GeneralStar™

# SUPPLEMENTAL APPLICATION FOR MEDICAL SPAS

## *MISCELLANEOUS HEALTHCARE FACILITIES PROGRAM*

*NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.*

**Instructions to the Applicant.**

A. This supplemental application must be accompanied by the General Application for Miscellaneous Healthcare Facilities Program, form GSM-MHCF-06-01.
B. Please answer **all** the questions on this supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
C. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
D. The application must be signed and dated by an owner, partner, officer or director of your facility.
E. The following additional information is required. Any delay in providing this information will delay the company's decision to provide requested coverage:
   1. Sample Patient Informed Consent forms
   2. Brochures, pamphlets, advertisements, or other descriptive literature of operations and services
   3. Credentialing guidelines

## I. GENERAL INFORMATION

This application has been formatted for ease of use based on the Applicant's core professional specialty. However, please answer each question as it relates to the professional services performed at the Applicant's facility.
Attach a separate page on the Applicant's letterhead if more space is required.

A. Applicant's / Entity's Name:_____

B. Indicate your Medical Director(s) and his/her medical specialty:

_____

Who is providing the "good faith exam" at your facility? _____

C. Annual gross revenues: Current: $_____ Projected: $_____

D. Annual Outpatient/Client visits: Current: _____ Projected: _____

E. Total personnel working at your facility:

| | Full Time | Part Time | Total |
|---|---|---|---|
| Employees* | | | |
| Contractors* | | | |

*Is a resume, curriculum vitae (CV), or training certificate attached for each individual indicated above? ☐ Yes ☐ No

## II. OPERATIONS

A. Do you require that patients sign an Informed Consent form? ☐ Yes ☐ No
B. Do all physicians/dentists performing procedures at your facility carry professional liability insurance? ☐ Yes ☐ No
C. Are parent/guardian signatures required on Informed Consent forms for patents/clients under the age of 18? ☐ Yes ☐ No
D. Do you sell any products with the facility's name and/or label on them? ☐ Yes ☐ No
   If yes, attach complete product list and indicate annual sales: $_____
E. Do you ever hold off-site events? ☐ Yes ☐ No
   If yes, please describe:
   _____

F. Are food and/or beverages served/sold on premises? ☐ Yes ☐ No
Is liquor served/sold on premises? ☐ Yes ☐ No
If yes to either of the above, please indicate annual sales:
Food / Beverages $ _____ Liquor $ _____

G. Is any cooking/food preparation done on premises? ☐ Yes ☐ No
If yes, please describe:
_____

H. Please indicate the number of the following on your premises (if none, write "N/A"):

| | Number |
|---|---|
| Swimming Pool | |
| Sauna | |
| Steam Room | |
| Whirlpool-type Spa | |
| Tanning Booths | |

Other (describe): _____

I. Do you operate a fitness club? ☐ Yes ☐ No
If yes, please describe:
_____

J. Do you provide daycare services solely for your patients/clients? ☐ Yes ☐ No
If yes, provide the following:
Maximum number of children at one time: _____
Do you accept infants < 3 months of age? ☐ Yes ☐ No
Ratio of Staff _____ to children _____
Activities provided: _____

Are the parents/guardians allowed to leave the premises without their child(ren)? ☐ Yes ☐ No

## III. PROCEDURES AND PERSONNEL

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 Screening | ____ Chiropractic |
| ____ Laser Hair | ____ Imaging Tests | ____ Detoxification |
| ____ Laser Skin | ____ Lab Tests | ____ Homeopathy |
| ____ Liposuction | ____ Nutrition | ____ Hormone Therapy |
| ____ Microdermabrasion | ____ Pain Management | ____ Mesotherapy |
| ____ Permanent Makeup | ____ Physical Examinations | ____ Mind/Body Medicine |
| ____ Photo Rejuvenation | ____ Physical Therapy | ____ Naturopathic Medicine |
| ____ Plastic Surgery | ____ Pre- / Post- Natal | ____ Nutrition Therapy |
| ____ Pre-/ Post- Operative | ____ Sexual Health | ____ Spirituality & Healing |
| ____ Sclerotherapy (veins) | ____ Sleep Health | ____ Thermal Waters |
| ____ Other (specify) | ____ Weight Loss | ____ Western Herbal Medicine |
| _____ | ____ Other (specify) | ____ Other (specify) |
| _____ | _____ | _____ |

**C. AESTHETIC / COSMETIC - Number of Professionals performing these procedures: _____. Complete the information below.**

| Name of Procedure | Designation of Professional(s) Performing Procedure | # of Procedures Performed Annually at Your Facility |
|---|---|---|
| 1. Acne Phototherapy and/or Photo Rejuvenation (blue light) | | |
| 2. Dental (specify Type) | | |
| 3. Facial Peels: | | |
| a. Chemical | | |
| b. Mechanical (aka dermabrasion, microdermabrasion) | | |
| c. Laser application | | |
| 4. Injections: | | |
| a. Botox | | |
| b. Collagen, Fat, Silicone | | |
| 5. Hair Removal: | | |
| a. Electrolysis | | |
| b. Laser Application | | |
| 6. Hair Transplant | | |
| 7. Liposuction (specify type) | | |
| 8. Permanent Makeup | | |
| 9. Plastic Surgery (specify type) | | |
| 10. Sclerotherapy (veins) | | |
| 11. Other (specify type) | | |

D. Do you take before and after pictures of patients involving the above (Item C) procedures? ☐ Yes ☐ No
If no, please explain:
_____

**E. PREVENTATIVE / WELLNESS – Number of Professionals performing these procedures: _____. Complete the information below.**

F. Is any methadone treatment administered? ☐ Yes ☐ No
If yes, indicate annual number of treatments: _____ and
attach description of treatment and controls used.

G. Is imaging performed at your facility? If yes, please indicate annual number of tests: ☐ Yes ☐ No

Mammograms _____
Ultrasounds _____
Bone Density _____
MRI/CT Scans _____
Other (describe) _____
_____

H. Do you use drugs as part of weight treatment plan for patients/clients? ☐ Yes ☐ No
If yes, percent of practice devoted to weight reduction: _____; and attach list of drugs used and frequency and duration of prescriptions; and copy of screening protocols for patients undertaking a weight treatment plan.

I. Do you sell dietary supplements? ☐ Yes ☐ No
If yes, identify brand names _____
Annual sales: $_____

**J. <u>COMPLEMENTARY / ALTERNATIVE</u> -- Number of Professionals performing these procedures: _____. Complete the information below.**

| Name of Procedure | Designation of Professional(s) Performing Procedure | # of Procedures Performed Annually at Your Facility |
|---|---|---|
| 1. Acupuncture | | |
| a. Limited to analgesia<br>Identify treatment use: | | |
| b. With laser or electro<br>Identify treatment use: | | |
| c. With direct moxibustion<br>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): | | |

**PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR FACILITY NOT SPECIFICALLY ADDRESSED HEREIN.**

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

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 fact material thereto, commits a fraudulent insurance act.

_____ _____ _____
Signature of Owner, Officer or Partner | Print Name and Title | Date