such supplements, remedies and/or nutraceuticals and the annual gross sales figures for each item sold.

15. Are any non-FDA approved treatments/procedures provided? ☐ Yes ☐ No

    If Yes, please explain: _____

16. Are each of the professionals performing procedures at your facility(ies) licensed/certified in accordance with applicable state and federal regulations? ☐ Yes ☐ No

17. Please indicate the name(s) and credentials of any individual who does or may perform injections (of any kind) on behalf of your facility(ies) and under what circumstances:

Name	Credentials

18. Please provide the name(s) and credentials of any individual who does or may perform chemical peels on behalf of your facility(ies) and under what circumstances:

Name	Credentials

III. OPERATIONS

1. For each of the following procedures, please indicate total number performed, receipts, and patient visits.

   NOTE: (1) Only those procedures you indicate in this insurance application can be considered for coverage; and (2) Not all procedures indicated on this application will be covered. Ask your insurance broker to assist you with any questions relating to coverage.

Procedure Name/Type	Total # Annual Procedures/Treatments		Total Annual Receipts		Total Annual Patient Visits	
	Last 12 Months	Next 12 Months	Last 12 Months	Next 12 Months	Last 12 Months	Next 12 Months
CLASS III						
Dermabrasion						
Botox injections for cosmetic purposes only						
Botox injections for purposes other than cosmetic only						
Fat injections						
Collagen injections						
Silicone injections						
Other injections (please specify): _____						
Mesotherapy						
Liposelection, Lipodissolve						
Sclerotherapy						
Moxibustion – direct						
Chelation therapy: for purposes other than for heavy metal treatment						
Weight management treatment involving injections and/or prescription drugs						
Ultrasound						
Mammography						
Colonoscopy						
Chiropractic or Traction Treatment						
Hair Transplants/Implants						
Any face lift including contour thread lifts, Aptos lifts and feather lifts or similar procedures						
Other Surgical Procedures						
Pigmented Lesion Removal						
CLASS II						
Microdermabrasion						
Permanent Makeup/ Micropigmentation						
Tattoo removal via laser						
Chemical Peels - Specify Solution Strength: _____						
Dental services: other than teeth whitening						
Hyperbaric treatment for purposes other than for the aiding of wound healing						
Acne Blue Light Treatment						
Photo Rejuvenation/Fotofacial						
Laser Hair Removal						
Laser Skin Treatment						

Procedure Name/Type	Total # Annual Procedures/Treatments		Total Annual Receipts		Total Annual Patient Visits	
	Last 12 Months	Next 12 Months	Last 12 Months	Next 12 Months	Last 12 Months	Next 12 Months
Laser Cellulite Treatment						
Thermal Wart Removal						
Electrolysis						
Addiction Treatment						
Chelation therapy for heavy metal treatment only						
Colonic						
Electrotherapy						
CLASS I						
Tattoo removal not via laser or surgery						
Weight management treatment not involving injections and prescription drugs						
Cosmetology (nails, hair, facials)						
Biofeedback/Bone Density Scans						
Massage						
Tanning						
Ear Candling						
Hyperbaric treatment: for purpose of aiding wound healing only						
Physiochineitherapy						
Ayurvedic Medicine						
Acupuncture						
Moxibustion – indirect only						
Dental services: teeth whitening only						

2. For each of the following, please indicate number of each type of staff member, 1099s, and annual payroll.

Personnel	# Full-Time	# Part-Time	# of 1099s	Annual Payroll
Physicians				
Licensed Nurses (RN/LPN/LVN)				
Physician Assistants				
Nurse Practitioners				
Aestheticians				
Electrologists				
Massage Therapists				
Student Interns				
Other (describe): _____				

IV. MEDICAL DIRECTOR INFORMATION

1. **Medical Director - Administrative Duties**

   a. Does your facility(ies) have a Medical Director? If No, skip this section completely. ☐ Yes ☐ No
   If Yes, please provide that person's name: _____

   b. Is the Medical Director a physician? ☐ Yes ☐ No
   If No, detail credentials of Medical Director: _____

   c. Describe the duties of the Medical Director (attach additional sheets as necessary): _____

d. If not the Medical Director, who is responsible for the day to day operation of your facility(ies)? _____

e. Indicate days and hours when the Medical Director is present in the office: _____

f. Is the Applicant requesting coverage for its Medical Director's administrative duties? ☐ Yes ☐ No

If Yes, please provide a copy of the contract(s).

g. Does the Medical Director have other professional liability coverage that will cover his or her administrative duties? ☐ Yes ☐ No

h. Current Medical Director is: ☐ Owner/Partner ☐ Independent Contractor ☐ Employee ☐ Other (please provide details): _____

2. **Medical Director – Patient Clinical Care**

a. Is the Applicant requesting coverage for the Medical Director's clinical care at your facility(ies)? ☐ Yes ☐ No

b. Does the Medical Director have other professional liability coverage that will cover his/her clinical care at your facility(ies)? (If Yes, please provide a copy of that insurance policy.) ☐ Yes ☐ No

c. If the Medical Director is a physician, is he/she onsite during all procedures and/or readily available? ☐ Yes ☐ No

d. Please provide the following information for each Medical Director(s) for whom clinical care coverage is being requested (attach additional sheets as necessary):

1) Medical Director-Physician's full name: _____

2) Medical Director-Physician's mailing address: _____

3) Medical license # and year and state of issuance: _____ 4) DEA #: _____

5) Date of Birth: _____ 6) Place of Birth: _____

7) Medical School and Year of Graduation: _____

8) Medical Specialty: _____ 9) Sub-Specialty: _____

10) American Board Certified? ☐ Yes ☐ No

If Yes, in what specialty? _____ Year Certified: _____

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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

DECLARATION AND SIGNATURE:
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true and complete. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Authorized Signature on Behalf of Applicant	Sub-Producer
Title/Date	Producer

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be fully completed, signed and dated to be considered for quotation.

COLONY
Member Argo Group

MEDICAL SPAS/ANTI-AGING CLINIC CHECKLIST

A complete submission contains the following supporting documents:

- ☐ Training Certificates for any Medical Director or Physician for whom coverage is being requested for any of the procedures indicated in Section III – Operations
- ☐ CV for any Physician for whom patient clinical care coverage is being requested
- ☐ List of herbal supplements, homeopathic remedies, and/or nutraceuticals distributed or sold at any location for which coverage is being requested, if applicable
- ☐ Copy of Medical Director's contract(s) with the medical facility(ies) for which coverage is being requested
- ☐ Copy of Medical Director's liability insurance policy indicating that professional liability coverage is provided for his/her patient clinical care performed on behalf of the facility(ies) for which coverage is being requested, if applicable
- ☐ Allied Medical General Application