GeneralStar
Beyond Security®

SUPPLEMENTAL APPLICATION

MEDICAL SPA
MISCELLLANEOUS HEALTHCARE FACILITIES

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

I. GENERAL INFORMATION

1	Applicant Name:			
2	Indicate your Medical Director(s) and his/her medical specialty:			
3	Who provides the "good faith exam" at your facility? :			
4		Projected	First Past Year	Second Past Year
	Annual gross revenues:			
	Annual Outpatient/Client visits:			
5	Total personnel at your facility:	Full- Time	Part- Time	Total
	Employees			
	Contractors			
6	Is a resume, curriculum vitae (CV), or training certificate secured for each individual indicated above?			☐ Yes ☐ No

II. OPERATIONS

1	Do you require that patients sign an Informed Consent form:	☐ Yes ☐ No
2	Do all physicians/dentists and other licensed professionals performing procedures at your facility carry professional liability insurance?	☐ Yes ☐ No
3	Are parent/guardian signatures required on Informed Consent forms for parents of clients under the age of 18?	☐ Yes ☐ No
4	Do you sell any products with the facility's name and/or label on them? If yes, attach complete product list. Annual sales:	☐ Yes ☐ No
5	Do you ever hold off-site events? If yes, please describe:	☐ Yes ☐ No
6	Are food and/or beverages served or sold on premises?	☐ Yes ☐ No
7	Is liquor served or sold on premises? If yes to either of the above, please indicate annual sales: Food / Beverages: Liquor:	☐ Yes ☐ No
8	Is any cooking/food preparation done on premises? If yes, please describe:	☐ Yes ☐ No
9	Please indicate the number of the following at your premises (if none, show "N/A"):	
	Swimming Pool	Number
	Sauna	
	Steam Room	
	Whirlpool – type Spa	
	Tanning Booths	
	Other (describe)	
1 0	Do you operate a fitness club? If yes, please describe:	☐ Yes ☐ No
11	Do you provide daycare services for your patients/clients? If yes, provide the following:	☐ Yes ☐ No
	a Maximum number of children at one time:	
	b Do you accept infants < 3 months of age?	☐ Yes ☐ No
	c Ratio of Staff to children:	
	d Activities provided:	
	e Are the parents/guardians allowed to leave the premises without their child(ren)?	☐ Yes ☐ No

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III. PROCEDURES AND PERSONNEL

12 A. Please check (✔) which of the following indicates your core professional specialty:

☐ Aesthetic / Cosmetic
☐ Preventative / Wellness
☐ Complementary / Alternative

B. Please check (✔) all procedures performed at your facility:

Aesthetic / Cosmetic	Preventative / Wellness	Complementary / Alternative
☐ Acne Therapy	☐ Addiction Therapy	☐ Acupuncture
☐ Botox / Collagen	☐ Bone Density	☐ Ayurvedic Medicine
☐ Cellulite	☐ Cardiovascular Medicine	☐ Biofeedback
☐ Chemical Peels	☐ Colonoscopy	☐ Chelation Therapy
☐ Dentistry	☐ Diabetes	☐ Chinese Medicine
☐ Dermatology	☐ Executive Health	☐ Chiropractic
☐ Laser Hair	☐ Screening	☐ Detoxification
☐ Laser Skin	☐ Imaging Tests	☐ Homeopathy
☐ Liposuction	☐ Lab Tests	☐ Hormone Therapy
☐ Microdermabrasion	☐ Nutrition	☐ Mesotherapy
☐ Permanent Makeup	☐ Pain Management	☐ Mind/Body Medicine
☐ Photo Rejuvenation	☐ Physical Examinations	☐ Naturopathic Medicine
☐ Plastic Surgery	☐ Physical Therapy	☐ Nutrition Therapy
☐ Pre-/ Post- Operative	☐ Pre- / Post- Natal	☐ Spirituality & Healing
☐ Sclerotherapy (veins)	☐ Sexual Health	☐ Thermal Waters
	☐ Sleep Health	☐ Western Herbal Medicine
	☐ Weight Loss	
Other:	Other:	Other:

C. Aesthetic / Cosmetic - Number of Professionals performing these procedures:

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Procedure	Designation of Professional(s) Performing Procedure	# of Procedures Performed Annually at Your Facility
Acne Phototherapy and /or Photo Rejuvenation (blue light)		
Dental (specify Type)		
Facial Peels: a. Chemical b. Mechanical (aka dermabrastion, microdermabrasion) c. Laser application		
Injections: a. Botox b. Collagen, Fat, Silicone		
Hair Removal: a. Electrolysis b. Laser Application		
Hair Transplant		
Lipsuction (specify type)		
Permanent Makeup		
Plastic Surgery (specific type)		
Sclerotherapy (veins)		

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	Other (specific type)		

D	Do you take before and after pictures of patients involving the above (item C) procedures? If no, please explain:	☐ Yes ☐ No
E	Preventative / Wellness Number of Professionals performing these procedures:	☐ Yes ☐ No
F	Is any methadone treatment administered? If yes, indicate annual number of treatments and Provide a description of treatment and controls used	☐ Yes ☐ No
G	Is imaging performed at your facility? If yes, indicate annual number of tests:	
	a Mammograms	☐ Yes ☐ No
	b Ultrasounds	☐ Yes ☐ No
	c Bone Density	☐ Yes ☐ No
	d MRI/CT Scans	☐ Yes ☐ No
	e Other (describe)	☐ Yes ☐ No
H	Do you use drugs as part of weight treatment plan for patients/clients? If yes, what is the percent of practice devoted to weight reduction: _____ %; and *1.* Provide a list of drugs used and frequency and duration of prescriptions; and 2. Provide screening protocols for patients undertaking a weight treatment plan.	☐ Yes ☐ No
I	Do you sell dietary supplements? If yes, identify brand names: Annual sales:	☐ Yes ☐ No
J	Complementary / Alternative: Number of Professionals performing these procedures:	☐ Yes ☐ No

Procedure	Designation of Professional(s) Performing Procedure	# of Procedures Performed Annually at Your Facility
1. *Acupuncture* a. *Limited to analgesia* *Identify treatment use:*		
b. *With laser or electro:* *Identify treatment use:*		
c. *With direct moxibustion* Identify treatment use and indicate scarring or non-scarring:		
2. Chelation Therapy as treatment for *Arteriosclerosis*		
3. Chiropractic Manipulation under *Anesthesia*		
4. Other (specify type):		

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VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.
By signing this Application, you represent and agree to each of the following five (5) items:

1	You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and	
2	This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply)	
	☐ Claim Information Supplemental Application	☐ Statement of No Known Claims Letter
	☐ Other:	
3	Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:	
	a	Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
	b	Representations you are making on behalf of all persons and entities proposed to be insured;
	c	A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4	This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.	
5	You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.	

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COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

Signature:	**Date:**
Print Signature:	

ADDITIONAL INFORMATION	
Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.	
Section # and Question #	**Comments**
Signature:	Date:

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