



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
<input type="checkbox"/> Acne Therapy	<input type="checkbox"/> Addiction Therapy	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Botox / Collagen	<input type="checkbox"/> Bone Density	<input type="checkbox"/> Ayurvedic Medicine
<input type="checkbox"/> Cellulite	<input type="checkbox"/> Cardiovascular Medicine	<input type="checkbox"/> Biofeedback
<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Chelation Therapy
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chinese Medicine
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Executive Health Screening	<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Laser Hair	<input type="checkbox"/> Imaging Tests	<input type="checkbox"/> Detoxification
<input type="checkbox"/> Laser Skin	<input type="checkbox"/> Lab Tests	<input type="checkbox"/> Homeopathy
<input type="checkbox"/> Liposuction	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Hormone Therapy
<input type="checkbox"/> Microdermabrasion	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Mesotherapy
<input type="checkbox"/> Permanent Makeup	<input type="checkbox"/> Physical Examinations	<input type="checkbox"/> Mind/Body Medicine
<input type="checkbox"/> Photo Rejuvenation	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Naturopathic Medicine
<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Pre- / Post- Natal	<input type="checkbox"/> Nutrition Therapy
<input type="checkbox"/> Pre- / Post- Operative	<input type="checkbox"/> Sexual Health	<input type="checkbox"/> Spirituality & Healing
<input type="checkbox"/> Sclerotherapy (veins)	<input type="checkbox"/> Sleep Health	<input type="checkbox"/> Thermal Waters
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Western Herbal Medicine
_____	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> 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. **COMPLEMENTARY / ALTERNATIVE** -- 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 Identify treatment use: _____	_____	_____
b. With laser or electro Identify treatment use: _____	_____	_____
c. With direct moxibustion 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