ADMIRAL INSURANCE COMPANY 520 PIKE STREET, SUITE 2929 SEATTLE, WA 98101 PHONE (206) 467-6511 – FAX (206) 467-6557 INTERNET: WWW.ADMIRALINS.COM	MEDICAL SPA PROFESSIONAL LIABILITY INSURANCE APPLICATION (CLAIMS MADE)

1. **Full Name of Applicant:** _____
   _____
   (Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. **Mailing and Location Address:** _____
   _____

3. **Other Locations:** _____
   _____
   _____

4. **Website Address (if applicable):** _____

5. **Date Established:** _____

6. **Type of Entity: ___Corp ___ Partnership ___ Individual ___ LLC ___ Other:** _____

7. **Is this entity owned by, associated with, or controlled by any other entity? _____ Yes _____ No If Yes, please give details.**
   _____

8. **Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:**

	Employee or Volunteer	Independent Contractor	Insured On Own Med Mal Policy
Physicians (no surgery)	_____	_____	____ Yes ____ No
Physicians (surgical)	_____	_____	____ Yes ____ No
Physician Assistants	_____	_____	____ Yes ____ No
Nurse Practitioners	_____	_____	____ Yes ____ No
Registered Nurses	_____	_____	____ Yes ____ No
LPN's or Nurse Aides	_____	_____	____ Yes ____ No
Aestheticians	_____	_____	____ Yes ____ No
Laser Techs	_____	_____	____ Yes ____ No
Medical Assistants	_____	_____	____ Yes ____ No
Massage Therapists	_____	_____	____ Yes ____ No
Other:_____	_____	_____	____ Yes ____ No

   ***Please attach copies of declarations pages on all individuals that carry their own medical malpractice.**
   ***Please note, basic policy does not cover independent contractors for their individual liability. If you are seeking coverage for independent contractors, please provide details on a separate attachment.**

9. **Are all of the above individuals licensed in accordance with applicable state and federal regulations?**
   _____ Yes _____ No If No, please attach a detailed explanation.

10. **Who is your Medical Director?** _____
    Please indicate below which coverage option you want, or if no coverage is desired for the Medical Director, check None.
    _____ Would you like to include coverage for the Medical Director's administrative duties only?
    (If Yes, please attach a completed Medical Directors application.)
    _____ Would you like to include coverage for the Medical Director's administrative duties and good faith exams only?
    (If Yes, please attach a completed Medical Directors application.)
    _____ Would you like to include coverage for the Medical Director's administrative duties & direct patient care?
    (If Yes, please attach a completed Medical Spa Physician's application.)
    _____ None

11. Has the applicant or any of the above employees and/or independent contractors: **YES** **NO**

(a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? _____ _____

(b) Ever been convicted of a criminal act other than traffic offenses? _____ _____

(c) Ever been treated for alcoholism or drug addiction? _____ _____

(d) Ever had any state professional license or license to prescribe narcotics suspended, revoked, renewal refused, or restricted, or ever voluntarily surrendered same? _____ _____

If Yes, please attach a detailed explanation.

12. Please indicate the estimated number of procedures that will be performed over the next 12 months:

# Per Year	PROCEDURES	# Per Year	PROCEDURES
_____	Acne Treatment	_____	Liposuction
_____	Acupuncture	_____	Mesoderm
_____	BOTOX	_____	Mesotherapy
_____	Brown Spot Removal	_____	Microdermabrasion
_____	Chemical Peels (Light)	_____	Permanent Makeup
_____	Chemical Peels (Medium-Heavy) Strength _____	_____	Photo Facial Rejuvenation (IPL)
_____	Collagen Injections	_____	Pigmented Lesion Removal
_____	Contour Threat Lift	_____	Sclerotherapy
_____	Dermal Fillers	_____	Skin Tag Removal
_____	Dermaplaning	_____	Tattoo Removal
_____	Ear Candling	_____	Teeth Whitening
_____	Electrolysis	_____	Thermage
_____	Hair Transplants	_____	Vein Treatment
_____	Hyperbaric Treatment	_____	Wart Removal
_____	Laser Cellulite Treatment	_____	Weight Loss Management
_____	Laser Hair Removal	_____	Other_____
_____	Laser Skin Resurfacing	_____	Other_____
_____	Lipodissolve	_____	Other_____
_____	Liposelection		

_____ **TOTAL # OF PROCEDURES FOR THE NEXT 12 MONTHS (SHOULD BE TOTAL OF ALL THE ABOVE)**

13. For the following procedures, please provide the additional information requested below.

Yes/No	Procedure	Who performs the procedure? (Provide medical designation.)	On which parts of the body?
_____	Contour Thread Lift	_____	_____
_____	Lipodissolve	_____	_____
_____	Liposelection	_____	_____
_____	Liposuction	_____	_____

- **IF YOU PERFORM A PROCEDURE THAT IS CALLED BY A DIFFERENT NAME, BUT ESSENTIALLY THE SAME AS ANY OF THE ABOVE PROCEDURES, PLEASE ANSWER THE QUESTION ACCORDINGLY.**
- **IF YOU PERFORM PROCEDURES OTHER THAN THOSE SHOWN ABOVE, PLEASE ATTACH A LIST OF THOSE PROCEDURES AND THE NUMBER OF ANTICIPATED PATIENT ENCOUNTERS FOR THE NEXT 12 MONTHS.**

14. Do you ever have Botox parties other than in your medical facility? _____ Yes _____ No If Yes, please provide details:

a. **Where are the parties held?** _____

b. **Who performs the Botox injections at the parties?** _____

c. **How many parties will you have over the next 12 months?** _____

d. **How many total encounters will you have at these parties over the next 12 months?** _____

15. Do you perform surgery at this facility? _____ Yes _____ No If yes, please provide complete details and list of all surgeries performed. _____

_____

16. **Is general anesthesia administered at the applicant's facility? _____ Yes _____ No If Yes, who administers the general anesthesia and for what types of procedures or patients? _____**
_____

17. **Does the applicant sell any products? _____Yes _____No If yes, please include product brochures and answer:**

    a. **What kind of products?_____**
    b. **Do any of these products require a physician's prescription? _____Yes _____No**
    c. **Do you label these products in your own name? _____ Yes _____No**

18. **State sources and amounts of total revenue:**

	Last 12 months	Estimate for next 12 months
a. Fee for service:	$_____	$_____
b. Product Sales	$_____	$_____
c. Other income:_____	$_____	$_____
d. Total Gross Revenues	$_____	$_____

19. **If the applicant has a training school, please provide the following: (provide details on last page if more room is needed)**

Profession for which students are being trained	Max # of students per session	# of sessions per year	% of time in clinical setting	Qualification of Faculty (MD, RN, PHD)
_____	_____	_____	_____%	_____
_____	_____	_____	_____%	_____

20. **Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If none, state NONE.)**

Carrier	Limit	Deductible	Premium	Policy Term
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

21. **What is the retroactive date on your current policy?_____**

22. **Is the applicant currently insured under a Commercial General Liability policy? _____ Yes _____ No If Yes, please attach a copy of the declarations page.**

23. **Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? _____ Yes _____ No If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program._____**
_____
_____

24. **Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? _____ Yes _____ No If Yes, please provide details including name of carrier and dates._____**
_____

25. **Has any claim ever been made against the applicant or any of its employees? _____ Yes _____ No. If Yes, please complete the Supplemental Claim Information Form at the end of this application for each and every claim.**

26. **Is the applicant aware of any circumstances which may result in any claim against them or their employees? _____ Yes _____ No If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident._____**
_____
_____
_____

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

_____ _____

Signature of Applicant or Authorized Representative **Date**

Please attach the following documents to this application:

- **Certificates of training for Employees & Physicians**
- **Copies of brochures, marketing or advertising materials**
- **Five years of currently valued company loss runs**
- **Information on disciplinary actions, license revocations, etc.**
- **Copy of most current declarations page**

Additional Comments or Details:

SUPPLEMENTAL CLAIM INFORMATION FORM

(Complete one form for each claim)

1. **Name of applicant/named insured:** _____
   _____
2. **Name of other parties or defendants named in suit:**_____
   _____
   _____
3. **Date of alleged error or occurrence, or contact date:**_____
4. **Date claim was made:** _____
5. **Name of claimant:** _____
6. **Name of Insurance Company handling your claim:** _____
7. **Present status of claim or final disposition:** _____
   _____
   _____
   Circle One: CLOSED OPEN
8. **Defense costs paid to date inclusive of any deductible:** _____
9. **If closed, total loss paid, inclusive of any deductible:** _____
10. **If claim is open or pending, what are the insurer's reserves?**
    Defense: _____ **Loss:** _____
11. **Description of case and events including allegations and assessment of liability:** _____
    _____
    _____
    _____
    _____
    _____
12. **Claimants last settlement demand:** _____

_____ _____

Date **Signature**