

PROFESSIONAL AND GENERAL LIABILITY APPLICATION MEDICAL SPA (Edition 06.2026)

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple names and locations, please attach list)
4. Telephone Number: _____ Website: _____ Date Established: _____

Section 2: Coverage Requested

5. Effective Date: _____
Liability Limits: \$ _____ / \$ _____
Deductible: \$ _____

Section 3: Financial Information and Operations

6. Gross Receipts (Past 12 Months): \$ _____
7. Estimated Gross Receipts (Next 12 Months): \$ _____
8. Does the applicant have any ancillary operations not stated above? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No
9. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No
10. Are any of the following services/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 ☐ Yes ☐ No
- i. If Yes, please confirm that criminal background checks are conducted on all staff performing massage services as part of the applicant's pre-employment screening procedures. ☐ Yes ☐ No
- ii. If massage services are provided, please confirm that the applicant does not offer prenatal or pregnancy massage services during the first trimester of pregnancy. ☐ Yes ☐ No
- n) Botox & Dermal Filler Injections ☐ Yes ☐ No
- i. If Yes, please confirm that the applicant does not allow any aesthetician with fewer than two years of experience to perform the injections described herein. ☐ Yes ☐ No
- o) Hyaluronidase Injections ☐ Yes ☐ No
- i. If Yes, please confirm that the applicant does not allow any aesthetician with fewer than two years of experience to perform the injections described herein. ☐ Yes ☐ No
- ii. If Hyaluronidase injections are administered, does the consent form disclose that outcomes cannot be predicted, that there is no assurance the treatment will resolve the client's concerns, and that there is a possibility the condition may worsen? ☐ Yes ☐ No
- p) Kybella Injections ☐ Yes ☐ No
- i. If Yes, please confirm that the applicant does not allow any aesthetician with fewer than two years of experience to perform the injections described herein. ☐ Yes ☐ No
- q) Phosphatidylcholine and Deoxycholate (PCDC) Injections ☐ Yes ☐ No
- i. If Yes, please confirm that the applicant does not allow any aesthetician with fewer than two years of experience to perform the injections described herein. ☐ Yes ☐ No
- r) Elective IV Hydration Therapy ☐ Yes ☐ No
- i. If Yes, please identify the substances that are or will be administered: _____
- _____
- ii. Please identify the individual, including full name and professional designation, responsible for pre-screening all patients prior to each treatment: _____
- iii. Please identify the individual, including full name and professional designation, responsible for performing Elective IV Hydration Therapy: _____
- _____
- s) Plasma Fibroblast ☐ Yes ☐ No
- i. If Yes, please confirm the number of Plasma Fibroblast procedures performed during the past 12 months and the number estimated for the next 12 months: _____
- t) Thread Lifts (or similar procedures) ☐ Yes ☐ No
- i. If Yes, please identify the type(s) of threads utilized and advise the number of procedures completed in the prior 12 months, as well as the number projected for the upcoming 12 months: _____
- _____
- u) Tumescant Liposuction / SmartLipo Procedures ☐ Yes ☐ No
- i. If Yes, please identify the individual(s), including full name and professional designation, authorized to perform these procedures, and advise the number of Tumescant/SmartLipo procedures completed in the prior 12 months and projected for the upcoming 12 months: _____
- _____
- v) Weight Loss Services ☐ Yes ☐ No
- i. If Yes, please confirm all methods utilized and, if medications are prescribed, identify all medications prescribed (Including brand names, if applicable): _____
- _____

w) Does the applicant perform any surgical or invasive procedures? ☐ Yes ☐ No
 i. If Yes, please provide a detailed description of the procedures performed and indicate the number of procedures completed during the past 12 months and the number estimated for the next 12 months: _____

x) Any other services or procedures not listed above? ☐ Yes ☐ No
 i. If Yes, please provide a detailed description of the procedures performed and indicate the number of procedures completed during the past 12 months and the number estimated for the next 12 months: _____

y) Does the spa operate any saunas (Including cold, hot, or infrared saunas) or light therapy beds? ☐ Yes ☐ No
 i. If Yes, please describe the equipment and advise the number of units in use: _____

11. Are FDA-approved drugs utilized for any off-label indications? ☐ Yes ☐ No
 If Yes, please identify the drug(s) including brand names, describe the off-label use(s), and indicate who is responsible for prescribing or administering the medication: _____

(Off-label use is defined as the administration or prescription of an FDA-approved drug for an indication, population, dosage, or route of administration not approved by the FDA.)

12. Are all services provided at the applicant's listed location address(es)? ☐ Yes ☐ No
 If No, please describe any off-site exposure, including a detailed explanation of the procedures performed, the types of off-site locations, the individuals performing the services, and the approximate percentage of total procedures conducted away from the applicant's location(s): _____

Section 4: Staffing

13. Employee and Independent Contractor Details:
 a) Provide the estimated **NUMBER** and type of **EMPLOYEES** for the next 12 months. ☐ If None

*Note: Full-time is defined as working more than 20 hours per week; part-time is defined as working fewer than 20 hours per week. Please include all owners who provide direct patient care under the **EMPLOYEES** section below.*

EMPLOYEES	FULL-TIME	PART-TIME	EMPLOYEES	FULL-TIME	PART-TIME
Aesthetician			Nail Technician		
Beautician/Cosmetologist			Nurse Practitioner		
CRNA / Surgical Technician			Physician Assistant		
Laser Technician			Physician (no patient contact)		
Massage Therapist			Physician (patient contact)		
Medical Assistant			Registered Nurse		
Clerical / Administrative			All Others (Describe):		

b) Provide the estimated **NUMBER** and type of **INDEPENDENT CONTRACTORS** for the next 12 months. ☐ If None

CONTRACTORS	FULL-TIME	PART-TIME	CONTRACTORS	FULL-TIME	PART-TIME
Aesthetician			Nail Technician		
Beautician/Cosmetologist			Nurse Practitioner		
CRNA / Surgical Technician			Physician Assistant		
Laser Technician			Physician (no patient contact)		
Massage Therapist			Physician (patient contact)		
Medical Assistant			Registered Nurse		
Clerical / Administrative			All Others (Describe):		

c) Are all individuals listed on Q13 subject to licensing requirements properly licensed? (If No, attach details) ☐ Yes ☐ No

14. Are you seeking coverage under this proposed insurance for the independent contractors? ☐ Yes ☐ No

If No, is coverage at equal or greater limits maintained by each independent contractor? ☐ Yes ☐ No

15. 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, provide required limits: \$ _____ / \$ _____

16. Medical Director and Physician Details:

a) Does state law or any other governing authority require the medical spa to appoint a physician as Medical Director? ☐ Yes ☐ No

If No, please provide details: _____

b) Please provide the Medical Director's full name, including professional designation:

c) Is coverage being requested for the following:

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

d) If direct patient care is provided, please list the services and/or procedures for which coverage is requested:

17. a) Is coverage sought for direct patient care provided by any other physician? ☐ Yes ☐ No

b) If Yes, please provide the complete name(s), including professional designation(s):

c) Please list the services and/or procedures for which coverage is requested:

18. If any mid-level practitioners (Nurse Practitioners, Physician Assistants, or CRNAs) provide services on behalf of the applicant, do they have a supervising or collaborating physician? ☐ Yes ☐ No
- If No, does the state or any other governing body require such mid-level personnel to practice under a supervising or collaborating physician? ☐ Yes ☐ No

Section 5: Employee Screening / Controls

19. 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
20. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:
- ☐ Applications/Resumes ☐ Criminal Background Checks ☐ Licensure Verification
☐ Drug Testing ☐ Education/Training/Competence

Section 6: Regulatory and Inspection

21. Disclosure of Disciplinary or Legal History:
- Attach a detailed explanation for any **YES** answers below:
- Has the applicant or have any of the employees:
- a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
 b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)? ☐ Yes ☐ No
 c) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
 d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered? ☐ Yes ☐ No

Section 7: Insurance History

Currently valued loss runs for all prior coverage are required.

22. Professional Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____



23. General Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

Section 8: Claims and Incidents

24. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details) ☐ Yes ☐ No
25. Has any claim been made against the insured or its employees that would be covered by this policy in the past 5 years?
If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported) ☐ Yes ☐ No
26. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees that would be covered under this policy? (If Yes, attach details) ☐ Yes ☐ No

Signature and Attestation

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, time stamp, and originating email address.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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

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