

Acne Blue Light Treatment						
Botox Injections						
Chemical Peels Specify Solution Strength_____						
Electrolysis						
Hair Transplants						
Laser Hair Removal						
Laser Skin Treatment Specify Type						
Massage						
Microdermabrasion						
Other Injections Specify Type (fat, collagen, silicone)						
Permanent Makeup/ Micropigmentation						
Other						

5. Are any of the procedures listed in question 4 above performed by a physician or dentist?*[] Yes [] No
 If Yes, do all physicians and dentists carry Professional Liability Insurance?[] Yes [] No

* If coverage is requested for any physicians or dentists submit a separate Application for Physicians & Surgeons Professional Liability Insurance (MM-30000) for each physician or Application for Dentists Professional Liability Insurance (SM666) for each dentist.

IV. STAFF

1. Does the Applicant employ anyone?[] Yes [] No
 If Yes, indicate by profession the number of individuals employed:

- ___ Aesthetician ___ Registered Nurse
- ___ Electrologist ___ Technician (specify type) _____
- ___ Massage Therapist ___ Other (describe) _____

2. Does the Applicant supervise anyone other than its own employees?[] Yes [] No
 If Yes,

(a) Indicate by profession the number of individuals supervised:

- ___ Aesthetician ___ Registered Nurse
- ___ Electrologist ___ Technician (specify type)
- ___ Massage Therapist ___ Other (describe)

(b) Provide a detailed explanation of the responsibilities for each profession and specify the relationship to the Applicant.

V. HISTORY

1. List the Applicant's prior Professional Liability Insurance for each of the last three (3) years, including the current year:
If none, check here []

Insurance Company	Limits of Liability	Inception/ Deductible (if any)	Expiration Dates Premium	Claims Made or Retroactive (MM/DD/YYYY) Occurrence Form	Date
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2. List the Applicant's prior General Liability Insurance for each of the last three (3) years, including the current year:
If none, check here []

Insurance Company	Limits of Liability	Inception/ Deductible (if any)	Expiration Dates Premium	Claims Made or Retroactive (MM/DD/YYYY) Occurrence Form	Date
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V. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's locations:

(a)

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
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1

2

3

4

(b)

	Location 1	Location 2	Location 3	Location 4
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Square Footage

Year Built

Year Remodeled

Number of Stories

Type of Construction
(frame, brick, concrete)

Percentage of Building
Occupied by Applicant

Other occupants?
(Yes/No)

2. Are all of the Applicant's locations equipped with:
 - (a) Complete Sprinkler System?.....[Yes [No
 - (b) At least two clearly marked exits on each floor?.....[Yes [No
 - (c) Self-closing fire doors on each floor?.....[Yes [No
 - (d) Automatic fire alarm system connected to a local fire department?.....[Yes [No
 - (e) Smoke detectors?.....[Yes [No
 - (f) Emergency electrical system?.....[Yes [No
 - (g) Heat sensors?.....[Yes [No
 - (h) Fire escape(s)?.....[Yes [No
 - (i) Posted emergency evacuation procedures?.....[Yes [No
 - (j) Properly maintained fire extinguishers?.....[Yes [No
3. Does the Applicant have a written safety program in place?.....[Yes [No
If Yes, attach a copy of the written safety program.
4. Does the Applicant have written procedures for incident reporting?.....[Yes [No
5. Do any of the Applicant's locations have any:
 - (a) Exposure to flammables, explosive, chemicals?.....[Yes [No
 - (b) Catastrophe exposure?.....[Yes [No
 - (c) Exposure to radioactive materials?.....[Yes [No
6. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? [Yes [No
7. Does the Applicant:
 - (a) Loan or rent machinery or equipment to others? [Yes [No
 - (b) Own any elevators or escalators? [Yes [No
If Yes,
(i) Provide the model of the elevator(s) and/or escalator(s):

(ii) Are the elevators and/or escalators serviced by the Applicant or under a maintenance contract? [Yes [No
 - (c) Own or rent any parking facility? [Yes [No
 - (d) Provide any recreational facility? [Yes [No
 - (e) Have a swimming pool on the premises? [Yes [No
 - (f) Sponsor any sporting or social events? [Yes [No
8. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? [Yes [No
If Yes, attach a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
9. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? [Yes [No
If Yes, provide details for each incident.

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

Name of Applicant _____ Title _____
Signature of Applicant _____ Date _____



Atlantic Specialty Lines, Inc.

APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.) PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis) APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

- a. Full name of Applicant: _____
- b. Principal business premise address: _____
(Street) (County)
- _____ (City) (State) (Zip)
- c. Professional Corporation (for profit) Partnership
 Professional Corporation (non-profit) Professional Association
 Other (describe) _____
- d. Date established: _____
- e. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____
- f. Business, corporate or partnership name: _____
- g. Name of all partners or members of the firm who provide professional services: _____

- h. Professional societies or associations in which you are a member: _____

- i. Please attach a copy of letterhead or other business stationery.

2. OPERATIONS

- a. States Clinics are registered and licensed to practice: _____

If none, please explain.
- b. Clinics professional specialty: _____

- c. Do you maintain any beds for overnight occupancy? Yes No. If yes, also complete application form SM 5864 or SM 686.
- d. Total sq. ft. that you occupy (all locations): _____
- e. Division of patients or clients:
- | | | |
|-------------------------------|----------------------------|---------------------------------------|
| (i) Hemodialysis _____% | (vii) Psychiatric _____% | (xiii) Bariatrics _____% |
| (ii) Holistic Medicine _____% | (viii) Drug Addicts _____% | (xiv) Physical Rehabilitation _____% |
| (iii) Surgical _____% | (ix) Alcoholics _____% | (xv) Disability Evaluation _____% |
| (iv) Stress Testing _____% | (x) Obstetrical _____% | (xvi) Research or Experimental _____% |
| (v) Communicable _____% | (xi) Dental _____% | (xvii) Other _____% |
| (vi) Family Planning _____% | (xii) Pediatric _____% | _____ 100% |

- f. Does Clinic use a collection agency?.....[Yes [No
 If yes, name of agency: _____
 Does the agency have authority to file a collection suit on Clinics behalf?.....[Yes [No
- g. Do owners, partners or directors, (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?.....[Yes [No
 If yes, give details including name, location, size and number of beds. _____

- h. Do you own or operate any business other than that shown in question 1a?.....[Yes [No
 If yes, please attach detailed explanations of this activity.
- i. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)?.....[Yes [No
 If yes, please attach a copy of ALL of the advertisements.
- j. Names and locations of any hospitals or institutions Clinic use is in practice: _____

- k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?.....[Yes [No
 If yes,
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?.....[Yes [No
 (ii) Provide the name and title of the Applicant's Privacy Officer. _____
 Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

3. PROFESSIONAL SERVICES

- a. Do you perform:
- (i) Acupuncture or acupuncture anesthesia? Explain: _____[Yes [No
 (ii) Angiography/arteriography/venography? Describe: _____[Yes [No
 (iii) Catheterization (other than urinary or umbilical)? Describe: _____[Yes [No
 (iv) Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion?.....[Yes [No
 (v) Injection of radioisotopes and/or use of irradiated substances? Describe:.....[Yes [No

 (vi) Radiation therapy and/or chemotherapy? Describe: _____[Yes [No
 (vii) Psychiatric shock therapy?.....[Yes [No
 (viii) Silicone injections? Describe: _____[Yes [No
 (ix) Spinal anesthesia (other than saddle blocks or caudals)?[Yes [No
 (x) Laser treatment? Describe: _____[Yes [No
 (xi) Experimental procedures or research testing? Describe in detail on separate sheet.....[Yes [No
 (xii) Hypnosis? Describe: _____[Yes [No
- b. Do you perform:
- (i) Norplant insertion/removals advise # yearly.....[Yes [No
 (ii) Surgery other than incision of superficial boils or suturing superficial fascia?.....[Yes [No
 (iii) Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker?.....[Yes [No
 (iv) Tonsillectomies and/or adenoidectomies and/or caesarean sections? [Yes [No
 (v) Cosmetic plastic surgery? Describe: _____[Yes [No
 (vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles?.....[Yes [No
 (vii) Hysterectomies?.....[Yes [No
 (viii) Open reduction of fractures? Describe: _____[Yes [No
 (ix) Surgery for weight reduction of patients?[Yes [No
 (x) Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): _____[Yes [No
 (xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: _____[Yes [No
 (xii) Silicone implants? Describe: _____ [Yes [No
 (xiii) Sterilization procedures? Describe: _____[Yes [No

- (xiv) Biopsies and/or endoscopies? List types performed: _____...[] Yes [] No
- (xv) Sex change operations? Describe and advise number yearly: _____...[] Yes [] No
- (xvi) Experimental surgery or surgical research? Describe in detail on separate sheet.[] Yes [] No
- (xvii) Other surgery? Describe: _____...[] Yes [] No

- c. (i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility?.....[] Yes [] No
If yes, answer (ii) and (iii) below.
- (ii) List ALL surgical procedures performed (including minor surgery): _____

- (iii) Do you administer anesthesia (other than topical or local infiltration)?.....[] Yes [] No
If yes, please attach detailed explanation.
- d. Do you perform hospital emergency room care for patients not your own?.....[] Yes [] No
If yes, please attach explanation and also advise the number "patient contact" hours MONTHLY by you:

 - (i) Emergency Room Physicians _____ hrs. (iii) Nurses _____ hrs.
 - (ii) Paramedics _____ hrs. (iv) Other _____ hrs.

- e. Do you use drugs for weight reduction or patients?.....[] Yes [] No
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.
- f. Do you administer any methadone treatment?.....[] Yes [] No
If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months _____; Next 12 months _____.
- g. Number of annual x-ray exposures: for diagnosis _____; for treatment _____.
- h. If x-ray treatment is given, what qualifications are required of the staff? _____
- i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity.....[] Yes [] No
- j. Attach detailed description of any additional activities and/or procedures which you performed.

4. STAFF

a. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE.

	Employees and <u>Volunteers</u>	Independent <u>Contractors</u>		Employees and <u>Volunteers</u>	Independent <u>Contractors</u>
(i) Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	_____	_____	(xi) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	_____	_____
(ii) Physicians: Minor surgery or obstetrical procedures not constituting major surgery	_____	_____	(xii) Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet	_____	_____
(iii) Proctologists, Ophthalmologists and Urologists	_____	_____	(xiii) Unlicensed Interns	_____	_____
(iv) General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____	(xiv) Dentists (no oral surgery)	_____	_____
(v) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	_____	_____	(xv) Orthodontists	_____	_____
	Employees and <u>Volunteers</u>	Independent <u>Contractors</u>		Employees and <u>Volunteers</u>	Independent <u>Contractors</u>

- (vi) Oral Surgeons _____
- (vii) Nurse Anesthetists _____
- (viii) Optometrists, Opticians _____
- (ix) Pharmacists _____
- (x) Perfusionists _____
- (xvi) Podiatrists _____
- (xvii) Chiropractors _____
- (xviii) RN, LPNs _____
- (xix) Other _____
- (xx) _____

NOTE: If you require any of the above to be Named Insureds, please submit separate application for each such individual.

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation?.....[] Yes [] No
If no, please attach explanation.

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

- (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association?.....[] Yes [] No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?.....[] Yes [] No
- (iii) Ever been treated for alcoholism or drug addiction?.....[] Yes [] No
- (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?.....[] Yes [] No
- (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?.....[] Yes [] No

d. Do you supervise any individual other than your own employees?.....[] Yes [] No

If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals.

Also, indicate by profession the number of individuals supervised.

<u>Number</u>	<u>Type of Profession</u>	<u>Number</u>	<u>Type of Profession</u>
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technician	_____	_____

5. REVENUES

a. Please state sources and amounts of total revenue:

<u>Source</u>	<u>This Fiscal Year</u>	<u>Next Fiscal Year</u>
(i) Charitable Contributions	\$ _____	\$ _____
(ii) Government Funding	\$ _____	\$ _____
(iii) Fee for Service	\$ _____	\$ _____
(iv) Other _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

b. Please provide number of outpatient visits:

<u>Type of Visit</u>	<u>Last 12 Months</u>	<u>Next 12 Months</u>
Clinics _____	_____	_____
Laboratory _____	_____	_____
Emergency Room _____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL NO. OF VISITS	_____	_____

c. If you have a training school, please complete the following. Attach separate schedule if needed.

Specify Profession Are Being Trained	Max. No. of Students Per Session	No. of Sessions Per Year	% of Time Involved in Clinical Setting	Number of Faculty	Qualifications of Faculty (i.e., MD, RN, PhD., etc.)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

6. AFFILIATIONS

- a. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients?.....[] Yes [] No
If yes, please attach detailed explanation and a copy of ALL of the advertisements.
- b. Are you employed by any individual or entity other than that shown in Question 1(a) ?.....[] Yes [] No
If yes, please attach explanation.
- c. Are you under contract to any individual or entity other than that shown in Question 1(a)?.....[] Yes [] No
If this contract contains a hold-harmless agreement, copy of contract must be attached.
- d. Are you in the employ of or under contract to any federal governmental entity?.....[] Yes [] No

7. HISTORY/CLAIMS

- a. Has any claim or suit been brought against you and/or any of your employees?.....[] Yes [] No
If yes, a supplemental claim information form must be completed for each claim or suit.
- b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees?.....[] Yes [] No
If yes, please give details on separate sheet.
- c. Please list general liability insurance carried for each of the past three years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Was this a		Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Claims Made		Retro Policy Form?	Date
					Yes	No			Yes	No		
_____	_____	_____	_____	_____	[]	[]	_____	_____	[]	[]	_____	_____
_____	_____	_____	_____	_____	[]	[]	_____	_____	[]	[]	_____	_____
_____	_____	_____	_____	_____	[]	[]	_____	_____	[]	[]	_____	_____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.

Name of Applicant Title (Officer, partner, etc.)

Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.



Atlantic Specialty Lines, Inc.

BROKER RISK SUMMARY (Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: