SUPPLEMENTAL QUESTIONNAIRE FOR MEDICAL SPA

OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
(A Risk Retention Group)

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San Francisco CA 94109-1336

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San Francisco CA 94188-0610

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The policy to which this application applies is issued by Ophthalmic Mutual Insurance Company (A Risk Retention Group). Risk retention groups may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.

Please PRINT or TYPE your answers and personally sign and date the warranty, authorization, membership agreement, disclosure form, and prior claims information supplement. Signature stamps are not acceptable.

Please answer all questions COMPLETELY, including any additional comments required, since incomplete information may delay processing. If a question does not apply, use N/A.

If the medical spa is a partnership or corporation, no coverage exists until Declarations listing the entity as an insured are issued.

1 Name of Medical Spa: _____

2 **A.** Mailing address: _____

_____
City *State* *County* *Zip code*

B. Phone: ( ) _____ **C.** Fax: ( ) _____

3 **A.** Contact person's name: _____ **B.** Title: _____

C. Email: _____ **D.** Phone (if different): ( ) _____

4 The medical spa must comply with each of the following requirements:

A. The medical spa must be located ☐ within the owner's ophthalmic office or ☐ within the same building as the owner's ophthalmic office. (Please check the applicable box to indicate where this medical spa is located.)

B. The facility must meet regulatory requirements for corporate ownership and the corporate practice of medicine.

C. If required by state law, the facility must be licensed or certified by the state in which it operates.

License/certification number: _____ State: _____

☐ Not required by state law

D. The facility must be in compliance with all applicable federal, state, and local laws and regulations that apply to medical spas (if any), including facility and equipment requirements such as square footage, water, restroom, and health and safety requirements.

E. The facility must be in compliance with all scope of practice laws and regulations. If there are conflicting regulations among the regulating agencies, the facility must follow the most stringent regulations.

F. Each provider must be adequately trained (and certified, if applicable) in each procedure he/she performs. **For each provider listed in question 19, please attach a copy of the certificate of completion of training for each medical procedure performed.**

G. The supervising physician(s) must be adequately trained (and certified, if applicable) in each procedure performed at the facility and must have the knowledge, skill, and ability to perform the procedure. **Please submit copies of the certificates of completion of training for the supervising physician(s).**

H. The Medical Director must have *direct* knowledge of the applicable federal, state, and local laws and regulations that apply to medical spas and to scope of practice as well as *direct* knowledge of the certification status and scope of practice of each employee.

I. The facility must be equipped with the medical personnel and equipment necessary to safely observe patients, deal with potential complications, and provide for the proper disposal of medical waste as required by OSHA.

J. The facility must maintain in full force and effect an insurance policy(ies) for general liability and premises liability exposures.

5 What is the legal structure of the medical spa?

☐ Sole proprietorship (unincorporated) ☐ Sole shareholder corporation ☐ Partnership

☐ Multi-shareholder corporation ☐ Limited liability partnership ☐ Limited liability corporation

6 Please list the name, specialty (if physician) or professional designation (if non-physician), and percentage of ownership for each owner of the medical spa. OMIC insureds, their immediate families, or both, must hold at least 50% of the ownership in the facility.

Name	Specialty/Designation	Percentage of Ownership

Continue on a separate page, if needed.

7 Date facility incorporated/opened for operation: _____

8 What are the facility's hours of operation?

☐ Monday _____ to _____

☐ Tuesday _____ to _____

☐ Wednesday _____ to _____

☐ Thursday _____ to _____

☐ Friday _____ to _____

☐ Saturday _____ to _____

☐ Sunday _____ to _____

9 Do you anticipate a significant change:

A. In the volume of procedures to be performed during the next 12 months?

☐ Increase in volume ☐ Decrease in volume ☐ No change expected

B. In the types of procedures to be performed during the next 12 months?

☐ No ☐ Yes (please list new procedures: _____

_____)

10 What form(s) of advertising (other than a general yellow pages listing) do you use? Please check all that apply.

☐ None ☐ Mass Mailings ☐ Print ☐ Radio ☐ Television ☐ Billboard

☐ Internet *(please provide web site address:* _____)

Submit copies of all advertising currently used.

11 Medical Director's name: _____ Specialty: _____

For questions 12 – 15, please explain all "no" answers in the Comments section.

12 Is a physician always available on-site during regular business hours? ☐ Yes ☐ No

If not:

A. Is the physician readily available by telephone within a 30-minute physical response? ☐ Yes ☐ No

B. How often is the physician on-site?_____

C. Does the physician review the medical records? ☐ Yes ☐ No

13 Does a physician examine each patient who undergoes medical services? ☐ Yes ☐ No

14 Does the facility maintain medical records for each patient who undergoes medical services? ☐ Yes ☐ No

15 Does each medical patient undergo a history and physical? ☐ Yes ☐ No

16 Please submit your written protocols regarding the role of the physician and non-physician employees in determining candidacy, informed consent, ordering the treatment, and supervising the care.

17 Please attach a sample informed consent document for each type of medical procedure performed.

18 List the number of service providers by category:

Provider	No. Full-time	No. Part-time	Full-time Equivalents
Physicians			
Nurses (RN/LVN/LPN)			
Aestheticians			
Technicians			
Cosmetologists			

19 In the chart below, please indicate all procedures performed at the facility, by whom, and the projected annual volume. *(Continue on a separate page, if needed.)*

Procedure	Physician	RN	LVN/ LPN	Aesthetician	Cosmetologist	Technician	Total Volume
Laser skin resurfacing							
IPL/fotofacial treatment							
Portrait (plasma energy)							
Aurora (electrical/ light energy)							
Thermage							
Chemical peels (superficial)							
Microdermabrasion							
Injection of Botox							
Injection of dermal fillers							
Sclerotherapy (spider veins)							
Hair removal using laser, IPL, or radio frequency/light							
Cellulite reduction							
Blue light acne treatment							
Laser tattoo removal							
Permanent makeup							
Manicure/pedicure							
Waxing							
Eyelash extensions							
Massage							
Other:							
Other:							
Other:							
Other:							

20 Does the facility have a written transfer agreement with the nearest acute care hospital to transfer patients in the event of an emergency? ☐ Yes ☐ No

If no, please explain in the **Comments** section.

21 How close is the nearest acute care hospital? _____ miles _____ minutes

22 For emergency situations, how are patients transported to the hospital? _____

23 Has any medical professional liability insurer canceled, declined coverage, refused renewal, or renewed your coverage under restrictive conditions, or have you ever withdrawn your application for coverage or voluntarily canceled due to unfavorable underwriting review? ☐ Yes ☐ No

If yes, please specify in the **Comments** section the action taken and reason for such action. Also submit a copy of any correspondence between you and the carrier concerning this action.

24 Has any investigation, revocation, suspension, restriction, denial, other disciplinary action, or change in status occurred with respect to the medical spa's license (if licensed) or operations? ☐ Yes ☐ No

If yes, please explain in the **Comments** section.

25 Have any fee complaints or professional conduct complaints been registered against the medical spa, its physician associates, or non-physician employees with your medical association or state or county medical society, state licensing board, or hospital medical staff? ☐ Yes ☐ No

If yes, please provide a copy of the complaint, your answer, and, if resolved, the final resolution. For professional conduct complaints, also submit copies of the patient charts and operative notes.

26 **A.** Have any professional liability or premises liability claims or suits been brought against the medical spa or its non-physician employees? ☐ Yes ☐ No

B. Are you aware of any facts or circumstances that may give rise to a claim or suit in the future? ☐ Yes ☐ No

If you answered "yes" to any of the above, please complete a **Prior Claims Information Supplement** for each circumstance. For more than one incident or claim, please use photocopies of the form.

27 If the medical spa is a separate entity:

A. What is your requested effective date of coverage?

B. Limits of liability will be shared with the owner-ophthalmologist/entity unless otherwise specified. Do you desire separate limits of liability? ☐ Yes ☐ No

COMMENTS:

"I have read and hereby agree to comply with OMIC's underwriting requirements specific to Medical Spas. I also agree to notify OMIC prior to implementing any intended changes to my responses above. **I understand that failure to comply with OMIC's underwriting requirements or to notify OMIC promptly of changes in my protocol may result in uninsured risk or termination of coverage."**

_____ _____

Signature of Authorized Representative *Date*

_____ _____

Authorized Representative's Name *Title*

HIPAA DISCLOSURE

Under the HIPAA Privacy Rules, you may disclose protected health information ("PHI") without patient authorization to medical professional liability insurers in order to obtain or maintain insurance coverage. OMIC will (1) maintain the confidentiality of PHI you provide to us, (2) use it only for purposes for which it was disclosed, and (3) notify you of any breach of confidentiality of PHI. If OMIC insures you, OMIC will become your business associate and will safeguard PHI in accordance with OMIC's Business Associate Agreement.

ARBITRATION CLAUSE

The OMIC professional and limited office premises liability policy contains an Arbitration Clause. By accepting the policy coverage, you will be bound by the terms of the Arbitration Clause. This Clause states that any dispute you have with OMIC arising out of the policy must be submitted exclusively to final and binding arbitration. Under the Clause, you agree not to proceed against OMIC in state or federal court and specifically acknowledge waiving your right to a jury trial. Any arbitration award rendered will be final and not subject to appeal. Arbitration will take place in any jurisdiction that is convenient to you and agreed to by the parties. Each party pays its own arbitration costs and the fees of its selected arbitrator and they share equally in the fees of the neutral arbitrator and any other arbitration costs. You must keep confidential the nature of the arbitration proceeding and the award.

WARRANTY AND ACCEPTANCE OF POLICY TERMS

I understand that for purposes of obtaining, retaining, and modifying insurance coverage all statements contained in this application and all required supplemental questionnaires are considered material to the issuance of coverage. I warrant that the information furnished as a part of this application is true to the best of my knowledge and is furnished in good faith. I further warrant that I have not withheld information that is likely to influence the judgment of OMIC in evaluating this application.

I agree to update this application while it is pending should there be any change in the information provided that may affect the application or its outcome, and to update such information if and after OMIC extends insurance coverage. I understand that failure to supply requested information on a timely basis, falsification or omission of information requested, or failure to update such information during the medical spa's term of coverage may result in a declination or termination of coverage or denial of coverage for a claim based on the omitted, false, or undisclosed information.

I understand that this application and any other application(s), supplemental questionnaire(s), and any other document(s) submitted to OMIC for the purpose of obtaining, retaining, or modifying insurance coverage with OMIC, together with the policy, the Declarations, and any endorsements, will constitute the contract of insurance between OMIC and the medical spa.

I acknowledge that as part of the ongoing underwriting review of the medical spa's insurance coverage with OMIC, certain information pertaining to any open or closed claim made under the medical spa's OMIC policy may be reviewed in determining whether coverage may be continued, and I consent to the communication of summary information between the claims and underwriting departments.

I understand that coverage does not become effective until this application is approved, the required premium for the insurance has been paid, and (if the medical spa is a separate entity,) Declarations listing the medical spa as an insured are issued.

I understand that the medical spa will become a member and insured of OMIC if this application is approved and the medical spa pays the required insurance premium, and the medical spa will then be bound by the terms of the insurance policy issued to it. I have read the policy included in the application materials carefully to determine the medical spa's rights and duties. I understand that I should discuss the coverage with my attorney, insurance advisor, or risk management consultant. By my signing this application as the medical spa's authorized representative, the medical spa agrees to be bound by the terms, conditions, exclusions, restrictions, and definitions of the OMIC professional and limited office premises liability insurance policy.

_____ _____

Signature of Authorized Representative
(Please do not use signature stamp.)

Title

_____ _____

Authorized Representative's Name

Date

AUTHORIZATION TO RELEASE INFORMATION

I consent to the communication of information and documents between OMIC and other insurance companies, credentialing organizations, certification organizations, professional associations, licensing agencies, and other persons who may have information pertaining to this application, the medical spa's qualifications for insurance, or claims under review.

I release from liability, to the fullest extent allowed by law, OMIC and its agents and representatives for their acts performed in connection with evaluating this application, the medical spa's qualifications for insurance, and claims under review.

I release from liability, to the fullest extent allowed by law, all individuals and organizations who provide information and documents to OMIC or its agents or representatives concerning this application, the medical spa's qualifications for insurance, or claims under review.

_____ _____

Signature of Authorized Representative
(Please do not use signature stamp.)

Title

_____ _____

Authorized Representative's Name

Date

MEMBERSHIP APPLICATION AND AGREEMENT—MEDICAL SPA

For and in consideration of the benefits to be derived therefrom, the Applicant hereby applies for membership in the Ophthalmic Mutual Insurance Company (a Risk Retention Group) ("OMIC"), the principal office being located at 126 College Street, Suite 400, Burlington, Vermont 05401; and the main business office being located at 655 Beach Street, San Francisco, California 94109.

The Applicant hereby acknowledges that:

1 The undersigned medical spa, hereafter referred to as "the Applicant," represents and warrants that the entity's ownership or control consists of at least 50% ophthalmologists who are licensed to practice medicine in each state where they practice and who are members of the American Academy of Ophthalmology.

2 The Applicant understands that this membership is subject to acceptance by OMIC.

3 Membership begins with the commencement of the policy period of a claims made and reported insurance policy issued by OMIC, and ends upon the cancellation or other termination of that policy. The period of membership shall not include any period of coverage under extended reporting or tail coverage endorsements. After termination of membership, the member shall have no further right to participate in any distribution of savings to members or in any distribution of assets upon the dissolution of OMIC, except for amounts that may be due to the member for loans or surplus contributions under separate instruments issued by OMIC.

4 The Applicant, through its authorized representative, has read the Bylaws of OMIC and agrees that if the medical spa's application for insurance is accepted by OMIC, the Applicant shall at such time become a member of OMIC. Membership shall, among other things, evidence ownership in OMIC to the extent required by Vermont law governing mutual insurance companies and risk retention groups. As a member of OMIC, the Applicant will be bound by the terms and conditions of the Bylaws of OMIC, as such may be amended from time to time.

_____ _____

Signature of Authorized Representative
(Please do not use signature stamp.)

Title

_____ _____

Authorized Representative's Name

Date

DISCLOSURE FORM: CLAIMS MADE AND REPORTED POLICY

IMPORTANT NOTICE TO INSUREDS

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT MERELY DESCRIBES SOME OF THE MAJOR FEATURES OF OMIC'S CLAIMS MADE AND REPORTED POLICY. READ YOUR POLICY CAREFULLY TO DETERMINE YOUR RIGHTS AND DUTIES AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

Your policy is a claims made and reported policy. It applies only to claims made against you and reported to OMIC after the inception date and within five days after the end of the policy period arising from professional services incidents that occur on or after the policy retroactive date. Upon termination of your policy, an extended reporting period may be available.

OCCURRENCE VS. CLAIMS MADE AND REPORTED

"Occurrence" and "claims made and reported" policies generally cover the same kinds of professional services incidents. However, claims for damages may be assigned to different policy periods depending on which policy you have.

In an "occurrence" policy, coverage is provided for liability because of professional services incidents that *occur during the policy period, no matter when the claim is made.*

In your "claims made and reported" policy, coverage is provided for liability because of professional services incidents *if the claim is first made against you and reported to OMIC during the policy period or within five days after the end of the policy period*. The claim must be a written notice or demand that you have received arising from an act, error, or omission in the provision of services. A claim is considered made when it is received by you and reported when it is received by us. A claim may be assigned to an earlier policy period if, for example, another claim based on the same professional services incident has already been made during the earlier policy period.

PRINCIPAL BENEFITS, CONDITIONS, EXCLUSIONS, AND RESTRICTIONS

The policy provides coverage for professional and limited office premises liability up to the maximum dollar limit specified in the policy and the policy Declarations. The principal benefits and coverages are explained in detail in your claims made and reported policy. The policy also contains certain conditions, exclusions, and restrictions. Please read your policy carefully and consult your attorney, insurance advisor, or risk management consultant for any questions you might have.

RENEWALS, RETROACTIVE DATES, AND EXTENDED REPORTING PERIODS

Your claims made and reported policy has some unique features relating to renewal, coverage of incidents with long periods of exposure, and extended reporting periods. These special provisions are described below.

Renewal

Your premium may increase or decrease upon renewal. You will receive notification in accordance with the terms of your policy.

Retroactive Date

When you have a retroactive date entered on the Declarations page, there is no coverage for professional services incidents that occur before the retroactive date, even if the claim is first made and reported during the policy period. If there is no retroactive date entered on the Declarations page, the policy will respond to claims first made during the policy period or within five days after the end of the policy period for covered professional services incident, no matter when the incident occurred.

If there is a retroactive date, it cannot be moved ahead in time except with your written consent and only under certain circumstances, including the following: you have changed insurers; there is a substantial change in your operations that increases your exposure to loss; or you have failed to provide us with information about the nature of your business or premises. It is important to understand how the claims made and reported policy's extended reporting period guarantees continuity of coverage if you are offered a renewal or replacement policy with a later retroactive date than the one in your current policy.

Extended Reporting Periods or "Tails"

If a claim is made and reported more than five days after the termination of your claims made and reported policy, you may not have coverage for that claim. Insured ophthalmologists, slots, and professional entity Policyholders may purchase an extended reporting period or "tail" endorsement, which will be offered with at least the aggregate limit of the Insured's terminated policy and will allow reporting for at least one year after the end of the policy. Carefully review the policy provisions regarding the available extended reporting period and the time during which you must purchase or accept any offered extended reporting period endorsement.

If the coverage under this policy of any Insured non-physician employee or locum tenens terminates, he or she will continue to be covered for claims based on incidents that occurred while the employee or locum tenens was employed by the Insured ophthalmologist or professional entity, even if the claim is not reported until after the employee or locum tenens is no longer employed, so long as the claim is first made and reported to OMIC within the policy period or extended reporting period applicable to the employer Insured. Limits of liability for the claim will be shared with the employer Insured.

If the coverage under this policy of any Insured professional entity that shares limits with another Insured terminates by reason of the dissolution or other termination of activity of the professional entity, the professional entity will continue to be covered for claims based on incidents that occurred while such professional entity was active, even if any such claim is not reported until after the professional entity ceases activity, so long as the claim is first made and reported to OMIC within the policy period or extended reporting period applicable to the Insured with which the professional entity shares limits.

_____ _____

Signature of Authorized Representative
(Please do not use signature stamp.)

Title

_____ _____

Authorized Representative's Name

Date

PRIOR CLAIMS INFORMATION SUPPLEMENT

Complete one form for each incident, claim, or suit. If you need additional space, please attach a separate page. Copy this form if more than one claim is being reported. Please type.

1 Name and Designation of Health Care Provider: _____

2 Name of Patient/Claimant: _____

3 Date(s) of Treatment: _____ Date of Claim/Suit: _____

4 Claimant's Allegation: _____

5 Name of Insurance Carrier Providing Defense: _____

6 Additional Defendants: _____

7 Status:
- ☐ Incident (reported to carrier on a precautionary basis only; verbal allegation or demand made)
- ☐ Claim (written demand made; notice of intent received; or other cases classified by your carrier as a claim)
- ☐ Suit (summons and complaint served)

8 Chronologic summary of events (including nature of treatment and your involvement). Your chronological summary of events should provide sufficient detail from which OMIC can make an independent assessment of the care rendered. **If case is still pending or indemnity has been paid, attach copies of patient charts and operative notes.**

_____

_____

_____

(Continue on the **Comments page***, if necessary. Be sure to sign and date any additional pages)*

9 Disposition of claim:

☐ Open **If open**, has the carrier indicated a desire to settle? ☐ Yes ☐ No

☐ Closed Amount of Settlement/Judgment: $ _____ Date closed: _____

NOTE: This policy will not apply to any claim arising from any professional services incident occurring prior to the effective date of the first policy issued to the applicant and continuously renewed thereafter if the applicant was aware of or could have reasonably known at the time of application that a claim or suit could develop from that incident.

"I understand that information submitted herein becomes part of the Supplemental Questionnaire for Medical Spa."

_____ _____

Signature of Authorized Representative *Title*

_____ _____

Authorized Representative's Name *Date*