Professional Program Insurance Brokerage is a
Division of SPG Insurance Solutions, LLC ©2024

Thank you for your trust in PPIB to support you with your Insurance needs. We're thrilled to do business with you and help protect what matters most to you. To get started, please follow these steps:

How to Submit Application

1. Complete Application -- Fill out the required information on the next few pages.
2. Save Application -- Once completed, save a copy to your computer so you can email it.
3. Sign Application -- Ensure it is signed by the business owner, either electronically or printed and signed.
4. Submit Application -- Send signed application to **submissions@ppibcorp.com.**

What to Expect Next?

After receiving your application, we will send you a confirmation email acknowledging receipt.

Within 3-5 business days, one of our insurance experts will reach out to you with any follow-up questions or a quote, depending on the status of your submission.

If you need the quote expedited, please indicate this when you submit your application via email.

If you need further assistance with the application, or have additional questions, please feel free to contact us at:

PHONE:
415.475.4300
877.655.0123

FAX:
415.475.4303

Submissions: submissions@ppibcorp.com

Let's Get Started

Fill Out Application on Next Page

MEDISPA APPLICATION

SECTION I: GENERAL INFORMATION

1. Applicant Name (First, Last): _____ Phone Number: _____
2. Business Name: _____
3. Email Address: _____ Website: _____
4. Your Mailing Address: _____
   City: _____ State: _____ Zip code: _____
5. Your Business Address (1): _____
   City: _____ State: _____ Zip code: _____
   County: _____ Sq Ft: _____
   Do you hold the lease for this location? ☐Yes ☐No
6. Business Address (2): _____
   City: _____ State: _____ Zip code: _____
   County: _____ Sq Ft: _____
   Do you hold the lease for this location? ☐Yes ☐No
7. Business operated as: ☐Corporation ☐LLC ☐LLP ☐Partnership ☐Individual ☐Independent Contractor
8. Is your business open 24 hours? ☐Yes ☐No
9. How long have you been in business? Annual gross receipts for all product sales: Annual gross receipts from all operations:

   _____ _____ _____

10. Is your business part of a franchise? ☐Yes ☐No If Yes, which one? _____
11. Do you provide services in homes of clients? ☐Yes ☐No If Yes, describe: _____
12. Do you provide services out of your home? ☐Yes ☐No If Yes, describe: _____
13. Do you have a mobile unit you provide services in? ☐Yes ☐No If Yes, describe: _____
14. Are you in compliance with all city, county, state ordinances? ☐Yes ☐No
15. Are you in compliance with CDC / Health Department guidelines? ☐Yes ☐No
16. Do all professionals have licenses / certifications for all states where services are performed? ☐Yes ☐No
17. Does the business have a company-wide privacy policy for keeping customer's information secure? ☐Yes ☐No
18. Is your company in compliance with Health Insurance, Portability & Accountability Act (HIPAA)? ☐Yes ☐No
19. Do you obtain written consent for any client photos posted online? ☐Yes ☐No ☐N/A
20. What type of anesthetics do you use? ☐Topical/Local ☐General/IV ☐Nitrous Oxide ☐N/A
    ☐Other: _____
21. Check ONE of the below regarding coverage for your technicians and / or artists:

    ☐I intend to cover technicians and / or artists working under my business name

    OR

    ☐I require all technicians and / or artists to obtain their own insurance and name my business as additional insured under their policy for professional and general liability

22. For new clients only, do you currently have insurance coverage? ☐Yes ☐No

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

If Claims Made, provide Retroactive Date: _____

MEDISPA APPLICATION

SECTION II: GENERAL LIABILITY

If this Section does not apply, Check Here ☐

1. Do you need General Liability? ☐Yes ☐No

   If No, what Company insures your General Liability Coverage? _____

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

   a. Wet Saunas: _____ b. Steam Rooms: _____ c. Salt Caves: _____

   d. Floatation Pods: _____ e. Soaking Pools / Tubs: _____

3. Does your lease require higher than $50K for Damage to Rented Premises? ☐Yes ☐No

   (this does NOT mean bodily injury and property damage)

   If Yes, select limits: ☐$100,000 ☐$300,000 ☐$500,000 ☐$1,000,000

4. Do you sell non-beauty or non-Medispa related products? ☐Yes ☐No

   If Yes, describe: _____ Gross receipts: _____

5. Do you sell any CBD / Hemp Products ☐Yes ☐No Gross receipts: _____

6. Do you have private label products for sale? ☐Yes ☐No

   If Yes, answer questions a-i:

   a. Provide gross receipts for private label products ONLY: _____

   b. Describe products being sold: _____

   c. Do you manufacture any of these products? ☐Yes ☐No

   d. Are the ingredients / component parts purchased from the US / Canada? ☐Yes ☐No

      If No, where were they purchased? _____

   e. Any new products being introduced in the next 12 months? ☐Yes ☐No

      If Yes, explain: _____

   f. Any foreign sales? ☐Yes ☐No

      If Yes, what percentage to what countries? _____

   g. Do you have a written recall plan in place? ☐Yes ☐No

   h. Are your products tested for contaminants, potency, etc.? ☐Yes ☐No

      If No, explain: _____

   i. Are written instructions included with products or a list of inherent hazards and warning against ☐Yes ☐No

7. Mark if either of the following coverage is needed: ☐ Non-Owned Auto ☐Hired Auto

   If so, answer questions a-f:

   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: ☐None ☐1-25 ☐25+

   e. Approximate combined number of Hired Auto trips annually: ☐None ☐1-25 ☐25+

   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? **If No, coverage will be excluded.** ☐Yes ☐No

SECTION III: TEACHING OF ANY SERVICE(S)

If this Section does not apply, Check Here ☐

1. Are you teaching or training any services to students who are not your current employees? ☐ Yes ☐ No

If Yes, answer questions a-f:

a. Are all students being taught 18 years of age or older? ☐ Yes ☐ No

b. How many students will be trained in the next 12 months? _____

c. How many hands-on procedures will each student perform for each service being taught? Describe (per service):

_____

d. Do you use a consent form that expressly states that individuals are being worked on by students? ☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own forms (if already approved by PPIB, no need to resubmit) OR ☐ I will use PPIB approved forms (https://www.ppibcorp.com/clientforms/)

e. Do you guarantee Job Placement / Employability? ☐ Yes ☐ No

f. Provide name of each teacher: *If need to add additional teachers provide a list on a separate sheet.*

Name: _____ Name: _____

Name: _____ Name: _____

SECTION IV: MEDISPA AESTHETICS & NATURAL WELLNESS SERVICES

If this Section does not apply, Check Here ☐

Schedule of Services	# of People Performing
Beauty Services: *Hair Dressing, Barbering, Manicures / Pedicures and Related Services, Topical Makeup Application, Eyelash Extensions / Tinting, Eyebrow and Facial Hair Threading, Waxing, Sugaring*	
Massage Therapy: *Massage, Body Wraps, Endermologie, Reiki, Dry Cupping (No Heat / Fire)*	
Natural Wellness Services: *Chakra Healing, Non-Cryo Compression Therapy, Yoga / Pilates Instruction, One-on-One Personal Training, Guided Meditation, Energy Healing, Hypnosis*	
Basic Aesthetics: *All Beauty Services, Massage Therapy, Natural Wellness Services, Facials, Aesthetic Peels, Electrology, Airbrush / Spray Tanning, Microdermabrasion, Needling / Collagen Induction Therapy Up to 2.0mm deep, LED Therapy, Microcurrent, Dermaplaning, Piercing for Earlobe and Outer Rim of Cartilage Only, Infrared Therapy, Infrared Saunas*	
Advanced Aesthetics: *All Basic Aesthetics, Medical Grade Peels, Cosmetic Ultrasound, Aesthetic Radio Frequency, Wart Removal, Skin Tag Removal, Aesthetic Cryo Spot Treatments, Non-Needle, Non-Prescription Spring Pressure Treatments, LED Teeth Whitening*	
Other Aesthetic Services: *Magnawave Energy Therapy, PEMF, TMS, TENS, BioFeedback Brain Optimization through wave technology including Energy Wave for Animals, Whole Body Vibration, Energy Wave Chair, Trichology, Topical PRP / PRF*	

Additional Aesthetic Services

☐ Microneedling over 2.0mm Deep	☐ Ear Candling	☐ Vajazzling	☐ Vajacials / Penacials
☐ Microneedling over 3.0mm	☐ Henna Tattoos	☐ Airbrush Tattoo	☐ Temporary Sticker Tattoos
☐ Body Jewels (excluding Vajazzling)	☐ Tooth Jewels	☐ Face and/or Body Painting	☐ Colon Hydrotherapy
☐ Permanent Jewelry	☐ Simple Nostril Piercing	☐ Anal Bleaching	☐ LED Hair Stimulation

Total Number of Technicians at Facility:	
Do you teach any of the above services?	☐ Yes ☐ No

SECTION V: AESTHETIC UNITS / DEVICES

If this Section does not apply, Check Here ☐

1. Answer Yes / No for each of the below:

a. UV Tanning Beds / Booths ☐Yes ☐No

b. Foot Detox: ☐Yes ☐No

c. Oxygen Inhalation Devices / Hydrogen Inhalation Devices: ☐Yes ☐No

d. Hyperbaric Oxygen Chambers: ☐Yes ☐No

If Yes, answer i-iii:

i. Do you require a primary care physician referral to provide treatment? ☐Yes ☐No

ii. Do you take medical insurance for this service? ☐Yes ☐No

iii. Are any Hyperbaric Oxygen Chamber(s) inflatable? ☐Yes ☐No

e. Vaginal Steam Baths (VSB): ☐Yes ☐No

i. I confirm my VSB consent form does warn clients of heat exposure. ☐Yes ☐No

SECTION VI: PERMANENT COSMETIC SERVICES

If this Section does not apply, Check Here ☐

Permanent Cosmetics / Pigment Removal: *Includes Ombré, Microblading, Microshading, Eyeliner, Eyebrows, Lips, Lipliner, Nipple Areola, Beauty Marks, Pigment Removal using commercially prepared Saline or Acid-Based solutions, Scar Camouflage, Bald Spot Repigmentation, Cheek Blush, Tiny Tattoos (2"x2" max)*

	Name(s) of Technician(s) to be Insured *If space is needed to add additional technicians provide a list on a separate sheet*	**Years of Experience**	**Do you teach any of these services?**
1.			☐Yes ☐No
2.			☐Yes ☐No
3.			☐Yes ☐No

TRAINING & EDUCATION

If less than 12 months of experience, provide training detail for each technician specific to these services and provide a copy of certificate of completion of training

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

1. 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 consent forms (if already approved by PPIB, no need to resubmit) **OR** ☐I will use PPIB approved forms (https://www.ppibcorp.com/clientforms/)

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

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

SECTION VII: DECORATIVE TATTOO & / OR BODY PIERCING

If this Section does not apply, Check Here ☐

1. Do all artists have formal training and/or have completed an apprenticeship in Tattooing and/or Body Piercing? ☐Yes ☐No
2. For minors, do you require written permission from a parent / guardian prior to service? ☐Yes ☐No ☐N/A
3. Do you use a Consent Form and Medical History Form on every client? ☐Yes ☐No

   If Yes, answer below:

   ☐I am submitting my own forms (if already approved by PPIB, no need to resubmit) **OR** ☐I will use PPIB approved forms (https://www.ppibcorp.com/clientforms/)
4. Do you offer tooth jewels? ☐Yes ☐No

Indicate number of Technicians				**# to be Insured**
All Tattoo / Body Piercers must have at least 1 year experience or be working under an apprenticeship for coverage to apply	Total Number of Tattoo Artists and / or Body Piercers:			
If you have 7 or less Technicians, please indicate name and service (s) performed:				
1.		☐Tattoo	☐Body Piercer	☐Both
2.		☐Tattoo	☐Body Piercer	☐Both
3.		☐Tattoo	☐Body Piercer	☐Both
4.		☐Tattoo	☐Body Piercer	☐Both
5.		☐Tattoo	☐Body Piercer	☐Both
6.		☐Tattoo	☐Body Piercer	☐Both
7.		☐Tattoo	☐Body Piercer	☐Both

Piercers under 1 Year Experience are limited to the following: *Eyebrow, Earlobe, Outer Rim Ear cartilage, Lower Lip-Sides and Center, Nostrils – Thin or Hyaline Cartilage Only, Navel, Nipples.*

Limitations to work on Minors:
Minor Piercing - *Ear, Nose, Lips, Tongue (midline only) & Eyebrow piercing on minors age 13 years or over with written parental consent (ear lobes children age 3 months or older) – if state law specifies an older age, you must follow state law.*
Minor Tattooing - *In states where legal age 16 or over with written parent consent.*

Equipment and Procedures –If Piercing answer questions 5-6

5. Is all jewelry you use made within US guidelines and/or meets EU / UK standards? ☐Yes ☐No
6. For new piercings, do you use jewelry specifically made for that purpose? ☐Yes ☐No

Equipment and Procedures –If Tattooing answer questions 7-8

7. Are all pigments you use from US or Canada manufacturers and/or EU / UK standards? ☐Yes ☐No
8. Do you EVER re-use needles? ☐Yes ☐No

SECTION VIII: LASER, IPL, RF (LIGHT / ENERGY)

If this Section does not apply, Check Here ☐

Light / Energy Professional (L/E Pro):	**DEVICES:** *FDA Class IIb, III & IV lasers & medical strength radio frequency.*
	SERVICES: *Hair removal, tattoo removal, veins, age spots, rosacea, photo rejuvenation, skin rejuvenation, skin tightening, wrinkle reduction, collagen induction therapy, cosmetic acne treatment, body contouring / cellulite treatment, scar revision, medical radio frequency, smoking cessation, acupuncture, skin tags, weight loss, allergy treatment, toe / nail fungus, psoriasis, vitiligo, erectile dysfunction, including all Light/Energy Basic services below.*
Light / Energy Basic ONLY (L/E Basic):	**DEVICES:** *FDA Class I or II, Low-Level Laser, Cold Laser, Plasma Device, hand-held cryotherapy device, radio frequency / high frequency (low level), non-invasive microwave.*
	SERVICES: *Wrinkle reduction, skin lesions, color correction, scar reduction, skin tags, age / sunspot treatments, cryo compression therapy, cosmetic ultrasound, pain therapy, skin tightening, destruction of fat cells, and / or the appearance of a smoother, more contoured area on the torso, arms or legs , body contouring / cellulite reduction (could be up to Class III device for this), hyperhidrosis, Vaginal Rejuvenation (NO HEAT), IntraOral services.*
Light / Energy Vaginal Rejuvenation II (L/E VRII):	*Heat generating CO2 including Light / Energy Vaginal Rejuvenation I*

TECHNICIANS & SERVICES

Name(s) of Technician(s) *If space is needed to add additional technicians, provide a list on a separate sheet*	**Medical Designation**	**Years of Experience**	**L/E Pro**	**L/E Basic ONLY**	**L/E VRII**	**Teacher**
1.			☐	☐	☐	☐
2.			☐	☐	☐	☐
3.			☐	☐	☐	☐
4.			☐	☐	☐	☐
5.			☐	☐	☐	☐

Indicate if any additional service(s) being performed:

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

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

1. Do you use a Consent Form and Medical History Form on every client? ☐ Yes ☐ No

If Yes, answer below:

☐ I am submitting my own consent forms (if already approved by PPIB, no need to resubmit) **OR** ☐ I will use PPIB approved forms (https://www.ppibcorp.com/clientforms/)

TRAINING & EDUCATION-*If less than 12 months of experience, provide training detail for each technician specific to these services and provide a copy of certificate of completion of training.*

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

SECTION IX: INJECTABLES

If this Section does not apply, Check Here ☐

Injectables:	*Botox for - Hyperhidrosis, Masseters, Décolletage, Trapezius & Platysmal Bands, Dermal Fillers in Face, Buttocks, Legs, Trapezius, Neck, Décolletage, Upper Arms, Earlobes & Hands, Carboxy Therapy, Sclerotherapy, Vitamins / Supplements, Mesotherapy, Kybella, Basic PRP, PRF (Platelet Rich Fibrin), Flu Shots, PDO Threading, Wound Healing (Only: Saline, Vitamins / Supplements, Lidocaine, and PRP), Immunotherapy for Allergies*
O / P Shots:	*Saline, Dermal Fillers and / or PRP into the Penis or "G" spot*
IV Therapy Only:	*Therapy provided through Intravenous means of Saline, Vitamins / Supplements, Anti-Nausea medication, Acetaminophen and Non-Steroidal Anti-Inflammatory Agents, with or without light.*
***Vitamin / Supplements:**	*The Injection of Vitamin A, B, C, D, E and K, Amino Acids, and / or other non-prescription therapeutic supplements.*

TECHNICIANS & SERVICES

	Name(s) of Technician(s) *If space is needed to add additional technicians provide a list on a separate sheet*	**Medical Designation**	**Years of Experience**	**Injectables**	**O and / or P Shots**	**IV Therapy**	**Teacher**
1.				☐	☐	☐	☐
2.				☐	☐	☐	☐
3.				☐	☐	☐	☐
4.				☐	☐	☐	☐

1. ☐ Orthopedic / Joint / Prolotherapy / Trigger Points Injections: Name of Technician(s): _____

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

2. Do you offer Kenalog Injections? ☐ Yes ☐ No Name of Technician(s): _____

3. Do you offer Ketamine Injections? ☐ Yes ☐ No

4. Do you offer services with Psilocybin or other Psychedelic drugs? ☐ Yes ☐ No

5. Other: _____

SECTION X: MEDICAL WELLNESS SERVICES

If this Section does not apply, Check Here ☐

Nutritional Services Only:	*Dietitian, Nutritional Counseling (no RX given), includes vitamin & supplements. Vitamin and Supplements include treatment with Vitamin A, B, C, D, E and K, Amino Acids, and or other Dietary Supplements*
Medical Wellness (Med Well):	*Appetite suppressants, hormone treatments, including pellets, vitamins / supplements, nutritional services and weight loss RXs including Wegovy & Rybelsus (semaglutide) & Mounjaro & Zepbound (tirzepatide), Phentermine, Phendimetrazine, Osymia, Topamax (topiramate), Contrave (naltexone HCl/bupropion HCl), Glucophage (metformin), Saxenda (liraglutide), and/or Xenical (orlistat)*

TECHNICIANS & SERVICES

	Name(s) of Technician(s) *If space is needed to add additional technicians provide a list on a separate sheet*	**Medical Designations**	**Years of Experience** *If less than 12 months of experience provide your certificate of completion of training*	**Nutritional Services Only**	**Medical Wellness**	**Teacher**
1.				☐	☐	☐
2.				☐	☐	☐
3.				☐	☐	☐

1. Confirm all technicians have been professionally trained and are licensed to perform the above services. ☐ Yes ☐ No
2. List any other weight loss RX medications: _____
3. Do you limit weight loss prescriptions for clients with a BMI of 25+? ☐ Yes ☐ No
4. Are using any compounded weight loss prescriptions? ☐ Yes ☐ No
   a. If Yes, are the prescriptions compounded with vitamin and supplements only? ☐ Yes ☐ No
   b. Are the prescriptions used from a licensed compounding pharmacy? ☐ Yes ☐ No
5. Do you require your client to acknowledge off-label use of prescriptions on the consent form? ☐ Yes ☐ No ☐ N/A

SECTION XI: INVASIVE PROCEDURES

If this Section does not apply, Check Here ☐

	Name(s) of Technicians *If space is needed to add additional technicians provide a list on a separate sheet*	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 Scar Subcisions

☐ Other: _____

4. Have you had specific training in each of the above services being performed? ☐ Yes ☐ No

5. Do you use a Consent Form and After Care Form on every client? ☐ Yes ☐ No

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

7. Devices being used for procedures: _____

8. If you are doing Fat Transfers, answer questions a-d:

   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

SECTION XII: WALK-IN CRYOTHERAPY UNIT

If this Section does not apply, Check Here ☐

1. Number of Walk-In Cryotherapy Units *(does not include handheld cryo devices)*: _____

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

3. If working on minors 14 and 15, do you have parent / guardian present at all times and a signed parental / guardian consent form? (*working on minors age 13 years and under is excluded*) ☐ Yes ☐ No ☐ N/A

4. Do you use a Consent Form and Medical History Form on every client? ☐ Yes ☐ No

If Yes, answer below:

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

OR

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

SECTION XIII: OTHER SERVICES

If this Section does not apply, Check Here ☐

☐ Micro-coring Name(s): _____

☐ Non-Energy Needling 3.1mm to 5.0 mm Name(s): _____

☐ Energy Based Needling 3.1mm to 5.0mm Name(s): _____

☐ Acupuncture Name(s): _____

1. What other services and/or operations not listed already do you need coverage for?

_____

SECTION XIV: OTHER COVERAGE OPTIONS

If this Section does not apply, Check Here ☐

1. Do you want coverage for Defense Outside the Limit? ☐ Yes ☐ No Limit Requested: _____
2. Do you want coverage for Sexual Abuse at $25K / $50K? ☐ Yes ☐ No Other Limit Requested: _____
3. Do you want coverage for Cyber Liability? ☐ Yes ☐ No If Yes, indicate limit: ☐ $250K ☐ $500K
4. Do you want a Communicable Disease Limit up to $100K? *($50K already included)* ☐ Yes ☐ No
5. Do you want a License Action Reimbursement Limit up to $50K? *($25K already included)* ☐ Yes ☐ No
6. Do you want a HIPAA Limit up to $500K? *($250K already included)* ☐ Yes ☐ No

SECTION XV: ADDITIONAL INSURED

If this Section does not apply, Check Here ☐

Please note policies with General Liability coverage automatically include blanket Additional Insured coverage for all Landlords, Lessors or Leased Equipment, Tradeshow Sponsors, City / Health Departments and/or Permitting Offices, including Waiver of Subrogation and Primary / Non-Contributory Wording if contractually required.

1. Do you have an Additional Insured (AI) not included above who needs to be listed as an AI under the General Liability coverage? ☐ Yes ☐ No
   a. AI Name #1: _____
   b. Address: _____ Business Location #: _____
   c. Does the AI require the following? ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation
   d. Interest of Additional Insured? ☐ Franchisor ☐ Mortgagee ☐ City / Government agency ☐ Vendors ☐ Other: _____
   a. AI Name #2: _____
   b. Address: _____ Business Location #: _____
   c. Does the AI require the following? ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation
   d. Interest of Additional Insured? ☐ Franchisor ☐ Mortgagee ☐ City / Government agency ☐ Vendors ☐ Other: _____
2. Do you have an Additional Insured (AI) who needs to be named for Professional Liability? ☐ Yes ☐ No
   a. AI Name #1: _____
   b. Address: _____ Business Location #: _____
   c. Interest of Additional Insured? ☐ Franchisor ☐ Mortgagee ☐ City / Government agency ☐ Vendors ☐ Other: _____

MEDISPA APPLICATION

SECTION XVI: PROPERTY (Complete for **EACH** Location) If this Section does not apply, Check Here ☐

1. Location #: _____ Address: _____
2. Year Built: _____ Construction Type: _____ Number of stories: _____ Square Footage: _____
3. If building is over 20 years old, what year were the following upgraded? (*) information required
   *Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____
4. Roofing Material (Tile, Metal, Wood Shingles, etc.): _____
5. Are there sprinklers inside your unit? ☐ Yes ☐ No
6. Is there a Central Station Burglar Alarm inside your unit and in your control? ☐ Yes ☐ No
7. Do you sell or use jewelry? ☐ Yes ☐ No
   a. Do any of the pieces have a wholesale value of more than $250 per item? ☐ Yes ☐ No
   If Yes, please check value of jewelry ☐ $5K ☐ $10K ☐ $25K ☐ $50K ☐ over $50K
8. Name and address of Loss Payee: _____

Coverage Desired

Contents (excluding Light/Energy Devices): $: _____
Light/Energy Devices (if any): $: _____
Tenant Improvements: $: _____
Outside Sign: $: _____
Building: $: _____

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

Do you own the Building? ☐ Yes ☐ No

Optional Coverages

9. Do you want coverage for Property of Independent Contractors? ☐ Yes ☐ No
10. Do you want coverage for Contingent Business Income? ☐ Yes ☐ No $10K limit (Off Premise Power Outage)
11. Do you need coverage for any of this property in Transit or at a temporary Location? ☐ Yes ☐ No If Yes, $: _____

---

1. Location #: _____ Address: _____
2. Year Built: _____ Construction Type: _____ Number of stories: _____ Square Footage: _____
3. If building is over 20 years old, what year were the following upgraded? (*) information required
   *Roof: _____ *Plumbing: _____ *Wiring: _____ *HVAC: _____
4. Roofing Material (Tile, Metal, Wood Shingles, etc.): _____
5. Are there sprinklers inside your unit? ☐ Yes ☐ No
6. Is there a Central Station Burglar Alarm inside your unit and in your control? ☐ Yes ☐ No
7. Do you sell or use jewelry? ☐ Yes ☐ No
   a. Do any of the pieces have a wholesale value of more than $250 per item? ☐ Yes ☐ No
   If Yes, please check value of jewelry ☐ $5K ☐ $10K ☐ $25K ☐ $50K ☐ over $50K
8. Name and address of Loss Payee: _____

Coverage Desired

Contents (excluding Light/Energy Devices): $: _____
Light/Energy Devices (if any): $: _____
Tenant Improvements: $: _____
Outside Sign: $: _____
Building: $: _____

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

Do you own the Building? ☐ Yes ☐ No

Optional Coverages

9. Do you want coverage for Property of Independent Contractors? ☐ Yes ☐ No
10. Do you want coverage for Contingent Business Income? ☐ Yes ☐ No $10K limit (Off Premise Power Outage)
11. Do you need coverage for any of this property in Transit or at a temporary Location? ☐ Yes ☐ No If Yes, $: _____

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

1. Have you had any past Professional, General Liability, Cyber and / or Property Claims, whether or not insured? ☐Yes ☐No

If Yes, describe:

2. Do you have knowledge of an event, circumstance, or other (other than listed above) prior to the effective date of the proposed policy that may result in a claim or incident? ☐Yes ☐No

If Yes, describe:

3. 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? ☐Yes ☐No

4. Have you ever, or any applicant ever, been charged or convicted of a criminal offense? ☐Yes ☐No

5. Has any liability suit, arbitration or other claim proceeding been brought against you, your business, or any applicant for any alleged malpractice? ☐Yes ☐No

MEDISPA APPLICATION

SECTION XVIII: 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. All technicians have been properly trained and licensed as necessary for all services they are performing and/or on the devices they are using.
3. All technicians are properly licensed in each jurisdiction they are performing services in.
4. Every client (except for Medispa Aesthetics & Natural Wellness, Foot Detox or Nutritional Services) must sign a consent form for the particular service being provided prior to the treatment. No coverage will apply if there is not a signed & completed form on file. If I change a consent form for Laser / IPL, Walk-in Cryotherapy, Permanent Cosmetics, Decorative Tattooing or Body Piercing it must be approved by the insurance company.
5. All Permanent Cosmetics, Decorative Tattooing and Body Piercing equipment is pre-sterile, one-time use or sterilized to medical grade standards.
6. The business is in compliance with all AMA, FDA, CDC and / or State Laws for all devices, products, and services.
7. There are limitations to work on minors and individuals who are pregnant and / or nursing.
8. I understand that Class IV laser services and all Invasive procedures must be performed at a properly licensed business location (No residential sites).
9. I understand and agree this Application and any supplements attached hereto will be relied upon for the insurance policy.
10. I understand and agree that failure to provide true and accurate response to the forgoing questions may result in the voiding of the insurance issued in reliance on this application and/or denial of claims under the policy issued.
11. I authorize and consent to investigation of information of my business including authorization to every person or entity, public or private, to release the company, 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.
12. If I am aware of any claim or incident arising from any time prior to today, I must advise the company at this time.
13. The liability policy applied for may apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the policy or the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.
14. 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 or similar entity.

On Behalf of ALL Technicians Performing Laser / IPL services (if any), I understand:

1. All new Technicians need 6 months of 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 Technicians Performing Prescription Weight Loss Service (if any), I understand:

1. I will not provide prescription weight loss to those who are under 25 BMI.
2. That some trademarked medicine may not be allowed to be compounded.
3. The consent forms must mention if using off-label products.
4. I will not guarantee results.

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 the 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 -260º F.
4. All parts of body must remain at a distance of comfortable clearance from the active inner rim of the chamber during sessions.

On behalf of all Colon Hydrotherapy technicians (if any), I confirm:

1. The nozzle is discarded after use, or re-sterilized to medical standards.
2. Services are not performed on any individuals under 15 years of age.
3. A physician's prescription and parent/guardian permission is required prior to services being performed on individuals between the ages of 15 and 17 years.

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 Hyperbaric Oxygen Chambers (if any), I confirm:

1. Sessions are no longer than 5 hours.
2. Treatments will not be done on professional athletes.

(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 BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY.

APPLICANT SIGNATURE	TITLE	DATE SIGNED

REQUESTED EFFECTIVE DATE

LIABILITY LIMIT REQUESTED:

☐ $500K ☐ $1M ☐ $1M / $2M ☐ $1M / $3M ☐ $2M / $2M

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