

Laser Spa Professional Liability Application (Claims-Made Form)

1. Full Legal Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If there are multiple locations, please attach a complete schedule of all location addresses.)

4. Website Address (if applicable): _____

5. Date Business Started: _____

6. Type of Entity: Corp Partnership LLC Individual
Other (describe): _____

7. Is the entity owned by, associated with or controlled by any other entity? Yes No
If yes, explain: _____

8. Did you receive your training from Rocky Mountain Laser College, Lakewood, CO? Yes No
If No, where were you trained? _____

9. Professional Activities. Check all that apply and provide annual number of procedures.

| | Yes | No | Number |
|---|--------------------------|--------------------------|--------|
| Acid or Chemical Peels | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Solution Strength _____ % | | | |
| Acupuncture | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Botox Injections | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Collagen Implants | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cosmetic or Elective Surgery | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Describe: _____ | | | |
| Electrolysis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Holistic or Alternative Medicine | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Intense Pulse Light (IPL) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Where did you receive training for IPL? _____ | | | |
| Laser Treatments (non-surgical) | | | |
| Hair Removal | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin Resurfacing | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tattoo Removal | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Teeth Whitening | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Microdermabrasion | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pain Management (non-surgical) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Permanent Makeup Application | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Silicone Injections | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Total Number of Procedures: | | | _____ |

10. Does the applicant perform any surgical procedures? Yes No
 If yes, please provide details: _____

Please attach a complete list of all surgical procedures performed at this facility.

11. Does the applicant maintain any beds for overnight occupancy? Yes No
 If yes, what is the total number of beds? _____

12. Is anesthesia (other than topical or by means of infiltration) administered at the applicant's facility?
 Yes No If yes, how many procedures per year require general anesthesia? _____

13. Please provide the number of employees and independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

| | Employee or Volunteer | Independent Contractor | Insured on Own Med Mal Policy | |
|------------------------------|--------------------------|---------------------------|----------------------------------|-----------------------------|
| Aestheticians | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Certified Nurse Anesthetists | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chiropractors | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| LPN's or Nurse Aides | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Massage Therapists | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Medical Assistants | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nurse Practitioners | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physician Assistants | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physicians (no surgery) | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physicians (surgery) | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Registered Nurses | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Surgical Technicians | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| X-Ray Technicians | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other: _____ | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other: _____ | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

14. Are all of the above individuals licensed in accordance with applicable state and federal regulations? Yes No If No, please attach a detailed explanation.

15. Do you require that all customers review and sign Informed Consent forms prior to providing any services or procedures? Yes No If No, please attach a detailed explanation.

16. Do you utilize the Informed Consent forms provided/recommended by Rocky Mountain Laser College? Yes No
 If No, please attach copies of all of the Informed Consent forms that you do use.

17. Has the applicant or any of the above employees and/or independent contractors:

*Attach detailed explanation for each Yes response.

Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association?

Yes No

Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?

Yes No

Ever been treated for alcoholism or drug addiction?

Yes No

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

18. Please provide the sources and amounts of total revenue:

| | Last 12 Months | Estimate for next 12 Months |
|-----------------------|----------------|-----------------------------|
| Fee For Service: | \$ _____ | \$ _____ |
| Sales of Products: | \$ _____ | \$ _____ |
| Other (describe): | \$ _____ | \$ _____ |
| Total Gross Revenues: | \$ _____ | \$ _____ |

19. If the applicant provides training, please provide the following:

| Procedures and Equipment that Training is provided for | Max # of Students Per Session | # of Sessions Per Year | % of time in clinical setting | Qualifications of teaching staff |
|--|-------------------------------|------------------------|-------------------------------|----------------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

20. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage:

| Insurance Company | Limits | Deduct | Premium | Policy Term |
|-------------------|--------|--------|---------|-------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

21. Is the applicant currently insured under a Commercial General Liability policy? Yes No

22. Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? Yes No

If yes, please attach complete details including the name of the entity, your ownership interest or contractual relationship and information on their insurance program.

23. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, canceled or non-renewed?

Yes No If Yes, please provide details including name of carrier and dates.

24. Has any claim ever been made against the applicant or any of its employees? Yes No

If Yes, please complete the Supplemental Claim Information Form at the end of this application for each and every claim.

25. Is the applicant aware of any circumstances which may result in any claims against them or their employees? Yes No If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell, nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be mad a part of the policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Date

Signature of Applicant or Authorized Representative

Title of person signing application

Please attach the following documents:

- Resumes or CV's on principals and partners
- Copies of Brochures, marketing or advertising materials
- Five years of currently valued company loss runs
- Information on disciplinary actions, license revocations, etc.
- Copy of most current declarations page
- Copies of documents verifying training and certification

Supplemental Claim Information Form
(Complete one form for each claim)

1. Name of applicant/named insured: _____

2. Names of other parties or defendants named in suit: _____

3. Date of alleged error or occurrence, or contact date: _____

4. Date claim was made: _____

5. Name of claimant: _____

6. Name of Insurance Company handling your claim: _____

7. Present status of claim or final disposition: _____

8. Circle One: CLOSED OPEN

9. Defense costs paid, inclusive of any deductible: \$ _____

10. If closed, total loss paid, inclusive of any deductible: \$ _____

11. If claim is open or pending, what are the insurer's reserves:

Defense: \$ _____ Loss: \$ _____

12. Description of case and events including allegations and assessment of liability:

13. Claimant's last settlement demand: \$ _____

Date

Signature

Title of person signing