Hull & Company

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SUPPLEMENT FOR MEDICAL SPA/ANTI-AGING CLINICS

(USE WITH APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.) PROFESSIONAL LIABILITY INSURANCE (SM668))

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. Full name of Applicant: _____

2. Date continuous operations began: _____

   If the Applicant is a start-up operation, attach a copy of the Applicant's' business plan.

3. Website: _____

II. OPERATIONS

1. What is the professional specialty of the clinic? _____

   _____

2. (a) Provide a list of the Applicant's Medical Director(s): _____

   _____

   (b) Attach a CV for each of the Applicant's Medical Directors and a description of their duties.

3. Provide the percentage of the Applicant's patients/clients in the following categories:

(a)		(b)	
Beauty Shop (nails, hair, facials)	_____%	Patient/Client Ages:	
Dental	_____%	Less than 12 years old	_____%
Massage	_____%	12 to 18 years old	_____%
Medical Spa/Anti-Aging	_____%	Greater than 18 years old	_____%
Research or Experimental	_____%	TOTAL	100%
Surgical	_____%		
Weight Control	_____%		
Other (specify) _____	_____%		
TOTAL	100%		

III. PROFESSIONAL SERVICES

1. List all manufactured equipment used in the Applicant's practice and the purpose for which each is used:

   _____

   _____

   _____

2. Does all labeling of and use of drugs have FDA approval? ..... [ ] Yes [ ] No
   If No, explain. _____

3. Does the Applicant take before and after pictures of every patient? ..... [ ] Yes [ ] No
   If No, explain. _____

4. Provide the following information for each type of procedure that is performed and attach a Training Certificate, CV, Client Selection Protocol and Informed Consent for each procedure:

Procedure	Performed By (include name of all individuals performing each procedure)	Is Training Certificate Attached? (Yes/No)	Is CV Attached? (Yes/No)	Is Client Selection Protocol Attached? (Yes/No)	Is Informed Consent Attached? (Yes/No)	Number of Procedures
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 that 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	Deductible (if any)	Premium	Inception/ Expiration Dates (MM/DD/YYYY)	Claims Made or Occurrence Form	Retroactive Date

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	Deductible (if any)	Premium	Inception/ Expiration Dates (MM/DD/YYYY)	Claims Made or Occurrence Form	Retroactive Date

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)
1					
2					
3					
4					

(b)

	Location 1	Location 2	Location 3	Location 4
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