MEDISPA APPLICATION

Applicant Name: _____ Phone Number: _____

Business Name: _____

Email Address: _____ Website: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Business Address (1): _____

City: _____ State: _____ Zip code: _____

Type of Facility: _____ Square Footage: _____

Business Address (2): _____

City: _____ State: _____ Zip code: _____

Type of Facility: _____ Square Footage: _____

Business operated as: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Individual ☐ Independent Contractor

Is your business part of a franchise? ☐ Yes ☐ No If Yes, which one? _____

Business operated as a Medispa? ☐ Yes ☐ No If No, other: _____

Do you provide services out of your home? ☐ Yes ☐ No If Yes, explain: _____

Do you provide services in homes of clients? ☐ Yes ☐ No If Yes, explain: _____

Do you provide off-site services at multiple licensed business locations? ☐ Yes ☐ No If Yes, explain: _____

Do you have a mobile unit you provide services in? ☐ Yes ☐ No If Yes, explain: _____

Any Virtual Consults or intake appointments for any service? ☐ Yes ☐ No If Yes, explain: _____

How long in business? _____ Annual gross receipts from all operations? _____

Is your business in compliance with all City, County and / or State Ordinances / Laws? ☐ Yes ☐ No

Are you in compliance with CDC / Health Department guidelines? ☐ Yes ☐ No

Do all professionals have licenses? ☐ Yes ☐ No

Do you obtain written consent for any client photos you post online? ☐ Yes ☐ No ☐ N/A

What type of anesthetics do you use? ☐ Topical / Local ☐ General / IV ☐ Nitrous Oxide ☐ N/A ☐ Other: _____

SECTION I: GENERAL LIABILITY

If this Section does not apply, Check Here ☐

Do you need General Liability? ☐ Yes ☐ No If No, what Company insures your General Liability coverage? _____

If Yes, answer below:

1. Do you have any of the following units? If Yes, indicate number of units for each:

Saunas	_____	Steam Rooms	_____	Salt Caves	_____
Flotation Pods	_____	Showers	_____	Soaking Pools / Tubs	_____

2. Are you required to name any other person or entity as an Additional Insured on your Policy? ☐ Yes ☐ No
   a. If Yes, please provide Name and Address: _____
   _____ Business Location#: _____
   b. What is the interest of the Additional Insured? ☐ Landlord ☐ City / Government Agency ☐ Lessor ☐ Franchisor ☐ Other: _____
   c. Does the Additional Insured require the following: ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation

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3. Do you need Products Liability? ☐ Yes ☐ No Gross receipts: _____
4. Do you sell non - beauty related products? ☐ Yes ☐ No If Yes, describe: _____
5. Do you sell any CBD / Hemp Products? ☐ Yes ☐ No Gross receipts: _____
6. Do you private label products for sale? ☐ Yes ☐ No
   a. If Yes, provide gross receipts for private label products ONLY: _____
   b. Describe products being sold: _____
   c. Are the ingredients / component parts purchased from the US? ☐ Yes ☐ No
      If No, where are they purchased? _____
   d. Any new products being introduced in the next 12 months? ☐ Yes ☐ No If Yes, explain: _____
   e. Any foreign sales? ☐ Yes ☐ No If Yes, what percentage to what countries? _____
   f. Do you have a written recall plan in place? ☐ Yes ☐ No
   g. Are your products tested for contaminants, potency, etc.? ☐ Yes ☐ No If No, explain: _____
   h. Do you have written instructions with the products or inherent hazards and warnings against misuse? ☐ Yes ☐ No
7. Check one of the following boxes if the following coverage is needed: ☐ Non-Owned Auto ☐ Hired Auto ☐ Both
   If so, answer questions a-h:
   a. Do you currently have a commercial auto policy? ☐ Yes ☐ No
   b. Do you have a contractual requirement to carry Hired Auto? ☐ Yes ☐ No
   c. Under which circumstances do the employees use their personal vehicles? _____
   d. Approximate combined number of Non-Owned Auto trips annually? ☐ Under 10 ☐ 11-50 ☐ 50+
   e. Approximate combine number of Hired Auto trips annually? ☐ Under 10 ☐ 11-50 ☐ 50+
   f. Do you require your employees to carry their own insurance, with at least state minimum requirements, and obtain proof of insurance before you authorize them to use their own auto on company business? ☐ Yes ☐ No

SECTION II: TEACHING OF ANY SERVICE(S) ON APPLICATION

If this Section does not apply, Check Here ☐

Are you teaching or training any services? ☐ Yes ☐ No

If Yes, answer each of the below:

a. Are all students that are being taught 18 years of age or older? ☐ Yes ☐ No
b. How many students will be trained in the next 12 months? _____
c. Maximum number of students who will be attending each class? _____
d. How many hands-on procedures will each student perform for each service being taught? Describe (per service):
   _____
e. Do you use a model release form for all individuals that students work on? ☐ Yes ☐ No

   If Yes, answer below:

   ☐ I am submitting my own forms (if already approved by PPIB, no need to resubmit)

   ☐ I will use PPIB approved forms (**https://www.ppibcorp.com/clientforms/**)

f. Do you guarantee Job Placement / Employability? ☐ Yes ☐ No
g. Provide name of each Teacher:

   Name: _____ Name: _____

   Name: _____ Name: _____

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SECTION III: AESTHETICS & NATURAL WELLNESS

If this Section does not apply, Check Here ☐

Pick the best ONE for each Technician	# to be Insured
Beauty Services: Barbering, Nails, Eyelash & Brow Enhancements, Sugaring, Waxing, Threading, Topical Makeup Application	
Massage Therapy: Massage, Body Wraps, Endermologie, Reiki, Chakra Healing, Dry Cupping (No Heat / Fire)	
Natural Wellness Services: Non-Cryo Compression Therapy, Yoga / Pilates Instruction, One-on-One Personal Training, Guided Meditation Energy Healing, Hypnosis, Magnawave Energy Therapy, PEMF, TMS, TENS, BioFeedback Brain Optimization through wave technology, Whole Body Vibration, Energy Wave Chair, Trichology	
Medical Aesthetics: All Beauty Services, Massage Therapy, Natural Wellness Services, Facials, Aesthetic Peels, Electrology, Airbrush / Spray Tanning, Microdermabrasion, Needling / Collagen Induction Therapy, LED Therapy, Microcurrent, Dermaplaning, Medical Grade Peels, Cosmetic Ultrasound, Aesthetic Radio Frequency, Wart Removal, Skin Tag Removal, Aesthetic Cryo Spot Treatments, Non-Needle, Non-Prescription Spring Pressure Treatments, Topical PRP / PRF, Infrared Therapy	
Other Aesthetic Services: Earlobe, Outer Rim of Ear Cartilage, and Simple Nostril Piercing only; Ear Candling; Face and / or Body Painting; Henna Tattoo; Airbrush Tattoo; Temporary Sticker Tattoos, Tooth Jewels, Body Jewels and Anal Bleaching	
Do you teach any of the above services? ☐ Yes ☐ No	
Total Number of Technicians:	

SECTION IV: UNITS / DEVICES

If this Section does not apply, Check Here ☐

Indicate Number of Units for each

Oxygen Inhalation Devices # _____ Hyperbaric Oxygen Chambers # _____ Foot Detox # _____

Vaginal Steam Baths # _____ Hydrogen Inhalation Devices # _____

SECTION V: PERMANENT COSMETIC SERVICES

If this Section does not apply, Check Here ☐

PERMANENT COSMETIC SERVICE DEFINITIONS:

Permanent Cosmetics / Pigment Removal: Ombré, Microshading, Eyeliner, Eyebrows, Microblading, Lips, Lipliner, Nipple Areola, Beauty Marks, Pigment Removal using commercially prepared Saline or Acid-Based solutions

Microblading: Eyebrows only

Advanced Services: Scar Camouflage, Bald Spot Repigmentation, Cheek Blush

	Name of Technician to be Insured	Years of Experience	Permanent Cosmetics / Pigment Removal	Micro-blading	Advanced Services	Do you teach any of these services?
1.			☐	☐	☐	☐ Yes ☐ No
2.			☐	☐	☐	☐ Yes ☐ No
3.			☐	☐	☐	☐ Yes ☐ No

Pick which service (s) you will be performing:

Advanced Services *(additional training required):* ☐ Scar Camouflage ☐ Bald Spot Repigmentation ☐ Cheek Blush

Do you have everyone sign a Consent Form and complete a Medical History Form? ☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own forms (if already approved by PPIB, no need to resubmit)

☐ I will use PPIB approved forms (**https://www.ppibcorp.com/clientforms/**)

Do you take before and after photos of all work and schedule a follow-up appointment after each procedure? ☐ Yes ☐ No

Are all pigments / removal products you use from US or Canada manufacturers and / or to EU / UK standards? ☐ Yes ☐ No

Is all your equipment pre – sterile, one-time use? ☐ Yes ☐ No

TRAINING & EDUCATION- *If Less than 18 months of experience, provide training detail for each Technician specific to these services*

	# of Hours in Person	*# of Hours of Online*	*Name of School*	*Date(s) Attended*	*# of Procedures*
1.					
2.					
3.					

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SECTION VI: LIGHT / ENERGY

If this Section does not apply, Check Here ☐

LIGHT / ENERGY DEFINITIONS:

Light / Energy Basic (L/E Basic): Body Contouring / Cellulite Reduction (multiple modalities); Radio Frequency / High Frequency (low level); FDA Class I or II Cold Laser; Skin Tags Removal; Cosmetic Ultrasound; Non-Invasive Microwave for Hyperhidrosis and Plasma Treatments for wrinkles, skin lesions, color correction, scar reduction, Laser Pain Therapy must be done with LLLT

Light / Energy Tattoo Removal Only (L/E TR): Tattoo / Pigment removal using a Class IIb, III, or IV device

Light / Energy Professional (L/E Pro): Class IIb, III & IV Lasers & Medical Strength Radio Frequency, includes treatment of Veins, Age Spots, Rosacea, Photo Rejuvenation, Skin Rejuvenation, Skin Tightening, Wrinkle Reduction, Collagen Induction Therapy, Cosmetic Acne Treatment, Scar Revision, **Hair Removal**, Tattoo Removal, Smoking Cessation, Laser Acupuncture, Weight Loss, Allergy Treatment, Toe / Nail Fungus, Psoriasis, Vitiligo. *Also includes Light / Energy Basic*

Light / Energy Vaginal Rejuvenation I (L/E VRI): Cold Light / Energy device

Light / Energy Vaginal Rejuvenation II (L/E VRII): Heat generating CO2 including Light / Energy Vaginal Rejuvenation I

TECHNICIANS				SERVICES					
	Name of Technician	Medical Designation	Years of Experience	L/E Basic	L/E TR	L/E Pro	L/E VRI	L/E VRII	Teacher
1.				☐	☐	☐	☐	☐	☐
2.				☐	☐	☐	☐	☐	☐
3.				☐	☐	☐	☐	☐	☐
4.				☐	☐	☐	☐	☐	☐
5.				☐	☐	☐	☐	☐	☐

Indicate Service (s) being performed

☐ Intra Oral Tightening – Name of Technician(s): _____

☐ Energy Waves for Erectile Disfunction – Name of Technician(s): _____

☐ Morpheus8 or other RF Microneedling device – Name of Technician(s): _____ Max. Depth: _____mm

☐ Other: _____ Name of Technician(s): _____

Do you have everyone sign a Consent Form and complete a Medical History Form? ☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own forms (if already approved by PPIB, no need to resubmit)

☐ I will use PPIB approved forms (**https://www.ppibcorp.com/clientforms/**)

Do you have any of the following units? ☐ Yes ☐ No

If Yes, indicate number of units for each: ☐ LED Teeth Whitening: _____ ☐ LED Hair Stimulation: _____

TRAINING & EDUCATION - *If Less than 18 months of experience, provide training detail for each Technician (must include 30 hours except for Light / Energy Basic Services)*	
1.	
2.	
3.	

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SECTION VII: INJECTABLES

If this Section does not apply, Check Here ☐

INJECTABLES DEFINITIONS:

Injectables: Fillers, Botox, Latisse, Carboxy Therapy, Sclerotherapy, **Vitamins / Supplements***, Botox for - Hyperhidrosis, Masseters, Décolletage & Platysmal Bands, Dermal Fillers in Earlobes & Hands, Mesotherapy, Kybella, Cosmetic PRP, PRF (Platelet Rich Fibrin), IV treatments / Chelation therapy including with Light, Blood Draws, Flu Shots, QWO Cellulite Treatment (buttock only)

O / P Shots: Saline, Dermal Fillers and / or PRP into the Penis or "G" spot

PDO Threading: Using Biodegradable Polyester Sutures to Rejuvenate and Lift Sagging Skin on the Face

IV Therapy Only: Therapy provided through Intravenous means of Saline and **Vitamins / Supplements***

***Vitamin / Supplements:** The Injection of Vitamin A, B, C, D, E and K, Amino Acids, and / or Other Dietary Supplements

TECHNICIANS				SERVICES				
	Name of Technician	Medical Designation	Years of Experience	Injectables	O and/or P Shots	PDO Threading	IV Therapy	Teacher
1.				☐	☐	☐	☐	☐
2.				☐	☐	☐	☐	☐
3.				☐	☐	☐	☐	☐
4.				☐	☐	☐	☐	☐
5.				☐	☐	☐	☐	☐

Indicate Service (s) being performed

☐ Allergy Immunotherapy – Name of Technician(s): _____ Describe: _____

☐ QWO Cellulite Treatments – Name of Technician(s): _____

Indicate area of the body: ☐ Butt ☐ Legs ☐ Other: _____

☐ Dermal Filler Injections in the Buttocks – Max # of Vials: _____ Name of Technician(s): _____

☐ Dermal Filler Injections in the Legs – Max # of Vials: _____ Name of Technician(s): _____

☐ Dermal Filler Injections in the Arms – Max # of Vials: _____ Name of Technician(s): _____

☐ Wound Healing – Name of Technician(s): _____

If Yes, indicate the method: ☐ PRP ☐ Saline ☐ Lidocaine ☐ Other: _____

☐ Orthopedic / Joint / Prolotherapy / Trigger Points – Name of Technician(s): _____

If Yes, indicate the method: ☐ PRP ☐ Saline ☐ Lidocaine ☐ Other: _____

☐ Other: _____

TRAINING & EDUCATION - *If Less than 18 months of experience, provide training detail for each Technician*	
1.	
2.	
3.	

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SECTION VIII: CRYO PROFESSIONAL SERVICES

If this Section does not apply, Check Here ☐

Does Not Mean Walk-In Cryotherapy Unit or Cryo Sauna

CYRO PROFESSIONAL SERVICES DEFINITION:

Cryo Professional Services: The use of a Non-Invasive, Color-Blind Cryotherapy device (Class I or II) for Skin Tag Removal, Age / Sunspot Treatments, Pain Therapy and Management, Compression Therapy, Skin Tightening, Destruction of Fat Cells, and / or the appearance of a Smoother, more Contoured Area on the Torso, Arms or Legs. Can include work done on Face and Neck, as long as it is done with a Machine Specifically Designed for this Purpose. **Cryo Professional Services does not include Walk-In Cryotherapy units or Cryo Saunas**

TECHNICIANS				SERVICES	
	Name of Technician	Medical Designation	Years of Experience	Cryo Professional	Teacher
1.				☐	☐
2.				☐	☐
3.				☐	☐

Are handheld Cryo devices being used for any purposes not listed above? ☐ Yes ☐ No

If Yes, explain: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

Name of device being used (mark all that apply): ☐ T-Shock ☐ Cryoskin ☐ Coolsculpting ☐ Cryo Penguin

☐ Other: _____

TRAINING & EDUCATION - *If Less than 18 months of experience, provide training detail for each Technician*	
1.	
2.	
3.	

SECTION IX: WALK-IN CRYOTHERAPY UNIT

If this Section does not apply, Check Here ☐

Indicate Number of Units for Each excluding Cryo Pen and Handheld Devices:

☐ Walk-In Single Person Cryotherapy Unit: _____ ☐ Walk-In Multiple Person Cryotherapy Unit: _____

Manufacturer of each Cryotherapy Unit: _____

What temperature do you operate at? ☐ 0°F to -200°F ☐ -201°F to -260°F ☐ -261°F and colder

Is the cooling: ☐ Electric ☐ Liquid Nitrogen ☐ Carbon Dioxide ☐ Other: _____

What age limit do you operate on? ☐ 16 + ☐ 15 + ☐ 14 +

If working on minors 14 and 15, do you have parent / guardian present at all times and a signed parental / guardian consent form? ☐ Yes ☐ No ☐ N/A

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own forms (if already approved by PPIB, no need to resubmit)

☐ I will use PPIB approved forms (https://www.ppibcorp.com/clientforms/)

Does your Liquid Nitrogen provider have specific limit requirements? ☐ Yes ☐ No If Yes, please describe limits: _____

Are any cryotherapy unit (s) inflatable? ☐ Yes ☐ No Are any of these units mobile? ☐ Yes ☐ No

Are you required to name them as an Additional Insured? ☐ Yes ☐ No

If Yes, please provide Name and Address: _____

Do they require the following? ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation

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SECTION X: MEDICAL WELLNESS SERVICES

If this Section does not apply, Check Here ☐

MEDICAL WELLNESS DEFINITIONS:

Medical Wellness (Med Well): Appetite Suppressants, Weight Loss RXs (HCG, Phendimetrazine, Phentermine, Lipotropics, Lipo B, Didrex, Tenuate, Diethylpropion, Qsymia, Contrave, Topamax, Orlistat {Xenical}, Saxenda {Liraglutide}, Wegovy {Semaglutide}, Hormone Treatments including Pellets, **Vitamins / Supplements***, Nutritional Services

Nutritional Services Only (Nutrition): Dietitian, Nutritional Counseling (no RX given)

***Vitamin / Supplements (V / S):** The treatment with of Vitamin A, B, C, D, E and K, Amino Acids, and / or other Dietary Supplements

TECHNICIANS				SERVICES			
	Name of Technician	Medical Designation	Years of Experience	Med Well	Nutrition	V / S	Teacher
1.				☐	☐	☐	☐
2.				☐	☐	☐	☐
3.				☐	☐	☐	☐
4.				☐	☐	☐	☐
5.				☐	☐	☐	☐

List any other weight loss RX medications: _____

TRAINING & EDUCATION - *If Less than 18 months of experience, provide training detail for each Technician*	
1.	
2.	
3.	

SECTION XI: INVASIVE PROCEDURES

If this Section does not apply, Check Here ☐

	Name of Technician	Medical Designation	Years of Experience
1.			
2.			
3.			

Indicate Service (s) being performed

☐ Neograft Hair Transplant ☐ Fue / Strip Hair Transplant ☐ Upper Blepharoplasty ☐ Fat Transfers

☐ Needling 5.1mm to 7.0mm ☐ Removal of Moles (PA/NP/MD Only) ☐ Mini Tummy Tucks ☐ Tickle / Smart Lipo

☐ Tumescent Liposuction ☐ Laser / Ultrasound Assisted Lipolysis ☐ Cellfina ☐ Acne Subcisions

☐ Other: _____

Do you have everyone sign a consent form and complete a medical history form? ☐ Yes ☐ No

What type of anesthetics do you use? ☐ Topical / Local ☐ General / IV ☐ Nitrous Oxide ☐ N/A ☐ Other: _____

Devices being used for procedures: _____

If you are doing Fat Transfers answer the following?

a. Indicate Method of Removal: _____

b. Indicate the areas you re-inject: _____

c. Do you use the Brava System or something similar for injections in the breasts? ☐ Yes ☐ No ☐ N/A

d. Do you reinject fat into the person whom it was removed from? ☐ Yes ☐ No

MEDISPA APPLICATION

TRAINING & EDUCATION - *If Less than 18 months of experience, provide training detail for each Technician*	
1.	
2.	
3.	

SECTION XII: SUPERVISING / ASSISTANT STAFF

If this Section does not apply, Check Here ☐

Is there a medical director on your staff? ☐ Yes ☐ No

Name and Degree of your supporting Doctor: _____

Do you want to cover the doctor as Medical Director for the locations scheduled on page one? ☐ Yes ☐ No

Will there be any Medical Assistants / Phlebotomist on staff? Answer below (**cannot have medical designation**) ☐ Yes ☐ No

	Name of Technician	Services Assisting With	Blood Draws
1.			☐ Yes ☐ No
2.			☐ Yes ☐ No
3.			☐ Yes ☐ No

SECTION XIII: OTHER SERVICES

If this Section does not apply, Check Here ☐

If you provide any of the following, please indicate name(s) of Technicians – *may require separate application*

☐ Body Tattooing / Body Piercing Names: _____

☐ Acupuncture Names: _____

☐ Vajacials / Penacials Names: _____

☐ Non-Energy Needling 3.1mm to 5.0mm Names: _____

☐ Energy Based Needling 3.1mm to 5.0mm Names: _____

☐ Colon Hydrotherapy Names: _____

What other services not listed already do you want coverage for? _____

Will you have other operations you **do not wish** to cover on this policy? ☐ Yes ☐ No

If Yes, provide details: _____

SECTION XIV: OTHER COVERAGE OPTIONS

If this Section does not apply, Check Here ☐

Do you want coverage for Defense Outside the Limit? ☐ Yes ☐ No Limit Requested: _____

Do you want coverage for Sexual Abuse at $25K / $50K? ☐ Yes ☐ No Other Limit Requested: _____

Do you want coverage for Cyber Liability? If Yes, answer below. ☐ Yes ☐ No If Yes, indicate limit: ☐ $250K ☐ $500K

1. Does your business have a company-wide privacy policy for keeping customer information secure? ☐ Yes ☐ No
2. Is your company in compliance with the Health Insurance, Portability & Accountability Act (HIPAA)? ☐ Yes ☐ No

MEDISPA APPLICATION

SECTION XV: PROPERTY - Complete for EACH Location If this Section does not apply, Check Here ☐

Location #: _____ Address: _____

Year Built: _____ Construction Type: _____ Number of stories: _____ Square Footage: _____

If building is over 15 years old, what year were the following upgraded? **(*) information required**

*Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____

*Roofing Material (Tile, Metal, Wood Shingles, etc.): _____

*Is there a Central Station Burglar Alarm inside your unit and in your control? ☐ Yes ☐ No

Are there sprinklers inside your unit? ☐ Yes ☐ No

Name and address of Loss Payee: _____

Coverage Desired:

Contents Excluding Light / Energy Devices: $:_____

Light / Energy Devices: $:_____

Tenant Improvements: $:_____

Building: $: _____ Do you own the building? ☐ Yes ☐ No

Business Interruption: Amt Per Month: $: _____ Months to be covered: _____

Outdoor Sign: $: _____

Optional Coverages

Do you need coverage for any of this property in Transit or at a temporary Location? ☐ Yes ☐ No If Yes, $: _____

Do you want coverage for Contingent Business Income? ☐ Yes ☐ No $10K limit (Off Premise Power Outage)

Do you want coverage for Equipment Breakdown? ☐ Yes ☐ No

Location #: _____ Address: _____

Year Built: _____ Construction Type: _____ Number of stories: _____ Square Footage: _____

If building is over 15 years old, what year were the following upgraded? **(*) information required**

*Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____

*Roofing Material (Tile, Metal, Wood Shingles, etc.): _____

*Is there a Central Station Burglar Alarm inside your unit and in your control? ☐ Yes ☐ No

Are there sprinklers inside your unit? ☐ Yes ☐ No

Name and address of Loss Payee: _____

Coverage Desired:

Contents Excluding Light / Energy Devices: $:_____

Light / Energy Devices: $:_____

Tenant Improvements: $:_____

Building: $: _____ Do you own the building? ☐ Yes ☐ No

Business Interruption: Amt Per Month: $: _____ Months to be covered: _____

Outdoor Sign: $: _____

Optional Coverages

Do you need coverage for any of this property in Transit or at a temporary Location? ☐ Yes ☐ No If Yes, $: _____

Do you want coverage for Contingent Business Income? ☐ Yes ☐ No $10K limit (Off Premise Power Outage)

Do you want coverage for Equipment Breakdown? ☐ Yes ☐ No

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SECTION XVI: HISTORY: *Note – ALL questions must be answered. Failure to disclose claims history could invalidate coverage.*

1. Do you Currently have Other Insurance coverage? ☐ Yes ☐ No

Insurer	***Liability Limits***	***Premium***	***Exp. Date***	***Retro Date (if any)***

2. Has any applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled, or voluntarily surrendered by, or to, any state or federal licensing board or regulatory agency? If Yes, provide details on a separate sheet ☐ Yes ☐ No
3. Have you ever or any applicant ever been charged or convicted of a criminal offense? If Yes, provide details on a separate sheet ☐ Yes ☐ No
4. Has any liability suit, arbitration or other claim proceeding been brought against you, your business, or any applicant for any alleged malpractice? If Yes, provide details on a separate sheet ☐ Yes ☐ No
5. Have you, or any applicant, had any general liability, and / or cyber claims in the past 5 years whether or not insured? If Yes, describe details on a separate sheet of paper ☐ Yes ☐ No
6. Have you, or any applicant, had any property claims in the past 5 years whether or not insured? If Yes, describe details on a separate sheet of paper ☐ Yes ☐ No
7. Do you, or any applicant, have knowledge of an event, circumstance, or occurrence prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? If Yes, describe details on a separate sheet ☐ Yes ☐ No

ATTESTATION

On Behalf of ALL Technicians and Operations, I confirm:

1. No insurance will be offered for any service or individual unless specifically endorsed on to the policy and a premium is paid
2. That all Technicians have been properly trained and licensed as necessary for all services they are performing or on the devices they are using
3. Every client (except for Aesthetics and Natural Wellness, Nutritional Services or Outpatient Medical Care) must sign a consent form for the particular service being provided and medical history form prior to the treatment. No coverage will apply if there is not a signed & completed form on file. If I change a consent or medical history form for Laser / IPL, Walk-in Cryotherapy or Permanent Cosmetics, it must be approved by the insurance company
4. The business is in compliance with all AMA, FDA and / or State Laws for all devices, products, and services
5. Coverage is for specified facilities only unless the no location limitation endorsement is purchased
6. There are limitations to work on minors and individuals who are pregnant and / or nursing
7. If I am aware of any claim or incident arising from any time prior to today, I must advise underwriters at this time
8. The liability policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy
9. This insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund

On Behalf of ALL Light / Energy Technicians (if any), I understand:

1. All new Technicians need 6 months experience or 30 hours of Laser / IPL training, as well as an understanding of skin typing
2. No one will work on Skin Types V & VI until they have 6 months of experience with Laser / IPL devices

On Behalf of ALL Injectable Technicians (if any), I understand:

1. Each Technician must have specific training or 6 months experience to be eligible for injectable coverage
2. Injectables will only be purchased from manufacturer directly or their approved wholesalers

On Behalf of ALL Walk-in Cryotherapy Operations (if any), I understand:

1. If using liquid nitrogen, patient's head must be elevated outside the chamber at room temperature at all times, provided with appropriate protective clothing to prevent rapid freezing including but not limited to gloves, footwear & underwear, and supervised at all times while machine is in use
2. Sessions are no longer than 3 mins
3. Sessions must be at temperatures no lower than -200º F unless endorsed herein
4. All parts of body must remain at a distance of comfortable clearance from the active inner rim of the chamber during sessions

For UV Tanning Salon units (if any), I confirm:

1. That Lighting will not exceed 10% UVB in each unit
2. Maximum tanning exposure in each unit will NOT exceed 30 minutes per session per 24-hour period
3. All clients will wear goggles
4. Tanning controls will ONLY be set by a Staff Member
5. Tanning beds will be tested daily to ensure switches and timers operate properly
6. Drug reaction list and the FDA warning sign are posted as required by law

(For a full list of terms and conditions, consult the policy forms)

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS PRIOR TO BINDING (60 DAYS FOR RENEWALS). SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BE COMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY.

APPLICANT SIGNATURE	DATE SIGNED
TITLE	REQUESTED EFFECTIVE DATE / LIABILITY LIMIT REQUESTED

POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, **as defined in Section 102(1) of the Act, as amended:** The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2027, the date on which the TRIA Program is scheduled to terminate, or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 80% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A USD100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS USD100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED USD100 BILLION, YOUR COVERAGE MAY BE REDUCED.

THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

☐	(ACCEPT) I hereby elect to purchase coverage for acts of terrorism for a prospective premium of USD……
☐	(DECLINE) I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

_____ _____
Policyholder/Applicant's Signature Carrier

_____ _____
Print Name Policy Number

_____
Date