Rockbridge Underwriting, An RLI Company
3700 Buffalo Speedway, Suite 300
Houston, TX 77098
(713) 874-8800

MEDICAL SPA MEDICAL PROFESSIONAL UNDERWRITING QUESTIONNAIRE AND APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

I. GENERAL INFORMATION

Name of Applicant: _____

Mailing Address: _____
(Street) (County)

_____
(City) (State) (Zip Code)

Principle Practice Address: _____
(Street) (County)

_____
(City) (State) (Zip Code)

Website Address: Phone Number: Fax Number:

Type of Ownership:	☐ Corporation	☐ Partnership	☐ Sole Proprietorship	☐ Other (Describe)

Number of years under present ownership _____

Corporate Medical Director(s) : _____

Describe the Medical Director's Duties: _____

Attach a copy of the CV for each Medical Director.

Is coverage desired for Medical Director(s)?	☐ Yes	☐ No
Does the Medical Director also provide direct patient care?	☐ Yes	☐ No

II. EXPOSURES

a. Fully describe the applicant's operations: _____

b. Provide the following information for the past three years.

Procedure	Performed by (include the name & qualification of person performing each procedure)	Is Training Certificate Attached? (Yes/No)	Is CV Attached? (Yes/No)	Is Client Selection Protocol Attached? (Yes/No)	Number of Procedures		
					Prior 12 months	Current Year	Est. next 12 months
Acne Blue Light Treatment							
Botox Injections							
Chemical Peels (specify solution strength)							
Electrolysis							
Hair Transplants							
Laser Assisted Lipolysis							
Laser Hair Removal							
Laser/IPL Skin Treatment (specify type)							
Massage							
Mesotherapy and/or Lipodissolve							
Microdermabrasion							
Other Injections (specify type – fat, collagen, silicone)							
Permanent Make-up/Micropigmentation							
Sclerotherapy Injections							
Tattoo Removals							
Other (please describe)							

c. Does a physician or dentist perform any of the procedures listed in response to the last question?

☐ Yes ☐ No

If yes, do all the physicians and dentists carry their own Professional Liability Insurance? ☐ Yes ☐ No
Please attach a certificate of insurance to confirm coverage is in force.
If no, is coverage desired for them under this policy? ☐ Yes ☐ No

d. Is general anesthesia used for any of the procedures performed? ☐ Yes ☐ No
If yes, please provide details including the qualification of the professional administering the anesthesia & the number of procedures? _____

e. Is informed consent always obtained prior to performing a procedure? ☐ Yes ☐ No
If no, please provide details? _____

f. Provide the percentage of the Applicant's patients/clients in the following categories?

_____%	Acupuncture	_____%	Medical Spa/Anti-Aging
_____%	Beauty Shop (hair, nails, facials, etc.)	_____%	Plastic Surgery*
_____%	Chelation Therapy*	_____%	Research or Experimental*
_____%	Dental	_____%	Surgical*
_____%	Dermatology	_____%	Weight Control*
_____%	Hormone Therapy*	_____%	Other (Please describe)*
_____%	Massage		

*Please provide details if providing any of the above services marked with an asterisk: _____

g. Provide the ages of the patients/clients:

_____%	Less than 12 years old	_____%	Greater than 18 years old
_____%	12 to 18 years old	_____%	Total

h. Total Gross Revenue: Last 12 months: _____ Next 12 months: _____

III. MEDICAL INDEPENDENT EMPLOYEES/CONTRACTORS

Category

a.

MEDICAL SPECIALTY		EMPLOYEES			CONTRACTORS	
		Full Time	Part Time		Full Time	Part Time
Registered Nurse						
Licensed Practical Nurse						
Nurse Practitioner						
Physician Assistant						
Physician						
Esthetician						
Electrologist						
Massage Therapist						

Technician (specify type)						
Others (specify type)						

b. Does the applicant supervise anyone other than its own employees? ☐ Yes ☐ No

If yes, please provide details: _____

c. Are references listed by new applicants checked in writing? ☐ Yes ☐ No

d. Are diplomas, licenses and other credentials for applicants verified prior to employment? ☐ Yes ☐ No

e. Is the initial employment for a specified probationary period? ☐ Yes ☐ No
If yes, what is the probationary period? _____

f. Are any non-medical employees associated with your organization? ☐ Yes ☐ No

If yes, please describe: _____

IV. COVERAGE REQUESTED

Effective Date:	Retroactive Date:	Deductible/SIR:
☐ $100,000/$300,000	☐ $200,000/$600,000	☐ $250,000/$750,000
☐ $500,000/$1,000,000	☐ $500,000/$1,500,000	☐ $1,000,000/$3,000,000

Is Prior Acts coverage needed? _____ For Prior Acts coverage, please attach a schedule of physicians and retroactive dates.

V. PROFESSIONAL LIABILITY INSURANCE COVERAGE (for previous three year period).

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability	$	$	$
Deductible or SIR and Amount	☐ Deductible ☐ SIR $	☐ Deductible ☐ SIR $	☐ Deductible ☐ SIR $
Coverage Form	☐ Claims-Made ☐ Occurrence	☐ Claims-Made ☐ Occurrence	☐ Claims-Made ☐ Occurrence
Prior Acts Date			
Policy Period	Fr.: To:	Fr.: To:	Fr.: To:

* If Claims Made, attach copy of policy.

VI. CLAIMS INFORMATION

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No If yes, complete a claims supplement for each claim. Total Number of Claims Open Closed

VII. CONDITIONS OF APPLICATION

By applying for Medical Professional Liability Insurance from Mt. Hawley Insurance Company, I hereby:

- consent to inspection by Mt. Hawley Insurance Company or their agents of all documents that may be material to an evaluation of the group's qualifications and competence;

- release from liability Mt. Hawley Insurance Company, their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications;

- release from liability any and all individuals and organizations who provide information to Mt. Hawley Insurance Company or their agents, in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

Date	X Applicant's Signature

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.