NAS insurance
16501 VENTURA BLVD. SUITE 200 ENCINO, CA 91436
Lic. #0677191 · NASinsurance.com

APPLICATION for: Medical Spa Professional and General Liability Insurance

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

SECTION I - GENERAL INFORMATION

1. Full Name of the Applicant: _____

2. Physical Location Address: _____
(Number) (Street) (City) (State) (Zip Code)

3. Phone: _____ Website: _____

4. Limits of Liability requested: _____ Deductible: _____

5. Desired Effective Date: _____ Retroactive Date: _____

SECTION II - OPERATIONS

1. Number of Locations: _____ Projected gross revenues for all locations: _____

2. List the number and type of the Applicant's employees and independent contractors below:
_____ Doctor (M.D. / D.O.) _____ Registered Nurse _____ Aesthetician _____ Physician's Assistant
_____ Nurse Practitioner _____ Administrator _____ Other (specify): _____

3. Do any of the doctors listed in question 2 above provide direct patient care? ☐ Yes ☐ No
   a) If "YES", do the doctors carry their own medical professional liability insurance? ☐ Yes ☐ No

4. Are all staff appropriately licensed and trained in the procedures to be performed? ☐ Yes ☐ No

5. Does the Applicant provide written post-operative instructions for all procedures performed? ☐ Yes ☐ No

6. Does the Applicant have a physician available at all times for consultation and complications? ☐ Yes ☐ No

7. Does the Applicant have a Medical Director on staff? ☐ Yes ☐ No
   a) If "YES", please provide the name, professional designation, and medical specialty of the Medical Director:

_____

SECTION III - PROFESSIONAL SERVICES

1. Are all drugs and equipment used by the Applicant FDA-approved? ☐ Yes ☐ No
   Describe any off-label use of any drugs or equipment: _____

2. Does the Applicant take before and after pictures of every patient? ☐ Yes ☐ No
   If "NO", please explain: _____

3. Are all clients required to sign a patient consent form specific to the procedures to be performed prior to treatment? ☐ Yes ☐ No

4. Are parent or guardian signatures required on informed consents for all patients less than 18 years of age? ☐ Yes ☐ No

SECTION IV - PROCEDURES

1. Please provide a breakdown of the procedures performed in the table provided below.

Provide the number of projected annual patient encounters for each of the following:	Past 12 Month Treatment Counts	Next 12 Month Treatment Counts	Designation of Person(s) Performing Procedures (e.g. MD/DO, NP, PA, RN, etc.)
Beauty Shop (Hair, Nails, Facials, Wraps, etc.)			
Botox			
Chelation Therapy			
Chemical Peels			
<30% Solution Strength			
>30% Solution Strength			
Dermal Fillers			
Hormone Therapy			
Laser Cellulite Treatment			
Laser Hair Removal			
Laser Liposuction			
Laser Skin Treatments			
Laser Tattoo Removal			
Laser Vein Treatments			
Massage			
Mesotherapy/Lipodissolve			
Microdermabrasion			
Micropigmentation			
Photorejuvenation			
Sclerotherapy			
Teeth Whitening			
Wart/Skin Tag Removal			
Weight Loss Management			
HCG			
Prescription Medication			
Other._____			
Other:_____			
Other:_____			
Other:_____			
Other:_____			
Total # of Procedures:	0	0	

2. **Botox Injections**

Does the Applicant perform Botox Injections? ☐ Yes ☐ No
If "YES", please complete the following:

a) Who performs Botox Injections?
☐ Physician ☐ Physician's Assistant ☐ Nurse
☐ Dentist ☐ Nurse Practitioner ☐ Other – describe: _____

b) Are any Botox Injections performed off of the Applicant's premises? ☐ Yes ☐ No

c) Have all staff performing Botox Injections:

i) Received a minimum of eight hours of training specific to this procedure, including training in anatomy, physiology, technique, potential complications, and appropriate responses to complications as well as hands-on performance of at least one procedure on a live patient? ☐ Yes ☐ No

ii) Performed a minimum of ten procedures on live patients? ☐ Yes ☐ No

3. **Chemical Peels**

Does the Applicant perform Chemical Peels? ☐ Yes ☐ No
If "YES", please complete the following:

a) Who performs Chemical Peels with solution strength <30%:(check all that apply)
☐ Physician ☐ Physician's Assistant ☐ Nurse
☐ Dentist ☐ Nurse Practitioner ☐ Other – describe: _____

b) Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours of training specific to this procedure, including training in anatomy, physiology, skin typing, technique, potential complications, and appropriate responses to complications as well as hands-on performance of at least one procedure on a live patient? ☐ Yes ☐ No

c) Are all staff performing Chemical Peels with solution strength >30% licensed physicians with a specialty in either dermatology or plastic surgery? ☐ Yes ☐ No

If "NO", please explain: _____

4. **Dermal Fillers**

Does the Applicant perform Dermal Fillers (Artefill, Collagen, Hylaform, Restylane)? ☐ Yes ☐ No
If "YES", please complete the following:

a) Who performs Dermal Fillers?
☐ Physician ☐ Physician's Assistant ☐ Nurse
☐ Dentist ☐ Nurse Practitioner ☐ Other – describe: _____

b) Have all staff performing Dermal Fillers:
i) Received a minimum of eight hours of training specific to this procedure, including training in anatomy, physiology, technique, potential complications and appropriate responses to complications as well as hands-on performance of at least one procedure on a live patient? ☐ Yes ☐ No
ii) Performed a minimum of five procedures on live patients? ☐ Yes ☐ No

5. **Laser Skin Treatments**

Does the Applicant perform Laser Skin Treatments including Laser Hair Removal, IPL (Intense Pulse Light Treatments), Acne Blue Light Treatments, Laser Vein Treatments, and Laser Tattoo Removal? ☐ Yes ☐ No
If "YES", please complete the following:

a) Who performs Laser Skin Treatments?
☐ Physician ☐ Physician's Assistant ☐ Nurse
☐ Dentist ☐ Nurse Practitioner ☐ Other – describe: _____

b) Does the Applicant comply with the following standards of practice?
i) Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care? ☐ Yes ☐ No
ii) Prior to the initiation of any patient care activity, the patient has read and signed the clinic's policies and procedures regarding the safe use of lasers? ☐ Yes ☐ No
iii) Continuing education of all licensed medical professionals is mandatory and made available with reasonable frequency (including outside the office setting)? ☐ Yes ☐ No
iv) A minimum of ten procedures of preceptor training is required for each laser procedure and laser type? ☐ Yes ☐ No
v) Participation in all training programs, acquisition of new skills and number of hours spent in maintaining proficiency is well documented? ☐ Yes ☐ No
vi) After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician? ☐ Yes ☐ No

c) Does the Applicant comply with the following standards of practice for the use of laser-related technology by non-physician providers?
i) Any physician who delegates a laser procedure to a non-physician provider must be qualified to perform the same laser procedure by virtue of having received appropriate training in laser physics, safety, surgical techniques, pre and post-operative care, and the handling of resultant emergencies? ☐ Yes ☐ No
ii) All non-physician providers have received appropriate and documented training and education in the safe and effective use of laser-related technology and are licensed in the state of practice? ☐ Yes ☐ No

iii) All medical professionals follow written protocols specifically designed for laser procedures and perform all procedures under the direct supervision of an on-site physician? ☐ Yes ☐ No

iv) A supervising physician is available on-site to respond to any untoward event or emergency? ☐ Yes ☐ No

d) Does the Applicant perform Laser Skin Treatments (including Laser Hair Removal) on patients with skin types V or VI? ☐ Yes ☐ No

6. **Mesotherapy and/or Lipodissolve**

Does the Applicant perform Mesotherapy and/or Lipodissolve at the clinic? ☐ Yes ☐ No
If "YES", please complete the following:

a) Are all staff performing Mesotherapy and/or Lipodissolve licensed physicians with a minimum of eight hours of training in Mesotherapy and/or Lipodissolve including training in anatomy, physiology, contraindications, and potential complications as well as performance of at least one procedure on a live patient? ☐ Yes ☐ No

If "NO", please explain: _____

7. **Sclerotherapy Injections**

Does the Applicant perform Sclerotherapy Injections? ☐ Yes ☐ No
If "YES", please complete the following:

a) Are all staff performing Sclerotherapy Injections physicians who have received a minimum of eight hours of training specific to this procedure, including training in anatomy, physiology, technique, potential complications and appropriate responses to complications as well as hands-on performance of a minimum of one procedure on a live patient? ☐ Yes ☐ No

If "NO", please explain: _____

8. **Surgical or Minor Surgical/Invasive Procedures**

Does the Applicant perform surgical or minor surgical/invasive procedures? ☐ Yes ☐ No
If "YES", please complete the following:

a) Total number of surgical procedures:
   i) Past 12 months: _____
   ii) Next 12 months: _____

b) Who performs surgical and/or minor surgical/invasive procedures?
   ☐ Physician ☐ Physician's Assistant ☐ Nurse
   ☐ Dentist ☐ Nurse Practitioner ☐ Other –describe: _____

c) Is general anesthesia used for any surgical and minor surgical/invasive procedures? ☐ Yes ☐ No

d) Provide a complete list of all surgical and minor surgical/invasive procedures performed by the Applicant: (Attach a separate sheet if necessary.)

_____

_____

_____

_____

_____

SECTION V - LOSS HISTORY

1. Is the Applicant currently insured under a Commercial General Liability Policy? ☐ Yes ☐ No
   If "YES", please give details:

Insurance Company	Type of Coverage	Limits BI	Limits PD	From	To

2. Has any application for Professional Liability or General Liability Insurance made on behalf of the Applicant, any of its predecessors in business, or any of its present partners ever been declined, or has similar insurance ever been cancelled or renewal refused? ☐ Yes ☐ No

   If "YES", please describe: _____

3. Has any claim ever been made against the Applicant or any of its employees? ☐ Yes ☐ No
   If "YES", please attach details stating:
   a) date when claim was made;
   b) date the act giving rise to the claim was committed;
   c) name of the claimant;
   d) nature of the claim;
   e) amount involved including reserves and final disposition.
   f) a fully completed, signed and dated NAS Supplemental Claim Form (AS1857CLM-0412)

4. Is the Applicant aware of any circumstances which may result in any claim against the Applicant, its predecessors in business, or any of its present or past officers, directors, owners, partners or employees? ☐ Yes ☐ No
   If "YES", please give full details on the same basis as question 3.

5. If this is an application for renewal coverage, has the Applicant notified NAS Insurance Services of all litigation, administrative proceedings, demand letters, formal or informal governmental investigations or inquiries which have occurred in the past 12 months?
   ☐ Yes ☐ No ☐ None to Report

   If "YES", please indicate number of events in the last 12 months: _____
   If "NO", please forward notice and claim details to NAS Insurance Services, LLC. immediately

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

The undersigned declares that 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 this Application will be attached to and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on file by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the Applicant must notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall have the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

For Kentucky residents:
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 information concerning any fact material thereto for the purpose of misleading, commits a fraudulent insurance act which is a crime.

Name of Applicant: _____
Please print Title Date

Signature: _____
Name Date