CLIFTON Insurance Agency, Inc.

Insurance Specialists since 1982

PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR MEDICAL SPAS

1. Name of Applicant: _____

2. Corporation Name: _____

3. Location Address:_____
(If multiple locations please list separately)

4. Phone Number: _____ 5. E-Mail Address: _____

6. Gross Receipts for the Past 12 Months: $_____ Next 12 Months: $_____ Assets: $_____ Payroll: $_____

7. What was your total number of patient/client visits last year? _____ Estimated next year? _____

8. Are any of the following procedures performed (if yes, please indicate how many performed annually – if No, put N):

Acne Treatment _____ Botox & Dermal Fillers _____ Chemical Peels _____ Facials_____ HCG _____

Hormone Therapy _____ IPL _____ Laser Liposuction _____ Laser Hair Removal _____ Skin Resurfacing _____

Lipodissolve _____ Mesotherapy _____ Microdermabrasions _____ Micro-Needling _____

Permanent Make-Up _____ Sclerotherapy _____ Tattoo Removal _____ Vein Treatments _____

Weight Loss Services (if so, please describe including prescriptions prescribed):_____

9. Are there any procedures performed that are not listed above: _____ if so, please describe on page 2 below.

10. List the number and type of applicant's employees & independent contractors currently & estimated over the next 12 months (please include everyone, even if they have their own coverage elsewhere):

	Name	Professional Designation	Number Hours Worked Per Week	Coverage Desired?
(a)	_____	_____	_____	_____
(b)	_____	_____	_____	_____
(c)	_____	_____	_____	_____
(d)	_____	_____	_____	_____
(e)	_____	_____	_____	_____
(f)	_____	_____	_____	_____
(g)	_____	_____	_____	_____

(If additional employees/independent contractors, please list separately)

Canyon J. Clifton
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Office: 877-212-4368 Ext. 1
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11. Is coverage desired for:

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

(ii) The Medical Director's administrative & supervisory duties? Yes _____ No _____

(iii) The Medical Director's administrative & supervisory duties plus good faith exams and/or direct patient care?

Yes _____ No _____

If yes, please provide the Medical Director's Name: _____

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

12. Has any claim ever been made against the firm or any of its employees? Yes_____ No_____

If yes, number of claims _____ & please attach a completed Huntersure claims supplement for each claim or incident reported.

13. 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 _____

14. Prior Coverage _____ Yes _____ No Carrier: _____ Premium _____ Limits: _____
Deductible_____ Retroactive Date: _____

Prior Coverage Ever Refused or Revoked: ____ Yes* ____ No If so, please explain _____

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.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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

Additional Procedures Performed:

****ATTACH TRAINING CERTIFICATES AND CONSENT FORMS FOR ALL PROCEDURES TO THIS APPLICATION****

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Please complete if Property coverage is desired

Contents Limit Desired (Business Personal Property): _____

Type of equipment to be insured: _____

Description of contents to be insured:_____

Have you had any property claims or incidents: _____ If yes, please describe. _____
_____

Please complete if Hired and Non-Owned Auto is desired

1. Do you own or lease any vehicles: _____ If yes, please provide details: _____
_____

2. Do you obtain motor vehicle reports (MVR) for all of your employees or IC: _____ If yes, how often: _____

3. Do you obtain confirmation that your employees and independent contractors maintain their own auto insurance: _____

4. Have you had any automobile claims or incidents: _____ If yes, please describe. _____

Please complete if Cyber & Privacy is desired

1. Do you have antivirus software installed and enabled on all desktops, laptops and servers (excluding database servers)and is it updated on a regular basis? _____ If no, please explain _____

2. Do you have firewalls installed on all external gateways? _____

3. Do you take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fire-proof safe, or does your outsourced service provider meet this requirement: _____

4. Have you conducted a review of the business to ensure compliance with all relevant HIPAA legislation? _____

5. Do you ensure that all Protected Health Information transmitted over open networks or stored on portable devices is encrypted?_____

6. Do you process or store credit card information? _____ Are you PCI compliant? _____

IF DIRECTORS AND OFFICERS COVERAGE IS DESIRED, PLEASE ATTACH YOUR MOST RECENT AUDITED FINANCIALS.

IF EMPLOYMENT PRACTICES LIABILITY IS DESIRED, PLEASE CHECK HERE: _____

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