MEDI-SPA APPLICATION

1.1 Applicant Name:_____Phone:_____

Business Name:_____Website:_____

Mailing Address:_____City:_____State:_____Zip:_____

Business Address #1:_____Type of Facility?_____

City, State & Zip:_____

Business Address #2:_____Type of Facility?_____

City, State & Zip:_____

1.2 Business operated as: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Individual ☐ Independent Contractor

1.3 Business operated as Medi-spa?_____ If not, other:_____

1.4 How long in business?_____Do all professionals have licenses?_____

1.5 If business operated as a medi-spa, annual gross receipts from all operations:_____

1.6 Are you in compliance with all FDA and state laws as to use of lasers/IPLs/Light devices?_____

1.7 Do you have operations not listed on the below schedule?____If yes, provide details: _____

_____

1.8 Do you have Insurance for these operations?_____Name of Insurance company:_____

1.9 Products liability needed for products sold by you?____ Gross receipts(excluding private label):_____

Do you private label products for sale?_____ This requires a separate application and program.

Fill out all sections that apply below.

I. BEAUTY SERVICES

Category	Number to be Insured
1. Aesthetician Multiple Services	_____
2. Aesthetician Including Microdermabrasion	_____
3. Aesthetician Single Service **List Service:**_____	_____
4. Beautician/Nail Technician	_____
5. Electrology (Excluding All Other Services)	_____
6. Massage (Excluding All Other Services)	_____
7. Permanet Makeup (if yes separate application is required)	_____
8. Other: (Describe) _____	_____
TOTAL NUMBER OF OPERATORS **(Must add up to the numbers in column)**	_____

Definitions – PLEASE CIRCLE ALL SERVICES YOU ARE PROVIDING

* AESTHETICIANS: Facials, Peels, Waxing, Eyelash & Brow Enhancements, Body Wraps, Hair Nails Massage, Electrology
* BEAUTICIANS: Hair, Nails, Eyelash & Brow Enhancements

FACIALS, MEDICAL and/or AESTHETIC PEELS and/or MICRODERMABRASION

Do you use a consent form for all microdermabrasion and peel work? YES/NO If yes, attach a copy.

INDIVIDUALS TO BE LISTED FOR FACIAL WORK, PEELS AND/OR MICRODERMABRASION:

Name:_____Licenses held:_____

How long working with medical peels?_____Trained in peels used?_____

COVER: MEDICAL PEELS? YES/NO • AESTHETIC PEELS? YES/NO • MICRODERMABRASION? YES/NO

II. MEDICAL DIRECTOR

2.1 Is there a medical doctor on your staff?_____Do they work out of your office?_____

If in your office, give name and professional degree:_____

If no, give name, degree and address of your supporting doctor:_____

_____

2.2 Do you want to cover your medical director on the policy?_____

2.3 If yes, indicate any claims they have had in their medical career:_____

_____

III. LASER/IPL/LED SERVICES

3.1 Do you have everyone sign a consent form?_____ We must receive a copy of the form(s) you use.

3.2 Do you use a medical history form on everyone?____ We must receive a copy of the form(s) you use.

3.3 Do you provide goggles for all laser/IPL work on faces?_____

3.4 Do you want coverage for Skin Types V & VI?_____(1 yr exp. Required + $2500 Deductible)

3.5 Specific Light devices you want to be insured for:

Manufacturer of Laser /IPL Brand name & Type of Light device to be insured

_____

_____

_____

On behalf of all laser operators endorsed herein, I understand:

1. The Fitzpatrick Scale. I will not be insured to work on Skin Types V & VI unless specifically endorsed. Laser operators must have 1 year of experience to get this endorsement.
2. It is warrantied that for Class III & IV devices goggles must be worn by all people in the room at all times the laser is in use. All reflective surfaces will be covered.
3. Every client must sign a consent & medical history form. No coverage will apply if there is not a signed form on file.
4. For Class IV laser use, the room door will stay locked at all times the laser is in use or a sign must be posted on door: LASER IN USE, DO NOT ENTER
5. I understand there is is no coverage for prescription anesthetic use unless endorsed herein.
6. No insurance will be offered for the following treatments: i. any raised tissue with its own blood supply (such as moles), ii. Skin that is ulserated, broken (not intact), blistered or has open sores; iii. bulging veins or veins over 1.5 millimeters.

_____ _____

Signature of Applicant/Title Date

We prefer you use the carrier approved consent, medical history and aftercare forms that are available at www.medispa-ins.com

I will use PPIB forms: Signed:_____Title:_____

I am submitting my own forms for approval:Signed:_____Title:_____

No insurance binding can be considered until all forms are approved by PPIB

LIGHT SOURCE OPERATOR INFORMATION

OPERATOR TO BE NAMED:_____

1. Licenses held & license numbers:_____
2. How long have they been working with lasers/IPLs/light devices?_____
3. What services do you offer: Laser Hair removal?_____ Photo Rejuvenation?_____Tattoo removal?_____

   Veins (up to 1.5mm, spider veins)_____ Rosacea _____ Age/sun spots _____ Nonablative wrinkle reduction _____
4. What other services, not listed above, do you offer? _____

_____

5. Education in light source equipment: List all information as requested and include certificates of completion

Date Class Title Number of Hours

_____

_____

IV. BOTOX/DYSPORT/DERMAL FILLER OPERATOR

4.1 Are you in compliance with all AMA and state laws as to use of injectibles?_____

4.2 Do you have everyone sign a consent form?_____ We must receive a copy of the form(s) you use.

4.3 Do you use a medical history form on everyone?____ We must receive a copy of the form(s) you use.

I understand:

1. I will only have coverage in specified facilities unless the no locationi limit endorsement is purchased..
2. I will only buy Botox in the United States from Allergan or from an approved Allergan wholesaler or Dysport from Medicis or an approved Medicis wholesaler..
3. No insurance will be offered for any injectible work except as outlined on the MS PSL endorsement and applied for herein. .
4. Botox coverage is only provided for work on patients over 18.
5. Every client must sign a consent and medical history form and no coverage will apply if there is not a signed form on ile. If I change a form, it must be approved by the insurance company.
7. No coverage is provided for work on pregnant or nursing women.
8. There is no coverage for prescription medications except for anesthetics used with dermal fillers and/or anti-viral medication prescribed for one of the procedures.

_____ _____

Signature of Applicant/Title Date

We prefer you use the carrier approved consent and medical history forms that are available at www.medispa-ins.com

I will use PPIB forms: Signed:_____Title:_____

I am submitting my own forms for approval:Signed:_____Title:_____

No insurance binding can be considered until all forms are approved by PPIB

INJECTIBLE OPERATOR TO BE INSURED:_____

1. Licenses you hold & license numbers:_____
2. How long have you worked with Botox?_____Dysport?_____

Education in Botox/Dysport: List all information as requested and include certificates of completion

Date Class Title Number of Hours

_____

_____

3. How long have you been working with Dermal Fillers?_____

4. What dermal fillers do you offer? Restylane ☐ Captique ☐ Hylaform ☐ Zyplast ☐ Sculptra ☐ Juvederm ☐

Other_____

Education in Dermal Fillers: List all information as requested and include certificates of completion

Date_____ Class Title_____ Number of Hours_____

_____

_____

5. Estimated gross receipts from injectibles. _____

V. SCLEROTHERAPY

5.1 Do you have everyone sign a consent form?_____*Please provide copies of form*

5.2 Do you give everyone aftercare?_____*Please provide copies of form*

We prefer you use the carrier approved consent, medical history and aftercare forms that are available at www.medispa-ins.com

I will use PPIB forms: Signed:_____Title:_____

I am submitting my own forms for approval: Signed:_____Title:_____

No insurance binding can be considered until all forms are approved by PPIB

INDIVIDUAL TO BE NAMED:_____

1. List your sclerotherapy solution/products: _____

2. How long have you been doing sclerotherapy?_____ Hours of training:_____

Provide all certificates of training

3. Do you work on veins larger than 1.5mm?_____

VI. MESOTHERAPY SERVICES

6.1 Do you have everyone sign a consent form?_____*Please provide copies of form*

6.2 Do you give everyone aftercare?_____*Please provide copies of form*

6.3. Do you understand that Mesotherapy injections will only be offered for fat reduction, cellulite and wrinkles? _____
No coverage is provided for pain reduction or other Mesotherapy categories.

We require you use the carrier approved consent and aftercare forms that are available at www.medispa-ins.com

I will use PPIB forms: Signed:_____Title:_____

The limit of coverage for Mesotherapy is subject to a maximum of the per claim limit, with a $5,000 indemnity only deductible.

INDIVIDUAL TO BE NAMED:_____

1. How long have you been providing Mesotherapy services?_____
2. List your training classes and or experience with Mesotherapy injections: *Provide Certificate of Training*

_____

_____

3. Are all products used from licensed, compounding pharmacy?_____
Note only ingredients approved by the company will be covered
4. Do you understand that no more than 40ccs of product (excluding saline) can be used in any one area at any one visit, subject to a maximum of 100ccs in any one visit?_____ If using between 20ccs and 40ccs in one visit, clients must stay and relax and sign the dizziness section on the Mesotherapy consent form. _____ Initial

I warrant the above information is true, I accept the policy terms, and I will have every client sign an approved consent form prior to their Mesotherapy procedure

Signed_____Date:_____

VII. LED INCLUDING TEETH WHITENING & MICROCURRENT

7.1 Are you in compliance with all FDA & state laws as to use of LED devices?_____

7.2 Do you have everyone sign a consent form?_____

7.3 Do you use a medical history form on everyone?____ We must receive a copy of the form(s) you use.

7.4 Do you provide goggles for all LED work on faces?_____

7.5 What specific LED equipment do you want to insure?_____

_____

A. TEETH WHITENING

7.1a What solution is being used for whitening? _____

7.2a Total Number of LED Units to be covered?_____

7.3a. What services other than teeth whitening do you offer with the LED:_____

_____

7.4a. Do you provide customers with home whitening products? _____

If yes, do you provide written instructions for at home use? _____

7.5a Have all operators been trained in the use of LED Teeth Whitening?_____

I understand:

1. Every client must sign a consent & medical history form. No coverage will apply if there is not a signed form on file.
2. I understand there is no coverage for any prescription anesthetic use.
3. No insurance will be offered for any equipment that is not listed on the policy.
4. I understand for coverage to apply only trained technicians will turn on or operate the LED Device.
5. I understand if I treat pregnant women a written doctor's approval will be on file.

_____ _____

Signature of Applicant/Title Date

B. LED/MICROCURRENT

7.1b OPERATOR TO BE NAMED:_____

7.2b Licenses you hold & license numbers:_____

7.3b How long have you been working with LEDs?_____With Microcurrents?_____

7.4b What specific LED/Microcurrent equipment do you want to insure?_____

7.5b List all training in LED & Microcurrent equipment:_____

_____

7.6b What services do you offer with the LED & Microcurrent:_____

7.7b Do you do Microcurrent work on the face?_____

We prefer you use the carrier approved consent, medical history and aftercare forms that are available at www.medispa-ins.com

I will use PPIB forms: Signed:_____Title:_____

I am submitting my own forms for approval: Signed:_____Title:_____

No insurance binding can be considered until all forms are approved by PPIB Do you provide goggles for all LED &

HISTORY: NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

8.1 Do you currently have insurance coverage? ___Yes ___No If claims made, most recent retroactive date:_____
If yes, please indicate the following:

Insurer	Policy #	Liability Limits	Premium	Exp. Date

8.2 List all claims history whether or not insured: If none, state so_____.

YR/Claim	Nature of injuries	Equip. Involved	Details, if Pending	Amt. if settled

8,3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or do you forsee that a claim may be brought as a result of said event, circumstance or occurrence? Yes/No
If yes, describe details of the event: _____

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to all Lloyd's of London syndiciates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE COMPANY

APPLICANT		TITLE
TODAY'S DATE	REQUESTED EFFECTIVE DATE	LIABILITY LIMIT REQUESTED

Total Number of Professioinals to be insured:_____

Can we email you your policy *(usually within 2-3 weeks)* ☐ **Yes** ☐ **No** _____**@**_____

One box below must be checked:

☐ **I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM**

☐ **I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM**

LANDLORD AS ADDITIONAL INSURED_____: _____

ADDRESS:_____CITY, STATE, ZIP:_____

LEASE COMPANY AS ADDITIONAL INSURED_____: _____

ADDRESS:_____CITY, STATE, ZIP:_____

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