HUNTERSURE LLC

PROFESSIONAL AND GENERAL LIABILITY APPLICATION
FOR MEDICAL SPAS

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____ Website Address: _____

5. a) Date Established: _____

b) Entity Type: Corp. _____ Partnership_____ Prof. Assoc. _____ Individual_____

6. a) Desired Effective Date: _____

b) Desired Limits of Liability: $_____ / $_____

c) Desired Deductible: $_____

7. a) Gross Receipts for the Past 12 Months: $_____

b) Estimated Gross Receipts for the Next 12 Months: $_____

c) Payroll for the Past 12 Months: $_____

d) Estimated Payroll for the Next 12 Months: $_____

8. Does the applicant have any ancillary operations? Yes _____ No _____

If yes, please provide details: _____

9. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, please provide details:
_____
_____

10. a) What was your total number of patient/client visits last year? _____

b) Estimated next year? _____

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11. Are any of the following procedures performed and if so, by whom:

Acne Treatment?	Yes _____	No _____	Qualification of Person: _____
Acupuncture?	Yes _____	No _____	Qualification of Person: _____
Botox & Dermal Filler Injections?	Yes _____	No _____	Qualification of Person: _____
Brown Spot Removal?	Yes _____	No _____	Qualification of Person: _____
Dermaplaning?	Yes _____	No _____	Qualification of Person: _____
Electrolysis?	Yes _____	No _____	Qualification of Person: _____
Facials, Chemical Peels & Microdermabrasion?	Yes _____	No _____	Qualification of Person: _____
HCG?	Yes _____	No _____	Qualification of Person: _____
Hormone Therapy?	Yes _____	No _____	Qualification of Person: _____
IPL & Photofacial Rejuvenation?	Yes _____	No _____	Qualification of Person: _____
Laser Cellulite Treatment?	Yes _____	No _____	Qualification of Person: _____
Laser Hair Removal?	Yes _____	No _____	Qualification of Person: _____
Laser Skin Resurfacing?	Yes _____	No _____	Qualification of Person: _____
Any other Laser Procedures?	Yes _____	No _____	Qualification of Person: _____

If yes to the above, please provide a detailed description of procedures performed: _____

_____

Lipodissolve?	Yes _____	No _____	Qualification of Person: _____
Massage Therapy?	Yes _____	No _____	Qualification of Person: _____
Mesotherapy?	Yes _____	No _____	Qualification of Person: _____
Permanent Make-Up?	Yes _____	No _____	Qualification of Person: _____
Pigmented Lesion Removal?	Yes _____	No _____	Qualification of Person: _____
Sclerotherapy?	Yes _____	No _____	Qualification of Person: _____
Skin Tag Removal?	Yes _____	No _____	Qualification of Person: _____
Tattoo Removal?	Yes _____	No _____	Qualification of Person: _____
Teeth Whitening?	Yes _____	No _____	Qualification of Person: _____
Vein Treatment?	Yes _____	No _____	Qualification of Person: _____

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Wart Removal? Yes _____ No _____ Qualification of Person: _____

Waxing? Yes _____ No _____ Qualification of Person: _____

Weight Loss Services? Yes _____ No _____ Qualification of Person: _____

If yes to the above, please provide a detailed description of procedures performed: _____

_____

Any surgical and/or invasive procedure? Yes _____ No _____

If yes to the above, please provide a detailed description of procedures performed: _____

_____

Any other procedures? Yes _____ No _____

If yes to the above, please provide a detailed description of procedures performed: _____

_____

12. a) List the number and type of applicant's employees currently including estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Aesthetician	_____	Laser Technician	_____
Nurse Practitioner	_____	CRNA/Surgical Technician	_____
Physician Assistant	_____	Massage Therapist	_____
Medical Assistant	_____	Chiropractor	_____
Other (please describe)	_____	Clerical/Admin	_____

b) List the number and type of independent contractors estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Aesthetician	_____	Laser Technician	_____
Nurse Practitioner	_____	CRNA/Surgical Technician	_____
Physician Assistant	_____	Massage Therapist	_____
Medical Assistant	_____	Chiropractor	_____
Other (please describe)	_____	Clerical/Admin	_____

c. Are all the above individuals listed in response to question 12a & b licensed in accordance with applicable state and federal regulations

Yes _____ No _____ If no, attach explanation.

13. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes _____ No _____ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes _____ No _____

14. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

Yes _____ No _____ If yes, at what limits? $_____ / $_____

15 a) Who is the Medical Director? _____

b) Is coverage desired for:

(i) The Medical Director's administrative duties only? Yes _____ No _____

(ii) The Medical Director's administrative duties & good faith exams only? Yes _____ No _____

(iii) The Medical Director's administrative duties & direct patient care? Yes _____ No _____

If yes to part (iii), please provide a list of all procedures/services provided by the Medical Director:

_____

_____

16. Are all services provided at the applicant's location address(s)? Yes _____ No _____

If no, please provide details of any off-site exposure including what procedures are performed, at what types of locations, by whom and what % this is of total procedures performed: _____

_____

_____

17. Are FDA approved drugs ever used for "off-label" purposes? Yes _____ No _____

If yes, please provide details of the drugs and the off-label purposes for which they are used & by whom:

_____

_____

18. a) Do you conduct pre-employment screening and investigation? Yes _____ No _____

b) Do you question prospects about previous claims or suits? Yes _____ No _____

c) Are employees required to actively participate in continuing education? Yes _____ No _____

d) Do you prepare job descriptions and instructional manuals for your staff? Yes _____ No _____

e) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

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19. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	_____	Criminal Background Checks	_____
Drug / HIV/ Hepatitis Testing	_____	Licenses Held	_____
Education/Training/Competence	_____	Multi-State Registry	_____

20. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

21. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	_____	_____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c) Ever been treated for alcoholism or drug addiction?	_____	_____
d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____

22. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes_____ No_____

If yes, give details, including name, location size and number of beds:

_____

23. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

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24. Give General Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

25. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?

Yes_____ No_____

If yes, please give details _____

26. Has any insurer cancelled or refused to renew any similar insurance during the past five years?

Yes_____ No_____

If yes, please give details _____

27. Has any claim ever been made against the firm or any of its employees?

Yes_____ No_____

If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3)name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

28. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes_____ No_____ If yes, please give full details.

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Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)