HUNTERSURE LLC

**PROFESSIONAL AND GENERAL LIABILITY APPLICATION**
**FOR MEDICAL SPAS (Edition 04.01.24)**

1. Name of Applicant/Entity as it should read on the policy: _____

2. Mailing Address: _____

3. Location Address: _____

(If multiple names and locations, please attach list)

4. a) Website Address: _____
   b) Date Established: _____

5. a) Gross Receipts for the Past 12 Months: $_____
   b) Estimated Gross Receipts for the Next 12 Months: $_____

6. Does the applicant have any ancillary operations? Yes _____ No _____
If yes, please provide details: _____

7. Are any of the following procedures performed:

a) Electrolysis? Yes _____ No _____

b) Facials, Chemical Peels & Microdermabrasion? Yes _____ No _____

c) IPL & Photofacial Rejuvenation? Yes _____ No _____

d) Laser Cellulite Treatment? Yes _____ No _____

e) Laser Hair Removal? Yes _____ No _____

f) Laser Skin Resurfacing? Yes _____ No _____

g) Permanent Make-Up? Yes _____ No _____

h) Sclerotherapy? Yes _____ No _____

i) Laser Tattoo Removal? Yes _____ No _____

j) Laser Vein Treatment? Yes _____ No _____

k) Waxing? Yes _____ No _____

l) Hormone Therapy? Yes _____ No _____

m) Massage Therapy? Yes _____ No _____
   i. If yes, can you confirm that you perform criminal background checks on all massage therapists as part of the pre-employment screening process? Yes_____ No_____
   ii. If performing prenatal/pregnancy massages, can you confirm that you are not willing to offer prenatal/pregnancy massages during the 1st trimester of pregnancy? Yes_____ No_____

n) Botox & Dermal Filler Injections? Yes _____ No _____
   i. If yes, can you confirm that you do not allow any aesthetician with less than two years' experience to perform the injections set forth in this question? Yes_____ No_____

o) Hyaluronidase Injections? Yes _____ No _____
   i. If yes, can you confirm that you do not allow any aesthetician with less than two years' experience to perform the injections set forth in this question? Yes_____ No_____.
   ii. If performing Hyaluronidase injections, does the Hyaluronidase injection consent form advise clients that they cannot predict the outcome or confirm that this will resolve any problems they are experiencing and cannot guarantee that it will not make it worse? Yes _____ No _____

p) Kybella Injections? Yes _____ No _____
   i. If yes, can you confirm that you do not allow any aesthetician with less than two years' experience to perform the injections set forth in this question? Yes_____ No_____

q) Phosphatidylcholine and Deoxycholate (PCDC) Injections? Yes _____ No _____
   i. If yes, can you confirm that you do not allow any aesthetician with less than two years' experience to perform the injections set forth in this question? Yes_____ No_____.

r) Elective IV Hydration Therapy? Yes _____ No _____
   i. If yes, please confirm what substances are or will be administered, confirm who (complete name including professional designation) is pre-screening all patients prior to each treatment, and confirm who (complete name including professional designation) is performing Elective IV Hydration Therapy: _____
   _____
   _____

s) Peptide Therapy? Yes _____ No _____
   i. If yes, please confirm what peptides are or will be administered, and confirm who (complete name including professional designation) is performing Peptide Therapy:_____
   _____

t) Plasma Fibroblast? Yes _____ No _____
   i. If yes, please confirm the # of Plasma Fibroblast procedures performed over the past 12 months and estimated for the next 12 months: _____

u) Thread Lifts? Yes _____ No _____
   i. If yes, please confirm the type of thread lifts used, and advise the # of Thread Lift procedures performed over the past 12 months and estimated for the next 12 months: _____
   _____

v) Tumescent/Smart Lipo? Yes _____ No _____
   i. If yes, please confirm who (complete name including professional designation) is performing them, and the # of Tumescent/Smart Lipo procedures performed over the past 12 months and estimated for the next 12 months:
   _____

w) Weight Loss Services? Yes _____ No _____
   i. If yes, please confirm all methods used and if medications are prescribed, please confirm all medications prescribed: _____
   _____
   _____

x) Any surgical and/or invasive procedure? Yes _____ No _____
   i. If yes, please provide a detailed description of procedures performed, and the # of procedures performed over the past 12 months and estimated for the next 12 months: _____
   _____

y) Any other procedures not referenced above? Yes _____ No _____
   i. If yes, please provide a detailed description of procedures performed: _____
   _____

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8. List the estimated number and type of applicant's employees and independent contractors for the next 12 months. If none, state none. **PLEASE NOTE**: Full-time means they work over 20 hours per week and part-time means they work under 20 hours per week. (Please include all owners with direct patient care under the employee section below).

a) List the number and type of EMPLOYEES:

| **Employed** | # Part-time | # Full-time | **Employed** | # Part-time | # Full-time |
|---|---|---|---|---|---|
| Registered Nurse | _____ | _____ | Physician (patient contact) | _____ | _____ |
| Licensed Practical Nurse | _____ | _____ | Physician (no patient contact) | _____ | _____ |
| 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:

| **Contracted** | # Part-time | # Full-time | **Contracted** | # Part-time | # Full-time |
|---|---|---|---|---|---|
| Registered Nurse | _____ | _____ | Physician (patient contact) | _____ | _____ |
| Licensed Practical Nurse | _____ | _____ | Physician (no patient contact) | _____ | _____ |
| Aesthetician | _____ | _____ | Laser Technician | _____ | _____ |
| Nurse Practitioner | _____ | _____ | CRNA/Surgical Technician | _____ | _____ |
| Physician Assistant | _____ | _____ | Massage Therapist | _____ | _____ |
| Medical Assistant | _____ | _____ | Chiropractor | _____ | _____ |
| Other (please describe): _____ | _____ | _____ | Clerical/Admin | _____ | _____ |

c) Are all individuals shown in response to questions 8a & b who are subject to state or federal licensing requirements so licensed? Yes _____ No _____ If no, attach explanation.

9. Do you require independent contractors (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage? Yes _____ No _____
If yes, what is the minimum limit required? $_____ / $_____
If no, is coverage desired with shared limits on this policy? Yes _____ No _____

10. 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? $_____ / $_____

11. a) What is the complete name including professional designation of the Medical Director: _____
b) Is coverage desired for:
(i) The Medical Director's administrative duties? Yes _____ No _____
(ii) The Medical Director's supervisory duties? Yes _____ No _____
(iii) The Medical Director's good faith exams? Yes _____ No _____
(iv) The Medical Director's direct patient care? Yes _____ No _____
c) If direct patient care, please list the services/procedures for which coverage is desired: _____
_____
d) Please confirm if the state or any other governing body require the medical spa to have a physician acting as Medical Director. Confirmed _____ Not Confirmed/Unknown _____

12. Is coverage desired for any other physician's direct patient care? Yes _____ No _____
a) If yes, please list complete name(s) including professional designation(s): _____
b) Please list the services/procedures for which coverage is desired: _____
_____

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13. If any mid-level personnel (Nurse Practitioners, Physicians Assistants, or CRNAs) provide services on behalf of the applicant, do they have a supervising/collaborating physician? Yes _____ No _____
If no, please confirm that any such mid-level personnel are not required by state or local law or regulation to work under a supervising/collaborating physician. Confirmed _____ Not Confirmed/Unknown _____

14. 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 percentage of total procedures are performed off-site: _____
_____
_____

15. Are FDA approved drugs ever used for "off-label" purposes? Yes _____ No _____
"Off-label" use means the use of a drug to treat any disease or medical condition that has not been approved by the Food and Drug Administration (FDA), including but not limited to, for an unapproved indication or in an unapproved age group, dosage, or route of administration.
If yes, please provide details of the drugs and the off-label purposes for which they are used and by whom:
_____
_____

16. a) Do you conduct pre-employment screening and investigation? Yes _____ No _____
b) Are employees required to actively participate in continuing education? Yes _____ No _____
c) Do you prepare job descriptions and instructional manuals for your staff? Yes _____ No _____
d) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

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

Applications _____ Criminal Background Checks _____

Education/Training/Competence _____ Licenses Held _____

18. ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:
Has the applicant or have any of the above employees:
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? Yes _____ No _____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes _____ No _____
c) 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? Yes _____ No _____

19. Provide details of Professional Liability coverage for last five years for the firm. If none, state none:

| 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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20. Provide details of General Liability coverage for last five years for the firm. If none, state none:

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

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

21. Has the Named Insured or any owner of the Named Insured ever had their professional liability or general liability coverage cancelled or non-renewed?

Yes _____ No _____ If yes, please give details: _____

22. Has any claim been made against the Named Insured or any of its employees in the last five years?

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.

23. Is the applicant aware of any circumstances which may result in any claim against the insured or any of its employees that would be covered by this policy?

Yes _____ No _____ If yes, please give full details: _____

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.

**ELECTRONIC SIGNATURE:** If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date and time stamp.

Name of Applicant: _____

Please Print Title

Signature: _____

Name Date

Email Address: _____ Telephone Number: _____

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