LASER APPLICATION

Applicant Name: _____ Phone: _____
Business Name: _____
Email Address: _____ Website: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Business Address #1: _____
City: _____ State: _____ Zip: _____ ✧Square Feet _____
Type of Facility? _____
Business Address #2: _____
City: _____ State: _____ Zip: _____ ✧Square Feet _____
Type of Facility? _____

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

Business operated as Medi-spa? ☐Yes ☐No If not, other: _____

Annual gross receipts from all operations? _____

Total number of procedures performed annually? _____

How long in business? _____ Do all professionals have licenses? ☐Yes ☐No

Products liability needed for products sold by you? ☐Yes ☐No Gross receipts (excluding private label) _____

Do you private label products for sale ☐Yes ☐No This requires a separate application

Do you want to include General Liability ☐Yes ☐No If yes, provide Square Feet above ✧

If No what company insures your General Liability? _____

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

If yes please provide details: _____

Do you have: Saunas/Steam Rooms? ☐ Yes ☐ No If yes, # to Insure: _____
Soaking Pools? ☐ Yes ☐ No If yes, # to Insure: _____
Showers? ☐ Yes ☐ No If yes, # to Insure: _____

I. BEAUTY SERVICES

Category – Pick the best ONE for each technician based on definitions below.	**Number to be Insured**
Beauticians	
Massage	
Aesthetician	
Medical Aesthetician, do you use Levulan? ☐ **Yes** ☐ **No**	
TOTAL NUMBER OF TECHNICIANS	

Are any of the technicians above covered for other medispa services on this policy? If so, list technician names:

_____

DEFINITIONS:

* **BEAUTICIANS**: Hair, Nails, Eyelash & Brow Enhancements, Waxing, Threading, Topical Makeup Application
* **MASSAGE:** Massage, Body Wraps, Endermologie, Reiki
* **AESTHETICIANS**: All Beautician services AND Facials, Aesthetic Peels, Body Wraps, Massage, Electrology, Microdermabrasion, Ear Piercing, Airbrush Tanning, Ear Candling, Aesthetic Body Treatments
* **MEDICAL AESTHETICIANS:** All Beautician, Aesthetician Services AND Needling/MCA, Medical Grade Peels, LED/Microcurrent, Non-invasive Ultrasound, Radio Frequency, Dermaplaning, Ear Candling

1.1 Have you ever been trained in massage? ☐ Yes ☐ No
1.2 Do you use a consent form for medical peels? ☐ Yes ☐ No
1.3 Do you want coverage for sexual abuse? ☐ Yes ☐ No
(If yes choose limit) ☐ $50,000 Aggregate/$25,000 Claim ☐ $100,000 Aggregate/$50,000 Claim ☐ $200,000 Aggregate/$100,000 Claim
☐Other Limit: _____

II. TEETH WHITENING/HAIR STIMULATION

If this section does not apply, check here ☐

2.1 Total Number of Units to be covered? _____

2.2a Do you provide customers with home whitening products? ☐ Yes ☐ No

2.2b If yes, do you provide written instructions for home use? ☐ Yes ☐ No

2.3 Have all operators been trained in LED Hair Stimulation? ☐ Yes ☐ No

On behalf of all LED Teeth Whitening technicians, I understand:

1. Every client must sign a consent & dental history form. No coverage will apply if there is not a signed form on file.
2. I understand there is no coverage for any prescription anesthetic use.
3. I understand if I treat pregnant women a written doctor's approval will be on file.

On behalf of all Hair Stimulation technicians, I understand:

1. Coverage is excluded for any guarantees of hair growth
2. Coverage is available only for units designed specifically for hair stimulation
3. I understand for coverage to apply only trained technicians will turn on or operate the Device.
4. I understand a signed consent and medical history form must be on file for coverage to apply

Signed _____ Dated: _____

III. LASER/IPL/RADIO FREQUENCY SERVICES

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

I am submitting my own forms for approval ☐ I will use PPIB Approved Forms ☐

3.2 Do you provide goggles or eye shields for all laser/IPL work on faces? ☐ Yes ☐ No

3.3 Are you in compliance with all FDA and state laws as to use of lasers/IPLs/Light devices? ☐ Yes ☐ No

On behalf of all laser operators endorsed herein, I understand:

1. The Fitzpatrick Scale. I will not be insured to work on Skin Types V & VI unless I have 6 months of experience with Lasers/IPLs.
2. It is warranted that for Class III & IV devices goggles must be worn by all people in the room at all times the laser is in use. All reflective surfaces will be covered.
3. Every client must sign a consent & medical history form. No coverage will apply if there is not a signed form on file.
4. For Class IV laser use, the room door will stay locked at all times the laser is in use or a sign must be posted on door: LASER IN USE, DO NOT ENTER
5. I understand there is no coverage for EMLA anesthetic use.
6. No insurance will be offered for the following treatments: i. any raised tissue with its own blood supply (such as moles), ii. Skin that is ulcerated, broken (not intact), blistered or has open sores; iii. Bulging veins,veins or cherry hemangiomas over 3.0 millimeters.
7. I understand coverage for laser hair removal work on individuals under the age of 14 is excluded
8. I understand all new Laser/IPL technicians must have six months experience or thirty hours training to be eligible for laser/IPL coverages
9. I AM USING ONLY CLASS III AND IV DEVICES THAT HAVE BEEN APPROVED FOR SALE BY THE FDA.

_____

Signature of Applicant/Title Dated

We prefer you use the carrier approved consent, medical history and aftercare forms that are available at www.medispa-ins.com

No insurance binding can be considered until all forms are approved by PPIB

OPERATOR INFORMATION *(Laser/IPL/Radio Frequency)*

OPERATOR TO BE NAMED: _____

1. Licenses held & license numbers: _____
2. How long have they been working with these devices? _____
3. What services do you offer: ☐ Laser Hair removal ☐ Photo Rejuvenation ☐ Tattoo removal ☐ Rosacea ☐ Skin Tag Removal ☐ Veins (up to 3.0mm, spider veins) ☐ Nonablative wrinkle reduction ☐ Cellulite Reduction ☐ Nail/Toe Fungus ☐ Age/sun spots ☐ Smoking Cessation ☐ Laser Acupuncture Weight Loss ☐ Laser allergy services ☐ Laser acupuncture
4. What other services, not listed above, do you offer? _____
5. Education in light source equipment: List all information as requested

Date	Class Title	Number of Hours

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Photocopy this page if covering more than 3 people

IV. MEDICAL DIRECTOR

4.1 Is there a medical doctor on your staff? ☐ Yes ☐ No Do they work out of your office? ☐ Yes ☐ No

4.2 Give name and degree of your supporting doctor: _____

4.3 Do you want to cover the doctor as medical director on the policy? ☐ Yes ☐ No

4.4 If yes, indicate any claims they have had in their medical career:

4.5 Is the doctor a medical director for other facilities? ☐ Yes ☐ No

4.6 If so, should coverage be extended? ☐ Yes ☐ No

Number of facilities: _____

For what services: _____

_____

V. DIRECT PATIENT CARE/PHYSICIAN

If this section does not apply, check here ☐

5.1 Name of Physician(s): _____

5.2 Do you offer Direct Patient Care for services not otherwise listed on this application? ☐ Yes ☐ No

If Yes, please describe services: _____

_____

Do you offer prescriptions not otherwise listed herein? ☐ Yes ☐ No

If Yes, please list categories: _____

_____

VI. ADDITIONAL OPERATORS/SERVICES PROVIDED (Additional applications may be required)

	Technician	Services Provided	Yrs of Experience
OTHER SERVICES	1.		
	2.		
	3.		

☐ Removal of Warts
☐ Removal of Moles
How are they removed?
_____

☐ Acupuncture
☐ Hypnosis
☐ Acne Subcision

☐ Oxygen Devices # of Units _____
☐ Flotation Devices # of Units _____
☐ Hyperbaric Oxygen Chambers # of Units _____
☐ Salt Caves/Rooms # of Rooms _____
☐ UV Tanning # of Units _____
☐ Foot Detox # of Units _____

Category	Number to Insure
Permanent Makeup Techs	_____
Personal Trainers	_____
Colon Hydrotherapy Techs	_____

Optional Coverages – Check Boxes for Those Coverages You Would Like a *Quote*

Defense Outside Limits ☐ Yes ☐ No
Defense Outside the Limits ☐ Yes ☐ No
HIPAA Reimbursement ☐ Yes ☐ No
Communicable Disease ☐ Yes ☐ No

VII- HISTORY: NOTE: All questions must be answered. **Failure to disclose claims history could invalidate coverage.**

7.1 Do you currently have insurance coverage? ☐ Yes ☐ No If yes, indicate the following:

Insurer	*Policy #*	*Liability Limits*	*Premium*	*Exp. Date*

If claims made, most recent retroactive date: _____

7.2 Have you ever had professional liability insured refused, declined, cancelled or accepted on special terms? If yes, provide details on a separate sheet ☐ Yes ☐ No

7.3 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

7.4 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

7.5 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

7.6 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

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the 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.

I understand 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.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

APPLICANT SIGNATURE	**TITLE**
DATE	**REQUESTED EFFECTIVE DATE**
LIABILITY LIMIT REQUESTED	

Can we email you your policy *(usually within 2-3 weeks)* ☐ **Yes** ☐ **No** _____@_____

One box below must be checked:

☐ **I ELECT TO PURCHASE TERRORISM COVERAGE AT AN ADDITIONAL PREMIUM**

☐ **I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT AN ADDITIONAL PREMIUM**

ADDITIONAL INSURED: Certificate Holder (Landlord or Lessor) If necessary, add other names on separate paper.

NAME:_____

ADDRESS:_____

Submit