EVOLUTION INSURANCE BROKERS

8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-678-7342 • Fax 800-478-9880

COSMETIC MEDICINE AND LASER TREATMENTS

A. General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: _____ Fax: _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

_____

Contact Person: _____ Producer's Name: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

_____

Applicant is: **o** Individual **o** Corporation **o** Partnership **o** Joint Venture **o** Other: _____

Is this a new business? **o** Yes **o** No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: _____

_____

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: _____

_____

_____

Annual Payroll: $ _____ Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: _____

_____

_____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? **o** Yes **o** No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: _____

Fax: _____ Years with Company: _____

Employee's Responsibilities: _____

B. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor ever had a claim? **o** Yes **o** No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? **o** Yes **o** No

If yes, please explain: _____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? **o** Yes **o** No

If the standard markets are declining placement, please explain why: _____

_____

C. Other Insurance

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	**2**	**3**
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	$	$	$

D. Desired Insurance

Per Act/Aggregate		OR	Per Person/Per Act/Aggregate	
o	$50,000/$100,000	**o**	$25,000/$50,000/$100,000	

o	$150,000/$300,000	**o**	$75,000/$150,000/$300,000
o	$250,000/$1,000,000	**o**	$100,000/$250,000/$1,000,000
o	$500,000/$1,000,000	**o**	$250,000/$500,000/$1,000,000
o	Other: _____	**o**	Other: _____

Self-Insured Retention (SIR): **o** $1,000 (Minimum) **o** $1,500 **o** $2,500 **o** $5,000 **o** $10,000

E. Business Activities

1. Please attach copies of:
   a. Informed Consent forms currently used by your company. Note: This form must be received before a quote can be issued.
   b. Have all licensed medical doctors complete a Physicians and Surgeons application form, if applicable, and attach it to this application.
   c. Enclose a current copy of your CV.
   d. Have any licensed medical person who is an employee of the Applicant complete a copy of the attached Individual Named Employee form.
2. Are you a U.S. citizen? ☐ Yes ☐ No

   If no, describe your status and date of entry into USA: _____

   _____

   Date of Birth: _____ Place of Birth: _____
3. Education and Experience:
   a. Institution: _____
   b. Name and Address / Years of Training / Degree or Certification Attained

   _____ From _____ To _____ _____

   _____ From _____ To _____ _____

   _____ From _____ To _____ _____
4. Where have you practiced your profession during the last 10 years?

   _____ From _____ To _____

   _____ From _____ To _____

   _____ From _____ To _____
5. Have you ever failed any professional licensing or specialty organization examination? ☐ Yes ☐ No

   If YES, please attach a detailed explanation, including the dates and location.

F. APPLICANT PRACTICE

1. Please indicate your professional specialty (check all that apply). Please also Indicate the approximate annual receipts of your patients or clients among these procedures.

☐ Full Body Waxing	$	☐ Laser Non-Ablative Skin Resurfacing	$
☐ Laser Hair Removal	$	☐ Laser Vascular Lesions Treatment	$
☐ Laser Photo Rejuvenation	$	☐ Light Source Hair Removal	$
☐ Anti-Aging Treatments	$	☐ Laser Ablative Resurfacing	$
☐ BOTOX Cosmetic Services	$	☐ Laser Treatment of Vascular Leg Veins	$
☐ Microdermabrasion	$	☐ Optical Diagnostic Imaging	$
☐ Chemical Peels	$	☐ Non-Ablative Photo-rejuvenation	$

☐ Skin Rejuvenation	$	☐ Optical Diagnostic Services	$
☐ Collagen Injections	$	☐ Non-Ablative Wrinkle Reduction	$
☐ Eye Brow Coloring	$	☐ Remodeling of Acne Scars	$
☐ Sciero Therapy	$	☐ TELANGIECTASITS Treatment	$
☐ Permanent Makeup	$	☐ Port Wine Stains Treatment	$
☐ Elysee Exfoliations	$	☐ Skin Cooling Treatment	$
☐ Electrolysis	$	☐ Skin Cancer Treatment	$
☐ Massage Therapy	$	☐ Laser Treatment of Cutaneous Vascular Lesions	$
☐ Herbal Medicine	$	☐ Removal or Treatment of Warts, Moles, Cysts, Keratosis Skin Tags, and other benign growths	$
☐ Weight/Stress Mgmt.	$	☐ Non-Ablative Remodeling of Photo-damaged Skin	$
☐ Collagen Remodeling	$	☐ Low-Level Therapy for Migraines, Arterial Disease, Diabetes Mellitus, Coronary Artery Disease, or Prolapsed Interverbebral Disc.	$
☐ Tissue Welding	$	☐ Laser Tattoo Removal	$
☐ ACID Peels	$	☐ Other: _____	$

2. Please provide the number of patient or client visits:

TYPE OF VISIT	NUMBER OF VISITS LAST 12 MONTHS	NUMBER OF VISITS NEXT 12 MONTHS
Clinic		
Laboratory		
Other (Specify)		
TOTAL NUMBER OF VISITS		

3. Please specify any professional societies or associations in which you are a member: _____

_____

_____

4. Are you associated with, or do you work for a physician, surgeon, dentist, or dermatologist? ☐ Yes ☐ No
   a. If Yes, please give the name and the specialty of the licensed person:

   _____

5. Are all individuals in accordance with applicable state and federal regulations? ☐ Yes ☐ No
   If NO, please attach an explanation.
6. Do you perform or assist in any surgical procedures? ☐ Yes ☐ No
   a. If yes, list all surgical procedures performed (including minor surgery): _____

   _____

   _____

   _____

b. Is anesthesia, other than topical anesthesia or by means of local infiltration, administered by either yourself or someone else? ☐ Yes ☐ No
If YES, please attach a detailed explanation.

c. Do you perform/assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ☐ Yes ☐ No

If YES, please attach a detailed explanation.

7. Do you perform radiation therapy? ☐ Yes ☐ No

8. Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action? ☐ Yes ☐ No
If YES, please attach a detailed explanation.

G. PERSONNEL

1. Please list the number of independent contractors who provide professional services on your behalf. If NONE, state NONE.

CONTRACTOR PROFESSION	NO.	CONTRACTOR PROFESSION	NO.	CONTRACTOR PROFESSION	NO.
Inhalation Therapists		Laboratory Technicians		Nurse Anesthetists	
Nurses, Licensed Practical		Nurse Practitioner		Nurse, Registered	
Opticians		Optometrists		Perfusionists	
Pharmacists		Physiotherapists		Social Workers	
Speech Therapists		Other (specify)		Other (specify)	

2. Do you supervise any individuals who are not your own employees? ☐ Yes ☐ No

If YES, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

_____

_____

_____

H. APPLICANT HISTORY/CLAIMS

1. Attach a detailed explanation for any "Yes" answers. Have you or any of your employees:

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 of a violation of any law or ordinance, other than traffic offenses? ☐ Yes ☐ No

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

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

e. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

f. Had any claim or suit been brought against you/them? ☐ Yes ☐ No

2. Does each employed or contracted physician, surgeon, or dentist maintain separate Medical Malpractice Insurance? ☐ N/A ☐ Yes ☐ No

3. List any board certifications you hold: _____

4. Do you provide "in home" treatment or services of any kind? ☐ Yes ☐ No

   If YES, please explain: _____

5. Is there anyone employed or contracted that is a member of the Nurses Service Organization (NSO)? ☐ Yes ☐ No

   a. Name(s) of such person(s): _____ ☐ RN ☐ LPN ☐ NP ☐ CN

   b. Does that person have Professional Liability insurance with NSO? ☐ Yes ☐ No

6. Is all labeling of drugs and use of devices with approval of the FDA? ☐ Yes ☐ No

   If NO, explain: _____

7. Does your firm formally and fully disclose whether or not any device or treatment is considered investigational, and also fully and formally disclose any off-label use of devices, drugs or other materials? ☐ Yes ☐ No

   If NO, please explain: _____

   _____

8. Do you take before and after pictures, and pictures at various stages of treatment or care of every patient? ☐ Yes ☐ No

   If NO, why not? _____

9. Do you keep records and/or journals that will document your:

   a. Education received? ☐ Yes ☐ No

   b. Certificates issued? ☐ Yes ☐ No

   c. Dates and number of hours of education or training? ☐ Yes ☐ No

I. Medical Equipment

1. Does Applicant sell, rent, or lease any medical equipment to others, or do maintenance on same? ☐ Yes ☐ No

   If yes, list total annual gross receipts: $_____; and indicate the receipts per each category below:

Category I	EXPENDABLE ITEMS – Intended for one-time usage and disposed (i.e., adhesive tape, bandages, or hypodermic needles, etc.). Annual Sales: $_____
Category II	NON-EXPENDABLE ITEMS – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, patient lifts, traction apparatus, or ambulatory aids such as walkers, wheelchairs, etc. Annual Sales: $_____ Annual Revenue from Lease/Rental: $_____
Category III	DIAGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices. Annual Sales: $_____ Annual Revenue from Lease/Rental: $_____

Category IV	LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition. Annual Sales: $_____ Annual Revenue from Lease/Rental: $_____

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

PHYSICIANS AND SURGEONS CLAIMS-MADE COVERAGE

ADDITIONAL INFORMATION FORM

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheets if necessary.

QUESTION #	COMMENTS

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any

premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name

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NAMED NURSE INFORMATION

(RNS, LPNS, AND NURSES AIDES)

Applicant/Insured _____ Date: _____

Address _____

NOTE: Only Nurses, (RNS, LPNS, and AIDES) scheduled will be provided coverage under any policy issued to an Insured by the Insurer. Nurses without State License numbers will be excluded from coverage.

NAME AND ADDRESS	DATE OF BIRTH	STATE LICENSE NUMBER	RNS / LPNS / AIDE	STATE	DATE HIRED

Signature: _____ Title: _____