1-877-245-5887
Return application by fax or email
fax: (310) 796-9054
email: info@cbmalagains.com

CBMALAGA
Insurance Services LLC

POLICY NUMBER: _____
COMPANY USE ONLY

MEDICAL SPA LIABILITY APPLICATION

INSTRUCTIONS

1. PLEASE PRINT LEGIBLY. IF THE APPLICATION IS APPROVED, THE POLICY WILL BE BASED ON THE INFORMATION PROVIDED.
2. PLEASE ANSWER ALL QUESTIONS. IF A QUESTION IS NOT APPLICABLE, PRINT, "N/A".
3. IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SUPPLEMENTAL FORM.

I. ORGANIZATION INFORMATION

A. BROKERAGE FIRM/AGENCY INFORMATION

CB Malaga Insurance Services LLC - www.cbmalagains.com
BROKERAGE FIRM/AGENCY NAME

CITY, STATE AND ZIP CODE

BROKER/AGENT NAME

BROKER/AGENT LICENSE NUMBER AND TYPE

877 - 245 - 5887
PHONE

FAX

E-MAIL

B. CONTACT INFORMATION

APPLICANT NAME

MAILING ADDRESS

COUNTY

STREET ADDRESS (IF DIFFERENT)

CONTACT PERSON NAME

TITLE

PHONE

FAX

E-MAIL

WEBSITE ADDRESS

C. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM)**:** _____
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF THE APPLICANT'S CURRENT POLICY.

D. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM)**:** _____
ANNUAL POLICY TERMS WILL BEGIN AND END ON THE SAME MONTH AND DAY.

II. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	OCCURRENCE/CLAIMS-MADE	DEDUCTIBLE
□ **PROFESSIONAL LIABILITY FACILITY**	$_____ PER EVENT/ $_____ AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	□ NONE □ $5,000 □ $25,000 □ $10,000 □ $50,000 □ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: □ INDEMNITY ONLY □ INDEMNITY AND EXPENSE
□ **GENERAL LIABILITY**	$_____ EACH EVENT/ $_____ GENERAL AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	□ NONE □ $5,000 □ $25,000 □ $10,000 □ $50,000 □ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: □ INDEMNITY ONLY □ INDEMNITY AND EXPENSE
□ **EXCESS PROFESSIONAL LIABILITY**	$_____ PER EVENT/ $_____ AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	
□ **EXCESS GENERAL LIABILITY**	$_____ EACH EVENT/ $_____ GENERAL AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	

(*) IF THERE ARE ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCS, PARTNERSHIPS, ETC.), PLEASE COMPLETE SECTION II (SCHEDULE OF RELATED ENTITIES) OF THE MEDICAL SPA SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF THE APPLICANT'S ORGANIZATIONAL CHART INCLUDING THE INFORMATION REQUESTED.

II. COVERAGES, LIMITS AND DEDUCTIBLES (CONTINUED)

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE FOR EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS, ORAL SURGEONS, CRNAS, NURSE MIDWIVES, CRNPS, PODIATRISTS, PHYSICIAN ASSISTANTS OR SURGICAL ASSISTANTS IS BEING REQUESTED, PLEASE COMPLETE SECTION III (COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE) OF THE MEDICAL SPA SUPPLEMENTAL APPLICATION.

III. GENERAL INFORMATION

A. TYPE OF LEGAL ENTITY (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

- ☐ PROFESSIONAL CORPORATION
- ☐ PARTNERSHIP OR PROFESSIONAL ASSOCIATION
- ☐ JOINT VENTURE
- ☐ LIMITED LIABILITY CORPORATION (LLC)
- ☐ OTHER (PLEASE EXPLAIN): _____

B. ENTITY OWNERSHIP (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

- ☐ PHYSICIAN OWNED
- ☐ HOSPITAL OWNED
- ☐ INDEPENDENTLY OWNED (PLEASE EXPLAIN): _____
- ☐ OTHER (PLEASE EXPLAIN): _____

C. HOW MANY LOCATIONS DO YOU HAVE? _____

PLEASE LIST ALL LOCATIONS. IF MORE THAN 3 LOCATIONS, PLEASE ATTACH A SEPARATE PIECE OF PAPER SHOWING THE ADDITIONAL LOCATIONS.

LOCATION #1:

_____

STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____ ESTIMATED NUMBER OF PATIENTS AT THIS LOCATION _____

LOCATION #2:

_____

STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____ ESTIMATED NUMBER OF PATIENTS AT THIS LOCATION _____

LOCATION #3:

_____

STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____ ESTIMATED NUMBER OF PATIENTS AT THIS LOCATION _____

D. DURING THE NEXT 12 MONTHS, ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS OR DOES THE APPLICANT PLAN ON ADDING ANY ADDITIONAL LOCATIONS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

E. LICENSES HELD BY THE FACILITY: _____

F. LIST ANY CERTIFICATIONS/ACCREDITATIONS HELD BY THE FACILITY: _____

_____

PLEASE PROVIDE A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

IF NONE, PLEASE EXPLAIN: _____

_____

G. MEDICAL DIRECTOR. (PLEASE LIST THE MEDICAL DIRECTOR FOR EACH FACILITY)**:**

_____ _____

NAME OF MEDICAL DIRECTOR SPECIALTY OF MEDICAL DIRECTOR

___-___-___ _____

PHONE EMAIL

PLEASE ATTACH A DESCRIPTION OF THE MEDICAL DIRECTOR'S DUTIES.

H. HOW OFTEN IS THE MEDICAL DIRECTOR ON-SITE AT THE FACILITY? _____

I. DOES THE MEDICAL DIRECTOR ALSO PROVIDE PROFESSIONAL SERVICES AT THE FACILITY? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

J. ANNUAL PAYROLL:

TOTAL ANNUAL PAYROLL: $_____ **TOTAL PROJECTED ANNUAL RECEIPTS:** $_____

IV. MED SPA OPERATIONS

A. Please provide the information requested below for each service provided at the applicant's facility.

SERVICES PROVIDED AT FACILITY	CURRENT # OF PROCEDURES ANNUALLY AT THE FACILITY	ANNUAL REVENUE FOR EACH PROCEDURE	PROJECTED # OF PROCEDURES TO BE PERFORMED AT THE FACILITY ANNUALLY	PROFESSIONAL(S) PERFORMING PROCEDURES (E.G. AESTHETICIAN, PA, NP, PHYSICIAN)
ACNE TREATMENTS: BLUE LIGHT THERAPY, VIBRADERMABRASION				
ACUPUNCTURE				
BOTOX				
CELLULITE TREATMENTS (WRAPS)				
CHELATION THERAPY				
CHEMICAL PEELS—SUPERFICIAL				
CHEMICAL PEELS—MEDIUM				
CHEMICAL PEELS—DEEP				
DAY SPA ACTIVITIES: WAXING, WRAPS, DERMOSONIC, EXFOLIATIONS, FACIALS, HAIR CARE, HYDROTHERAPY BATH, LASH EXTENSIONS, MAKE-UP APPLICATIONS, NAILS, REFLEXOLOGY, TANNING, YOGA				
EAR LOBE REPAIR				
ELECTROLYSIS				
FACIALS				
HAIR TRANSPLANT				
HERBAL OR VITAMIN SUPPLEMENTS OR REMEDIES				
HORMONE THERAPY				
INJECTIONS/FILLERS, RESTYLANE AND JUVEDERM				
LASER HAIR REMOVAL				
LASER LIPOSUCTION (SMART LIPO)				
LASER SKIN TIGHTENING: VELASMOOTH (CELLULITE TREATMENT WITH RADIO FREQUENCY), THERMAGE, ENDERMOLOGIE				
LASER SKIN TREATMENT: TITAN, GENESIS, FRAXEL				
LIPODISSOLVE				
LIPOINJECTION				
LIPOSUCTION (REGULAR)				
LIPOSUCTION (TUMESCENT)				
MASSAGE				
MESOTHERAPY				
MICRODERMABRASION				
MICROPIGMENTATION (PERMANENT MAKEUP)				
MINI FACELIFT				
PHOTO THERAPY: LEVULAN, PHOTO REJUVENATION (RPL), FOTO FACIALS				
RADIOFREQUENCY FACE LIFT PROCEDURES				
SKIN TAG REMOVAL				
SCLEROTHERAPY				
TATTOO REMOVAL				
WEIGHT CONTROL MEDICATIONS				
OTHER (PLEASE DESCRIBE)				

B. Does the facility provide any services or treatments outside of the locations previously listed on the application (i.e. in the home)**?** ☐ Yes ☐ No

If Yes, please describe: _____

IV. MED SPA OPERATIONS (CONTINUED)

C. **DO ALL EMPLOYEES PARTICIPATE AT THE TIME OF HIRE AND IN REGULARLY SCHEDULED TRAINING REGARDING SAFETY AND OPERATIONAL PROCEDURES?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

D. **DOES THE APPLICANT HAVE A WRITTEN SAFETY MANUAL USED BY ALL EMPLOYEES?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

E. **HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS?** ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

F. **DOES THE APPLICANT HAVE REGULARLY SCHEDULED MAINTENANCE AND CALIBRATION OF ALL EQUIPMENT?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

G. **DOES THE APPLICANT HAVE A WRITTEN COMPLIANCE MANUAL DETAILING THE APPROPRIATE CLEANING OF ALL EQUIPMENT?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

H. **IS THERE A PHYSICIAN ON LOCATION AT ALL TIMES?** ☐ YES ☐ NO

IF NO, PLEASE IDENTIFY THE SPECIALTY OF THE PRIMARY HEALTHCARE PROVIDER WHO *IS* ON-SITE, AS WELL AS A DETAILED DESCRIPTION OF THE RESPONSIBILITIES OF THIS INDIVIDUAL.

_____

I. **DOES THE APPLICANT REQUIRE ALL PATIENTS TO SIGN AN INFORMED CONSENT FORM SPECIFIC TO THE PROCEDURE TO BE PERFORMED?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

J. **ARE PARENT/GUARDIAN SIGNATURES REQUIRED ON INFORMED CONSENT FORMS FOR PATIENTS/CLIENTS UNDER THE AGE OF 18?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

K. **ARE ALL INDIVIDUALS WHO ARE PERFORMING PROCEDURES AT THE FACILITY AND WHO ARE ELIGIBLE TO PURCHASE PROFESSIONAL LIABLITY COVERAGE** (I.E. PHYSICIANS, DENTISTS, NURSE PRACTITIONERS, ETC.) **REQUIRED TO DO SO?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

L. **DOES A PHYSICIAN MEET WITH EACH PATIENT PRIOR TO THE SCHEDULED PROCEDURE?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN WHY THIS DOES NOT OCCUR: _____

M. **ARE "BEFORE" AND "AFTER" PICTURES TAKEN OF EVERY PATIENT?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

N. **DOES ANYONE AT THE FACILITY TREAT PATIENTS UNDER EITHER CONSCIOUS SEDATION OR GENERAL ANESTHESIA?** ☐ YES ☐ NO

IF YES, WHAT IS THE DISTANCE TO THE NEAREST HOSPITAL? _____

O. **DOES THE APPLICANT MANUFACTURE, SELL, HANDLE, DISTRIBUTE OR DISPOSE OF GOODS OR PRODUCTS?** ☐ YES ☐ NO

IF YES, ARE THESE PRODUCTS AVAILABLE FOR SALE AND/OR USE BY INDIVIDUALS OTHER THAN THE APPLICANT'S PATIENTS? ☐ YES ☐ NO

V. MEDICAL STAFF

A. **PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN, IF ANY, THAT PRACTICES AT THE FACILITY.** (IF MORE ROOM IS NEEDED, PLEASE ATTACH A SEPARATE ROSTER OF MEDICAL STAFF).

IMPORTANT NOTE: **IF COVERAGE IS DESIRED FOR PHYSICIANS, PLEASE INDICATE THAT ON SECTION III** (COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE)**, AND SECTION IV** (SCHEDULE OF MEDICAL PROFESSIONALS) **OF THE MEDICAL SPA FACILITIES SUPPLEMENTAL APPLICATION. ALSO, COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR EACH PHYSICIAN.**

PHYSICIAN'S NAME	INDICATE IF THE PERSON IS A: MEMBER (M) PARTNER (P) SHAREHOLDER (S) EMPLOYEE (E) CONTRACTED PHYSICIAN (C) OR ALL OTHER (AO)	PRIMARY LICENSE NUMBER	INDICATE PRIMARY SPECIALTY	BOARD CERTIFIED?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

VI. RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM THAT:

1. IDENTIFIES/RECONIZES PATTERNS OF OCCURRENCES OR POTENTIALS FOR OCCURRENCES? ☐ YES ☐ NO
2. IMPLEMENTS AND MONITORS CORRECTIVE ACTION PLANS? ☐ YES ☐ NO
3. DEVELOPS AND IMPLEMENTS ACTION PLANS FOR CONTINUOUS PROCESS IMPROVEMENTS? ☐ YES ☐ NO
4. MONITORS, ANALYZES AND SETS IN ACTION QUALITY INDICATORS? ☐ YES ☐ NO
5. EMPLOYS A SYSTEM FOR ASSESSING AND RESPONDING TO PATIENT AND EMPLOYEE SATISFACTION? ☐ YES ☐ NO
6. PROVIDES FOCUSED INTERVENTIONS AND EDUCATION TO IMPROVE PATIENT SAFETY? ☐ YES ☐ NO

B. IS THERE AN ORIENTATION PROGRAM FOR ALL NEW EMPLOYEES? ☐ YES ☐ NO

C. IS THERE ONGOING TRAINING FOR COMPLIANCE, SAFETY AND EQUIPMENT USAGE? ☐ YES ☐ NO

D. IS THERE A FORMALIZED INFECTION CONTROL PLAN, PARTICULARLY FOR THE CLEANING OF EQUIPMENT? ☐ YES ☐ NO

E. ARE STAFF TRAINED AND TESTED ON EMERGENCY PROCEDURES ON A REGULAR BASIS AND ARE DIRECTIONS FOR SUMMONING HELP AND/OR TRANSFER CLEARLY POSTED? ☐ YES ☐ NO

F. IS THERE A PROCESS TO RECEIVE, DISSEMINATE, AND ACT UPON VENDOR INFORMATION, WARNINGS OR RECALLS OF EQUIPMENT, SUPPLIES AND MEDICATIONS? ☐ YES ☐ NO

G. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR THESE ACTIVITIES:

NAME _____ TITLE _____

ARE THE RESPONSIBILITIES CLEARLY DEFINED IN THE JOB DESCRIPTION FOR THE POSITION? ☐ YES ☐ NO

VII. CREDENTIALING

A. DOES THE FACILITY OR ORGANIZATION HAVE BYLAWS? ☐ YES ☐ NO

B. DOES THE FACILITY OR ORGANIZATION HAVE FORMAL HIRING AND DISMISSAL POLICIES? ☐ YES ☐ NO

C. IS THERE VERIFICATION OF EDUCATION, LICENSURE AND CERTIFICATION IF THESE ARE REQUIRED FOR THE JOB FUNCTION? ☐ YES ☐ NO

D. HAS AN APPLICANT'S LICENSE OR CERTIFICATION EVER BEEN INVESTIGATED, LIMITED, REVOKED, SUSPENDED, REFUSED, CANCELLED, OR VOLUNTARILY SURRENDERED BY OR TO ANY STATE OR FEDERAL LICENSING BOARD OR REGULATORY AGENCY? ☐ YES ☐ NO
THIS INCLUDES, BUT IS NOT LIMITED TO MEDICARE, MEDICAID, OR REIMBURSEMENT PROGRAMS.

IF YES, PLEASE EXPLAIN: _____

E. DOES THE CREDENTIALLING PROCESS INCLUDE THE FOLLOWING:

1. PROOF OF MALPRACTICE INSURANCE (IF NOT OBTAINED THROUGH THIS POLICY)? ☐ YES ☐ NO
2. ARE CERTIFICATES OF INSURANCE OBTAINED? ☐ YES ☐ NO
3. OBTAINING OF REFERENCES FOR PROVIDERS AND EMPLOYEES? ☐ YES ☐ NO
4. ARE BACKGROUND CHECKS DONE (INCLUDING CRIMINAL HISTORY)? ☐ YES ☐ NO

F. IS COMPETENCY VALIDATION MONITORED AND DOCUMENTED ANNUALLY? ☐ YES ☐ NO

G. ARE SCOPE OF PRACTICE AND CLINICAL LIMITATIONS DEFINED IN JOB DESCRIPTIONS, PRIVILEGES, ETC? ☐ YES ☐ NO

H. WHO REVIEWS AND/OR APPROVES PHYSICIAN APPLICANTS (IF ANY)? _____

I. WHO REVIEWS AND/OR APPROVES ALL OTHER STAFF APPLICANTS? _____

J. DOES THE FACILITY HAVE FORMAL POLICIES FOR EXPECTED BEHAVIOR AND MECHANISMS FOR ENFORCING THE BEHAVIOR FOR THE FOLLOWING:

1. SEXUAL ABUSE AND/OR HARASSMENT ☐ YES ☐ NO
2. DISCRIMINATION AND/OR VIOLENCE ☐ YES ☐ NO
3. SUBSTANCE ABUSE ☐ YES ☐ NO

VIII. PHYSICAL PLANT

A. PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY THE APPLICANT.
A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES THAT PROVIDES THE INFORMATION REQUESTED BELOW IS ACCEPTABLE.

ADDRESS OF PROPERTY TO BE INSURED	USE/OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	FIRE PROTECTION*
PATIENT CARE BUILDINGS:						
OTHER BUILDINGS:						

*FOR EACH BUILDING, INDICATE IF THERE IS A: SPRINKLER SYSTEM—FULL, PARTIAL OR NO SPRINKLER SYSTEM; SMOKE DETECTOR, HEAT DETECTOR; FIRE ALARM—CENTRAL STATION OR LOCAL ALARM

VIII. PHYSICAL PLANT

B. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

IX. GENERAL LIABILITY

DO YOU DESIRE GENERAL LIABILITY COVERAGE? ☐ YES ☐ NO

IF NO, SKIP TO SECTION X.

A. IS THERE A PREVENTATIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR MEDICAL EQUIPMENT AT THE FACILITY? ☐ YES ☐ NO

1. HOW OFTEN ARE NON-EXPENDABLE MACHINES OR DEVICES INSPECTED AND MAINTAINED? _____
2. WHO PERFORMS THE MAINTENANCE ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS
3. IF INDEPENDENT CONTRACTORS, WHAT IS THE MINIMUM GENERAL LIABILITY LIMIT THAT IS REQUIRED BY THE FACILITY?

   $_____ / $_____
4. DOES THE APPLICANT OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THAT COVERAGE IS IN PLACE? ☐ YES ☐ NO

B. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT THE FACILITY OWNED BY PHYSICIANS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE PREVENTATIVE MAINTENANCE, INSPECTION AND REPAIR OF THE EQUIPMENT? _____

C. IS THE APPLICANT'S BIO-MEDICAL EQUIPMENT EVER LOANED OR DONATED TO OTHERS FOR THEIR USE? ☐ YES ☐ NO

IF YES, DESCRIBE: _____

D. DOES THE APPLICANT RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? _____

E. DOES THE APPLICANT USE AN ADVERSTISING AGENCY? ☐ YES ☐ NO

1. IF YES, WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS REQUIRED? $_____ / $_____
2. IS THE APPLICANT INCLUDED AS AN ADDITIONAL INSURED ON THE ADVERTISING AGENCY'S POLICY? ☐ YES ☐ NO
3. IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF THE APPLICANT? ☐ YES ☐ NO

F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE CHANGES PLANNED, INCLUDING THE TIME FRAME AND ESTIMATED COST: _____

G. PLEASE INDICATE BELOW, IF APPLICABLE, THE CORRESPONDING PROJECTED AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS.

SPECIAL ATHLETIC OR FUND RAISING EVENTS: RECEIPTS/YEAR: $_____

DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED: _____

H. DOES THE APPLICANT LEASE SPACE TO OTHERS? ☐ YES ☐ NO

_____

CITY, STATE AND ZIP CODE

_____ _____

SQUARE FOOTAGE OCCUPANCY/USE OF SPACE

1. DOES THE LEASE REQUIRE THE TENANT TO CARRY A GENERAL LIABILITY (GL) INSURANCE POLICY WITH A LIMIT OF $1,000,000 PER OCCURRENCE? ☐ YES ☐ NO
2. IS A CERTIFICATE OF INSURANCE OBTAINED ANNUALLY TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO
3. IS THE TENANT REQUIRED TO LIST THE APPLICANT AS AN ADDITIONAL INSURED ON THEIR GL POLICY? ☐ YES ☐ NO

X. EXCESS LIABILITY

DOES THE APPLICANT DESIRE EXCESS LIABILITY COVERAGE? ☐ YES ☐ NO

IF NO, SKIP TO SECTION XI.

A. HAS THE APPLICANT'S EXCESS PROFESSIONAL OR COMMERCIAL GENERAL LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, WHAT WAS THE PRIOR LIMIT AND WHEN WAS IT INCREASED?

$ _____ / $ _____ _____ / _____

MM YYYY

XI. COVERAGE HISTORY AND INFORMATION

NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATES OF MISSOURI AND CALIFORNIA.

A. HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER INSURANCE COVERAGE TO THE APPLICANT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

XI. COVERAGE HISTORY AND INFORMATION (CONTINUED)

B. PLEASE CHECK WHICH TYPE OF NOTICE THE APPLICANT'S PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE IT WILL FORMALLY RECOGNIZE A CLAIM UNDER ITS POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

☐ WRITTEN NOTICE FROM THE APPLICANT THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

C. HAS THE APPLICANT CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS, AS WELL AS INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS, AND HAVE THESE BEEN FORWARDED TO THE CURRENT INSURER? ☐ YES ☐ NO

IF YES, PROVIDE THE DATE OF THE REVIEW AND THE NAME AND TITLE OF THE PERSON CONDUCTING THE REVIEW:

_____ _____ _____

MM YYYY NAME AND TITLE

D. PLEASE PROVIDE THE APPLICANT'S INSURANCE HISTORY FOR THE LAST FIVE YEARS.

POLICY PERIOD	MOST RECENT YEAR	1 YEAR PRIOR	2 YEARS PRIOR	3 YEARS PRIOR	4 YEARS PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
GENERAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
EXCESS LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					

E. INDIVIDUAL LOSSES (COMBINED PAID AND RESERVED AMOUNTS OF $50,000 OR MORE INCLUDING EXPENSES).

PLEASE PROVIDE A DETAILED DESCRIPTION FOR ALL INDIVIDUAL LOSSES (1) OPEN AND; (2) CLOSED CLAIMS WITH COMBINED PAID AND RESERVED AMOUNTS OF $50,000 OR MORE INCLUDING EXPENSES.

1. DATE _____ _____ DOLLAR AMOUNT: $ _____
   MM YYYY
   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY
   DESCRIPTION: _____
2. DATE _____ _____ DOLLAR AMOUNT: $ _____
   MM YYYY
   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY
   DESCRIPTION: _____
3. DATE _____ _____ DOLLAR AMOUNT: $ _____
   MM YYYY
   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY
   DESCRIPTION: _____

XII. LOSS INFORMATION (IMPORTANT! FULLY COMPLETE)

FOR EACH CLAIM, POTENTIAL CLAIM OR SUIT MENTIONED BELOW, PLEASE COMPLETE SECTION I (LOSS HISTORY) OF THE REHABILITATION FACILITY SUPPLEMENTAL APPLICATION.

A. HAS THE APPLICANT (INDEPENDENTLY OR THROUGH A NAMED INSURED) BEEN INVOLVED NOW OR IN THE PAST, DIRECTLY OR INDIRECTLY, IN A CLAIM, POTENTIAL CLAIM, OR SUIT ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION OR ANY FORMER OR PRESENT EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE CORPORATION, PARTNERSHIP OR ORGANIZATION? ☐ YES ☐ NO

IF YES, HOW MANY? _____

IF YES, HAVE THESE BEEN REPORTED TO THE APPLICANT'S INSURER? ☐ YES ☐ NO

XII. LOSS INFORMATION (IMPORTANT! FULLY COMPLETE) (CONTINUED)

B. DOES THE APPLICANT OR ANY OF ITS EMPLOYEES/CONTRACTORS HAVE KNOWLEDGE OF ANY INCIDENT, OR UNEXPECTED ADVERSE OUTCOME RESULTING IN INJURY OR DEATH, CLAIM, POTENTIAL CLAIM, OR SUIT IN WHICH THE APPLICANT MAY BECOME INVOLVED, INCLUDING WITHOUT LIMITATION, KNOWLEDGE OF ANY INJURY ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES WHICH MAY GIVE RISE TO A CLAIM INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION, OR ANY FORMER OR PRESENT EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE CORPORATION, PARTNERSHIP OR ORGANIZATION WHICH MAY GIVE RISE TO A CLAIM? ☐ YES ☐ NO

IF YES, HOW MANY? _____

IF YES, HAVE THESE BEEN REPORTED TO THE APPLICANT'S INSURER? ☐ YES ☐ NO

XIII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION. IF NOT AVAILABLE, PLEASE EXPLAIN.

A. A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.
B. FINANCIAL INFORMATION. THE MOST RECENT THREE (3) YEARS OF FINANCIAL STATEMENTS INCLUDING THE AUDITOR'S OPINION, IF APPLICABLE.
C. MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.
D. COPY OF THE APPLICANT'S LETTERHEAD.
E. LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.
F. LOSS INFORMATION. RECENTLY VALUED LOSS RUNS FROM THE APPLICANT'S INSURANCE CARRIERS COVERING THE LAST (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS.
G. ANNUAL REPORT (IF ONE IS PUBLISHED).
H. ALL CURRENT **ADVERTISING MATERIALS.**
I. ORGANIZATIONAL CHART INCLUDING THE **NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.**
J. COPY OF THE APPLICANT'S CURRENT INSURANCE POLICY.

XIV. IMPORTANT NOTICE

THIS INSURANCE MAY CONTAIN CLAIMS-MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE AND REPORTED DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE. PLEASE READ AND REVIEW THE POLICY CAREFULLY.

XV. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DECEIVE, OR DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.

INITIAL HERE

XVI. PLEASE READ AND SIGN

ON BEHALF OF THE ENTITY APPLYING FOR COVERAGE HEREIN:
I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO MATERIAL FACT HAS BEEN KNOWINGLY SUPPRESSED OR MISSTATED.

I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY.

I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY PHYSICIAN, DENTIST, FIRM OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND COVERAGE.

BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT THERE IS NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED A COMPLETED APPLICATION; (2) OFFERED A PREMIUM QUOTE; AND (3) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND THAT IF THE PREMIUM OR FIRST INSTALLMENT IS PAID BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF THESE TERMS ARE NOT COMPLIED WITH, THERE WILL BE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING SUBMITTED.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER INDIVIDUALS OR ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND, IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REQUESTED, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION, AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

SIGNATURE OF AUTHORIZED INDIVIDUAL	TITLE	DATE

XVII. SUPPLEMENTAL INFORMATION

MEDICAL SPA SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF YOU HAVE BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE AND MARINE FOR LESS THAN TEN YEARS OR IF YOUR FACILITY PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE INSURANCE COMPANY.

THE LOSS INFORMATION SHOULD ADDRESS BOTH YOUR PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION.

CLAIM NUMBER _____

A. CLAIMANT NAME: _____ AGE: _____

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU. _____ _____
MM YYYY

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. _____ _____
MM YYYY

D. NAME OF DOCTOR(S), HEALTH CARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLVED IN THE CLAIM OR SUIT:

_____

E. DEFENDING INSURANCE CARRIER NAME:

_____

F. WAS A CLAIM MADE OR A SUIT FILED? ☐ YES ☐ NO

G. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT: ☐ OPEN ☐ CLOSED
IF CLOSED, DATE OF CLOSING/SETTLEMENT OR AWARD: _____ _____
MM YYYY

IF CLOSED, WAS PAYMENT MADE? ☐ YES ☐ NO

IF NO, WAS CLAIM OR SUIT WTIHDRAWN? ☐ YES ☐ NO

AMOUNT PAID ON YOUR BEHALF: $ _____

TOTAL AMOUNT OF SETTLEMENT OR AWARD: $ _____

WAS THIS MATTER CLOSED WITH YOUR CONSENT? ☐ YES ☐ NO

IF OPEN, HAS SETTLEMENT BEEN OFFERED? ☐ YES ☐ NO

IF OPEN, HAS TRIAL DATE BEEN SET? ☐ YES ☐ NO

TRIAL DATE: _____ _____
MM YYYY

H. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: _____

TREATMENT PROVIDED: _____

ALLEGED NEGLIGENCE: _____

ALLEGED INJURY: _____

I. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY INCLUDING YOUR LEVEL OF INVOLVEMENT).

_____

_____

II. SCHEDULE OF RELATED ENTITIES

LIST OF ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.)

NAME OF ENTITY	DESCRIPTION OF OPERATIONS	DATE ACQUIRED, CREATED OR MERGED	INDICATE YOUR OWNERSHIP PERCENTAGE IN THIS ENTITY	COVERAGE DESIRED? If yes, indicate shared or separate limits.

III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (IF SHARED OR SEPARATE PHYSICIAN OR ALLIED COVERAGE IS BEING REQUESTED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW

COVERAGE	REQUESTED LIMITS	OCCURRENCE / CLAIMS MADE	DEDUCTIBLE / SIR
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - <u>SHARED LIMIT COVERAGE</u>**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE MEDICAL SPA LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE MEDICAL SPA LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - <u>SHARED LIMIT COVERAGE</u>**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE MEDICAL SPA LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE MEDICAL SPA LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY- EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS-<u>SEPARATE LIMIT COVERAGE</u>**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE MEDICAL SPA.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ **PROFESSIONAL LIABILITY EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS- <u>SEPARATE LIMIT COVERAGE</u>**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE MEDICAL SPA.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE

<u>IMPORTANT NOTE:</u>

UNLESS OTHERWISE INDICATED BELOW, REQUESTED COVERAGE WILL BE LIMITED TO PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED, WHILE EMPLOYED OR UNDER CONTRACT WITH THE APPLICANT OR RELATED ENTITY (SERVICES LIMITED TO DUTY AND SCOPE OF SERVICES).

<u>CHECK ONE:</u>

☐ LIMITED TO DUTY AND SCOPE OF APPLICANT AS INDICATED ABOVE

☐ REQUESTING 24-HOUR COVERAGE

IV. SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR PHYSICANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND / OR ORAL SURGIONS, PLEASE PROVIDE THE INFORMATION BELOW. ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED (SHARED LIMIT OR SEPARATE LIMIT COVERAGE). CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

NAME OF MEDICAL PROFESSIONAL	EMPLOYMENT STAUS: (C)ONTRACT (E)MPLOYED (F)ACUTLY (R)ESIDENT	NUMBER OF PROCEDURES PERFORMED AT THE MEDICAL SPA	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOYMENT WITH NAMED INSURED	RESTRICTED (RE) TO NAMED INSURED'S OPERATION OR 24-HOUR (24)	LIMITS: SHARED (SH), SEPARATE (SE)

V. SCHEDULE OF MEDICAL PROFESSIONALS - CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND / OR SURGICAL ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION BELOW. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED. CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF CLAIMS MADE COVERAGE IS BEING REQUESTED, COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE DATE OF EMPLOYMENT WITH THE NAMED INSURED ENTITY. (*) IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE DATE OF THE EMPLOYMENT WITH THE NAMED INSURED, PRIOR ACTS COVERAGE WILL BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICAION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

Instructions For Completing Each Column

#1) Employment Status: (C) Contract, (E) Employed or (F) Faculty
#2) Specialty: CRNA, CRNP, Nurse Midwife, PA, Podiatrist, Surgical Assistant
#3) If CRNP or PA, Does Individual Prescribe Medication? Indicate Yes or No.
#4) If Claims Made coverage type, indicate retro date.
#5) Date of Employment with First Named Insured (FNI).
#6) Full Time Equivalency (FTE) - Calculate FTE by dividing the total # of hours of professional service per week by 40 hours.
#7) License Number.
#8) Coverage Scope: (RE) Restricted to Named Insured's Operation OR (24) 24-Hour Coverage.
#9) Limits: (SH) Shared or (SE) Separate.

Column #:	1	2	3	4	5	6	7	8	9
Name of Medical Professional	(C), (E) or (F)	Specialty	Prescr.? Yes/No	If CM, Retro Date	Date of Empl. With FNI	FTE	License #	(RE) or (24)	(SH) or (SE)