Medical Spa / Integrative Medicine Insurance Program Indication Application

***Professional Liability Solutions* * Charlotte NC * Rock Hill SC**

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NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM INDICATION ONLY. COVERAGE WILL NOT BE BOUND UNTIL RECEIPT, REVIEW AND UNDERWRITER ACCEPTANCE OF THEIR COMPANIES APPLICATION, AND PREMIUM PAYMENT.

Include full legal name and D/B/A: _____
Principal business premise address: _____
City, State, Zip:_____
Additional locations: _____
Phone: _____ Fax: _____ Email: _____
Number of Employees: Full Time _____ Part Time _____ Total _____
Provide name and specialty of Applicant's Medical Director _____
Does the Medical Director need coverage for Direct Patient Care? _____
Gross Receipts: Previous 12 months _____ Next 12 months _____
Has the Spa had any claims? _____ yes _____ no If yes, please provide details separate piece of paper.

Procedures Performed	Type of staff performing Procedure(s). i.e. RN, LPN etc.	Names of Staff performing Procedure(s) i.e. Jane Smith, R.N.	Actual # of Procedures Performed the previous 12 months	Est. Number of Procedures Performed next 12 months.
Bio-Identical Hormone Replacement Therapy				
Botox Injections				
Chemical Peels Specify Solution Strength				
Chelation Therapy				
Laser Hair Removal				
Laser Skin Treatment Specify Type _____				
Massage				
Cellulite Procedures – Specify Type_____				
Other Injections - Specify Type _____				
HCG				
Other _____				

Do you prescribe drugs for any of the services above? _____ If yes, please list them _____

****NOTE:** Only the procedures listed above will be included in your indication. If you are performing procedures or services that are not listed above, please indicate on a separate piece of paper so that we can make sure we get your facility properly covered.

_____ _____

Insured's Signature Date