

Laser Spa Medical Director Application (Claims-Made Form)

1. This application must be completed, signed, dated by the Medical Director of (name and address of laser-spa account): _____

Physician's Personal Information

2. Full Legal Name of Applicant: _____

3. Mailing Address: _____

4. Medical License # and State of Issuance: _____

5. Date of Birth: _____ Place of Birth: _____

6. Medical School and Year of Graduation: _____

7. Medical Specialty: _____ Sub-Specialty: _____

8. Are you American board Certified? Yes No
If Yes, in what specialty? _____ Year Certified: _____

Medical Director Services Information

9. Your relationship to the medi-spa entity named above:
 Owner/Partner Contractor Employee
Other (provide details): _____

10. How many hours per week are dedicated to medical director services only? _____

11. Do you also provide medical services at this facility? Yes No
If Yes, how many hours per week are dedicated to medical services only? _____
If Yes, please describe, in detail, the medical services that you provide: _____

12. How long have you worked as medical director at this facility? _____

13. Please describe your duties as medical director: _____

Prior Insurance and Claim Information

14. Do you currently carry Professional Liability Insurance for your medical director services?

Yes No If Yes, please complete the following:

Insurance Company Policy Term Limits of Liability Retro Date Premium

15. Has any claim ever been made against you solely as respects your duties as a medical director?

Yes No If Yes, complete the Supplemental Claim Information Form for each clam.

Also, please attach five years of currently valued company loss runs,

16. Are you aware of any circumstances, solely as respects your duties as a medical director, which may result in a claim against you? Yes No If Yes, please provide details:

17. Do you currently carry Medical Malpractice Insurance for your medical services?

Yes No If Yes, please complete the following:

Insurance Company Policy Term Limits of Liability Retro Date Premium

*Please attach a copy of your Medical Malpractice Insurance Declarations Page.

Has any claim ever been made against you for Medical Malpractice? Yes No

If Yes, complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs.

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

Please attach the following documents:

- A minimum of five years of currently valued company loss runs
- CV or resume
- Proof of medical malpractice coverage for applicant
- Proof of medical malpractice coverage for the medi spa facility
- A copy of the contract between applicant and medi spa facility

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