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APPLICATION FOR BOTOX / MEDICAL ESTHETIC PROCEDURE PROFESSIONAL LIABILITY INSURANCE

Along with the completed and signed app, please attach the following;
1. **Copy of existing Medical Malpractice Declarations Page**
2. **Copy of documentation for procedure training, for which coverage applicant is seeking**

The policy for which application is made provides coverage on a "CLAIMS MADE" basis.

1. Name of Physician or Dentist Applicant:_____

2. Name of Legal Entity for which coverage is requested (if applicant is not an unincorporated Solo Practitioner):_____

3. Telephone:_____ 4. Date Established:_____

5. Applicant's practice is a: Solo Practitioner (unincorporated) ☐ Solo Practitioner (incorporated) ☐

Partnership ☐ Corporation ☐ Other (describe) ☐ _____

6. Principal business address (please attach a schedule of additional locations if needed):

_____

7. Please state amount of total gross revenue derived from the applicant's entire practice:

a. Amount last 12 months:_____ b. Estimated next 12 months:_____

8. Please state amount of total gross revenue derived from medical aesthetic procedures:

a. Amount last 12 months:_____ b. Estimated next 12 months:_____

9. Please state approximate division of applicant's clients among the following (must total 100%):

Applicant's Medical Practice____%

(please specify specialty):
- ☐ Dermatology
- ☐ Internal Medicine
- ☐ ENT
- ☐ Ophtalmology
- ☐ Family Practice
- ☐ Other (please specify):_____

Applicant's Dental Practice____%

(please specify specialty):
- ☐ Endodontics
- ☐ Pediatric Dentistry
- ☐ General Dentistry
- ☐ Periodontics
- ☐ Oral Surgery
- ☐ Other (please specify):_____

Medical Aesthetic ____%

(please specify procedures offered):
- ☐ Botox Injections
- ☐ Sclerotherpy Injections
- ☐ Laser Hair Treatments
- ☐ SmartLipo/Laser Lipolisis
- ☐ Laser Skin Treatments
- ☐ Tattoo Removal
- ☐ Mesotherapy/LipoDissolve
- ☐ Dermal Fillers (please specify):_____
- ☐ Other (please specify_____

10. List all brand names of drugs & equipment used in the applicant's esthetic practice and purpose for which each is used:

_____
_____
_____

11. Provide the following information for all procedures performed, include proof of training/certification, informed consent forms and client selection protocols:

Procedures	**Performed By:**	**Is training certificate attached? Yes/No**	**Is CV attached? Yes/No**	**Is client selection protocol attached? Yes/No**	**Is informed consent attached? Yes/No**	**Number of procedures per year?**
Botox Injections						
Dermal fillers: Specify Type						
Laser Hair Treatments						
Laser Lipolysis / SmartLipo						
Laser Skin Treatments: Specify Type						
Mesotherapy / LipoDissolve						
Sclerotherapy						
Tattoo Removal						
Other: Describe:						

12. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No☐

13. Do you require contracted staff to carry their own Professional Liability Insurance? (certificate required) Yes ☐ No☐

14. Has the applicant or have any of the above employees: (Attach detailed explanation for any 'Yes' answers)

a. Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No☐

b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No☐

c. Ever been treated for alcoholism or drug addiction? Yes ☐ No☐

d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No☐

15. Has any similar insurance ever been declined or cancelled? If Yes, please attach an explanation. Yes ☐ No☐

16. List prior medical malpractice liability insurers for the past 3 years (if none, state none):

Insurer	Dates Covered (From-To) mm/dd/yyyy	Limits of Liability per Claim/Aggregate	Deductible	Premium	Coverage Type: Occurrence or Claims-Made
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	

17. Does the applicant currently have a professional liability insurance policy in place covering medical aesthetic procedures? Yes ☐ No☐

If yes, list prior professional liability insurers for the past 3 years:

Insurer	Dates Covered (From-To) mm/dd/yyyy	Limits of Liability per Claim/Aggregate	Deductible	Premium	Coverage Type: Occurrence or Claims-Made
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	

18. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? If Yes, please attach complete details including a description of the indicent(s). Yes ☐ No☐

19. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? If Yes, please complete a Supplemental Claims Information Form for each claim. Yes ☐ No☐

20. How many claims have been made in the last five (5) years? _____
a. Of these claims, how many involved medical aesthetic procedures? _____

It is understood and agreed that with respect to questions 14 and 15, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:_____ Date:_____

Signature of person authorized to execute on behalf of the applicant:_____

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated.

Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.

III-AES-3033 (12/07)