

## Medical Spa / Integrative Medicine Insurance Program Indication Application

Please fax to: Professional Liability Solutions 704 927 5981; Questions? 800-871-6871

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				
HCG				
Other				

Do you prescribe drugs for any of the services above? \_\_\_\_\_ If yes, please list them \_\_\_\_\_

**\*\*NOTE:** Only the procedures listed above will be included in your indication. If you are performing procedures or services that are not listed above, please indicate on a separate piece of paper so that we can make sure we get your facility properly covered.

### Prior Insurance History

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

Insured's Signature \_\_\_\_\_

Date \_\_\_\_\_