Professional Liability Solutions, LLC

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Medical Spa / Integrative Medicine Insurance Program Indication Application

NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM INDICATION ONLY. COVERAGE WILL NOT BE BOUND UNTIL RECEIPT, REVIEW AND UNDERWRITER ACCEPTANCE OF THEIR COMPANIES APPLICATION, AND PREMIUM PAYMENT.

Include full legal name and D/B/A: _____
Principal business premise address: _____
_____
Additional locations: _____
Phone: _____ Fax: _____ Email: _____
Number of Employees: Full Time _____ Part Time _____ Total _____
Provide name and specialty of Applicant's Medical Director _____
_____
Does the Medical Director need coverage for Direct Patient Care? _____
Gross Receipts: Previous 12 months _____ Next 12 months _____
Has the Spa had any claims? _____ yes _____ no If yes, please provide details separate piece of paper.

Procedures Performed	Type of staff performing Procedure(s). i.e. RN, LPN etc.	Names of Staff performing Procedure(s) i.e. Jane Smith, R.N.	Actual # of Procedures Performed the previous 12 months	Est. Number of Procedures Performed next 12 months.
Bio-Identical Hormone Replacement Therapy				
Botox Injections				
Chemical Peels Specify Solution Strength				
Chelation Therapy				
Laser Hair Removal				
Laser Skin Treatment Specify Type _____				
Massage				
Cellulite Procedures – Specify Type_____				
Other Injections - Specify Type _____				
Medical Weight Loss				
Other _____				

Prior Insurance History

Insurance Company	Limits of Liability	Deductible (if any)	Premium	Renewal Date	Retroactive Date

_____ _____
Insured's Signature Date