Worldwide Facilities, Inc.

# MEDI-SPA APPLICATION

The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

Instructions:
1) Please type or print clearly.
2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Appropriate).
3) If you need more space for your responses, continue on a separate sheet with letterhead and indicate question number.

**INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED:**

□ LOSS HISTORY – Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.

□ Copies of all marketing materials/brochures.

□ Current financial statements (audited if available).

□ Copies of most recent inspection reports within the past three years.

□ Copy of Informed Consent. Copy provided? □ Yes □ No

**GENERAL/OVERVIEW INFORMATION**

Applicant's Name: _____

Business Address: _____
Street City State Zip

Mailing Address: _____

Website: _____

Date Business Established: _____ If start-up then check the box: □ Yes (start-up)

Requested effective date: _____ Retroactive date: _____

Current Form Of Insurance: Professional Liability: □ Claims-made □ Occurrence
Commercial General Liability: □ Claims-made □ Occurrence

Applicant is a:
□ Corporation □ Partnership
□ Partnership Association □ Sole Proprietorship
□ Joint Venture □ Physician Owned
□ Other (*Please Explain*) _____

Applicant operates: □ For Profit □ Not for Profit

Franchise Operations: Company Owned # of Locations: _____ Franchised # of Locations: _____

**Limits of Liability – Primary***
□ $500,000/$1,500,000 □ $1,000,000/$3,000,000 □ Other _____
**Professional Liability and General Liability Limits must be the same, but apply separately.*

Deductible (applies separately to Professional Liability and General Liability)
□ $5,000 □ $10,000 □ $25,000 □ $50,000 □ Other _____

**Limits of Liability – Excess Coverage Requested** □ Yes □ No
□ $1,000,000/$1,000,000 □ $3,000,000/$3,000,000 □ Other _____

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Revenue Data – Provide historical, current and projected revenues:

| Revenues □ Fiscal □ Calendar | Year _____ | Year _____ | Current Year _____ | Projected Next 12 Months |
|---|---|---|---|---|
| | $ | $ | $ | $ |

Number of Locations: _____

If more than one location, list all locations: _____

_____

_____

**PROFESSIONAL LIABILITY EXPOSURE INFORMATION**

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

_____

2) Indicate the **total number of annual visits per type** for each of the Applicant's services:

| **Total Number of Annual Visits By Services Offered:** | **Total Procedures Current Year** | **Total Procedures Projected Next 12 Months** | **Performed by Physician, PA Dentist, RN, Aesthetician, etc.** |
|---|---|---|---|
| **Surgical (List Each Type):** | | | |
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| **Total** | | | |
| | | | |
| **Non–Surgical (List Each Type):** | | | |
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| | | | |
| **Total** | | | |

3) For those services in the prior Question that are performed by Physicians or Dentists:

(a) Do they carry their own Professional Liability coverage? □ Yes □ No

(b) If yes, list the minimum limits required: _____

(c) **Is coverage requested** for any Physicians or Dentist list above? □ Yes □ No If yes, attach Physicians application.

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4) What type of anesthesia is administered to patients?
□ None □ General
□ Local □ Conscious Sedation

5) Client/Patient Age Breakdown by percentage: □ Less than 21 years old _____%
□ 21 to 50 years old _____%
□ 50+ years old _____%
TOTAL 100 %

6) Do you plan to expand your locations offered, services and/or number of personnel? □ Yes □ No If yes, give details:

_____

_____

7) Does a physician perform the "good faith" initial exam? □ Yes □ No If no then why not? (give details): ____

_____

_____

**PRODUCTS LIABILITY**

8) Describe any products sold and their related $ revenue for (1) Current Year and (2) Projected Next 12 Months:

_____

_____

(a) Are any of these products FDA approved drugs? □ Yes □ No If yes, list each: _____

_____

_____

(b) If yes, are any FDA approved drugs used in an "off-label" manner? □ Yes □ No If yes, give details: ____

_____

_____

**STAFF**

9) Professional Employees/Independent Contractors – List each physician providing services at your facility.

| Medical Director - Name | Specialty | Insurance Carrier & Policy Number | Employee/ Contractor | Hours/Month |
|---|---|---|---|---|
| | | | | |
| | | | | |

10) Will the Medical Director have any direct patient contact or work in an administrative capacity only? _____

_____

11) Other Health Care Professionals – Indicate the number in each category, full-time and part-time.

| | Employees | | Contractors | |
|---|---|---|---|---|
| | Full Time | Part Time | Full Time | Part Time |
| Physicians | | | | |
| Physician's Assistants | | | | |
| Dentists | | | | |
| Aestheticians | | | | |
| Electrologists | | | | |
| Massage Therapists | | | | |
| Registered Nurses | | | | |

| | | | | |
|---|---|---|---|---|
| Nurse Practitioners | | | | |
| Medical Assistants | | | | |
| Other (define) | | | | |
| Other (define) | | | | |
| Other (define) | | | | |

12) For those health care professionals that are considered Independent Contractors:

(a) Do they carry their own Professional Liability coverage? □ Yes □ No

(b) If yes, list the minimum limits required: _____

(c) Do you request proof of coverage for Independent Contractors? □ Yes □ No

**RISK MANAGEMENT**

13) Has any outside organization conducted an inspection of your facility in the past 3 years? □ Yes □ No

If yes, please indicate the name of the organization and the type of inspection: _____

_____

_____

14) Is this facility licensed by the state? □ Yes □ No If yes, list the type of licensing and list the state(s). ____

_____

_____

15) Do any of the employees require licensing by the state? □ Yes □ No If yes, list the employee name, type of licensing and the state(s). _____

_____

16) Has the applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any state/federal licensing board or regulatory agency? □ Yes □ No If yes, give details. _____

_____

_____

17) List other accreditation(s), if any: _____

_____

18) List all associations that you are a member of: _____

_____

19) Does your facility have a formalized Risk Management Program? □ Yes □ No

20) Who coordinates your Risk Management Program?

Name: _____

Title: _____ Phone Number: _____

21) Is parental consent obtained for all minors treated at your facilities? □ Yes □ No

22) Does the Applicant take before and after photographs of every patient? □ Yes □ No If no, give details. ____

_____

_____

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23) Do you have any contractual agreements with independent contractors/providers to provide services at your facility?

□ Yes □ No If yes, give details and provide a copy of a sample contract. _____

_____

_____

Are certificates of insurance obtained from all contracted providers? □ Yes □ No

24) Please indicate all of the hiring/screening procedures used for professionals and others who provide services at your facility:

- □ Check of educational background, or residency program, when applicable.
- □ Check of previous employers □ In writing □ By telephone
- □ Check of personal references □ In writing □ By telephone
- □ Check on hospital privileges for physicians, oral surgeons and dentists.

How often do you update your list of specific privileges? _____

- □ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
- □ Require information on any professional liability or work-related claim that has previously been made against any individual.

25) Does your facility have written job descriptions? □ Yes □ No

**COMMERCIAL GENERAL LIABILITY INFORMATION (Complete This Section If Requesting GL Coverage)**

26) Please provide physical plant information as requested (use additional sheet if necessary):

| Address/Occupancy | Square Footage | Age | Type of Construction | # Floors | Type of Fire Protection* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

27) Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

| Name | Address | Interest |
|---|---|---|
| | | |
| | | |

28) Was the facility designed for patients to stay overnight? □ Yes □ No

29) Does the applicant own or lease equipment? □ Own □ Lease

30) Who is responsible for the inspection and maintenance of the equipment? _____

_____

_____

31) Are policies/procedures established to respond to/address patient medical emergencies while at the facility? □ Yes □ No

32) What is the construction? _____ Fire Protection Class? _____ Number of Stories? _____

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33) Are the electrical, heating and plumbing systems up to code and regularly inspected? □ Yes □ No

If yes, then inspected by whom and what date? _____

Is the building completely sprinklered? □ Yes □ No

If partially sprinklered, identify those areas that are sprinklered. _____

34) Are the fire alarms connected to a local fire station? □ Yes □ No

If yes, what was the date of the last fire alarm inspection? _____

### HISTORICAL CARRIER INFORMATION

35) Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

| **PRIMARY** | Insurer | Policy Period | Premium | Limits | Attachment | CM (w/ Retro) Or Occurrence |
|---|---|---|---|---|---|---|
| □ Professional Liability □ Commercial GL | | | | | | |
| □ Excess | | | | | | |
| □ Professional Liability □ Commercial GL | | | | | | |
| □ Excess | | | | | | |
| □ Professional Liability □ Commercial GL | | | | | | |
| □ Excess | | | | | | |
| □ Professional Liability □ Commercial GL | | | | | | |
| □ Excess | | | | | | |
| □ Professional Liability □ Commercial GL | | | | | | |
| □ Excess | | | | | | |

36) Has the applicant ever had any insurance company decline, cancel, rescind or non-renew Professional Liability coverage? □ Yes □ No If provide details. _____

_____

_____

_____

### LOSS HISTORY

37) Summary of 5 Year Loss History - Please provide claims history as requested:

| Year | # Open | Total Paid | # Closed | Total Paid | Total # of Claims | Total $ Paid Expense | Total $ Paid Indemnity | Total $ Paid |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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38) If no claims have been reported to you, then initial here: _____

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39) Large Loss Description – On a separate sheet of paper list any liability claims or suits made or brought against your facility during the past five years for amounts incurred greater than $50,000. If no claims or suits greater than $50,000 then check the box: □ Submitted on Separate Sheet of Paper
□ None Greater than $50,000

40) Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? □ Yes □ No If yes, give dates, allegations and disposition of each claim or suit in the comments section. _____

_____

41) Give the valuation date: _____

**OTHER**

42) Does the applicant offer day care services? □ Yes □ No

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE PART OF THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THIS APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

**THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.**

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____

Producer Name: _____

Address: _____

Telephone: _____

Fax: _____