Breckenridge
an accretive company

BRECKENRIDGE
ANTI-AGING CLINIC, MEDICAL SPA or WEIGHT LOSS CLINIC APPLICATION

SECTION 1: APPLICANT INFORMATION

Firm's Full Legal Name, Include Any DBA: _____

Primary Practice Address: _____ City/State/Zip: _____

Address for Additional Locations: ☐ No Other Locations _____

_____

Primary Insurance Contact: _____ Title: _____

Primary Telephone Number: _____ Email Address: _____

Web Address: _____

SECTION 2: INSURANCE COVERAGE DESIRED

1. Desired Coverage Effective Date: _____
2. Professional Liability limits requested: ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $1,000,000/$3,000,000
   ☐ Other Limits: $_____/$_____
3. If current coverage is a Claims Made policy, what is your Retroactive Date? _____
4. Would you like a quote for General Liability (limits will equal Professional Liability limits)? ☐ Yes ☐ No
5. Deductible Requested: ☐ None ☐ $2,500 ☐ $5,000 ☐ $10,000 Other: $_____

SECTION 3: INSURANCE HISTORY

Professional liability insurance history: ☐ Check here if the clinic/spa is buying coverage for the first time.

Policy Year	Professional Liability Carrier	Limits of Insurance	Deductible	Policy Effective Date	Annual Premium	Annual Revenue
Expiring Policy						
One Year Prior						
Two Years Prior						
Three Years Prior						
Four Years Prior						

SECTION 4: FACILITY AND OWNERSHIP INFORMATION

1. How many years has the clinic/spa been in operation? _____ Years under present ownership? _____
2. Which of the following best describes the ownership structure? ☐ Individual ☐ Partnership/PA ☐ Corporation/LLC
   ☐ Other (explain): _____
3. List all owners including their percentage of ownership and medical specialty: _____
   _____
4. a) Do you have a designated Medical Director? ☐ Yes ☐ No (If **No**, proceed to question 5)
   b) If **Yes**, what is their name and professional license? _____
   c) Does your Medical Director have any direct patient care exposure? ☐ Yes ☐ No If **Yes,** how many hours/week: _____
   d) Which of these best describes the Medical Director? ☐ Owner/Partner ☐ Employee ☐ Independent Contractor
5. Hours clinic/spa open per week? ☐ Less than 20 hours ☐ 21-40 hours ☐ 41-60 hours ☐ More than 60 hours
6. What is your anticipated clinic/spa revenue for the upcoming 12 months? $_____
7. List any medical services offered at your clinic/spa that may not be considered typical anti-aging, medi-spa or weight loss services, such as traditional family practice, obstetrics, urgent care, etc. and who is administering them:_____
   _____

SECTION 5: PROCEDURE/TREATMENT INFORMATION

For each procedure or treatment shown below, please estimate the number of procedures or treatments your clinic/spa will complete within the upcoming policy term. For the same period of time, please estimate the percentage of annual revenue from the procedures or treatments which must equal 100% when completed. If you do not plan to perform any procedures or treatments within a specific category, please leave the estimated number and revenue boxes empty.

FOR ANYTHING YOU PERFORM BELOW, PLEASE SUBMIT BLANK SAMPLES OF INFORMED CONSENT DOCUMENTS.

Procedure or Treatment (Check boxes for the method(s) you use.)	**Current Annual Number**	**Projected Annual Number**	**Projected Revenue Percent**	**List the Name and Specialty of All Practitioners Performing Procedure or Treatment**
Alternative Medicine: Acupuncture, Ayurvedic, Massage Therapy, Moxibustion, Reiki, etc.				
Chelation: Number of Treatments (Excluding Heavy Metal):_____				
Chemical Peel: Less than 30% Acidity				
Chemical Peel: Greater than 30% Acid				
Colon Hydrotherapy/Colonics:				
Cosmetology/Day Spa: Body Wraps, Facials, Hair, Nails, Tanning, Waxing, Etc.				
Cryotherapy:				
Fat Transfers:				
Hair Transplants: ☐ Follicle ☐ Strip ☐ PRP				
Hormone Therapy: Number of BHRT Procedures:_____				
Hyperbaric Oxygen Therapy:				
***Injectables – No Weight or Hormone Treatments:** Fillers, Toxins or Vitamin Shots				
Kybella: (FDA approved area only)				
Latisse:				
Laser Hair Removal:				
Lipodissolve/Mesotherapy Injections Solutions: _____				
Invasive Lipolysis – Extract under 3000cc ☐Laser ☐Tumescent ☐ Smart Lipo/Other: _____				
Invasive Lipolysis – Extract between 3000cc and 5000cc ☐Laser ☐Tumescent ☐ Smart Lipo/Other: _____				
Invasive Lipolysis – Extract 5001cc or more ☐Laser ☐Tumescent ☐ Smart Lipo/Other: _____				
Machine Based Cellulite/Fat – No Incision: Cyrolipolysis, Endermologie, Laser, Radio Frequency or Ultrasound				

Procedure or Treatment (Check boxes for the method(s) you use.)	Current Annual Number	Projected Annual Number	Projected Revenue Percent	List by Name and Specialty All Practitioners Performing Procedure or Treatment
Machine Based Skin/Vein: Acne or Tattoo Removal, Permanent Make-Up, Skin Resurfacing or Tightening, Veins, etc.				
Microdermabrasion:				
Pain Management:				
Platelet Rich Plasma: Treatment Area:: _____ _____				
Sclerotherapy:				
****Stem Cell Therapy:**				
Thread Lifts: Location on Body:_____ _____				
Weight Loss: hCG Diet, Injections or Drops				
Weight Loss Prescriptions – No hCG: Drug Name(s):_____ _____				
Vaginal Rejuvenation: Laser & Energy Based Devices				
"AWAKE" Cosmetic Surgery: Types: _____ _____				
Major Cosmetic/Plastic Surgery: Types: _____ _____ Where Performed: ☐Surgery Center ☐On-site Surgical Suite ☐ Other: _____				
Non-Aesthetic Clinic Visits: Specialty: _____ _____				

*If you offer any **injectable procedures**, please list below your top three filler/toxin/vitamin injections performed annually:

_____

If you offer any **Stem Cell Therapy, please list below the areas you treat:_____

_____

If you do not presently or plan to offer machine assisted procedures, check the box below and proceed to the next section.

☐ No Laser, Light Emitting Diode (LED), Radio Frequency (RF), Ultrasound or other powered cosmetic equipment.

If you offer machine assisted procedures, please list the manufacturer and trade name of the electronic cosmetic equipment you use or you plan to add during the upcoming year (i.e. CoolLipo, Lapix 2000, SmartLipo, Velashape, Zerona, etc.). Also, please provide a general estimate of the actual or planned date of purchase.

List the Manufacturer and Equipment Trade Names:

_____ Date of Purchase (mo/yr): ____/____ ☐ Owned ☐ Leased

_____ Date of Purchase (mo/yr): ____/____ ☐ Owned ☐ Leased

_____ Date of Purchase (mo/yr): ____/____ ☐ Owned ☐ Leased

Describe your maintenance/repair program for the above equipment: _____

_____

If you are using any non-FDA approved drug(s) or are using any FDA approved drug(s) off-label, please list below the name of the drug(s) and how you are using it: _____

_____

_____

SECTION 6: PERSONNEL

1. a) Complete the following table for Employed or Independent Contractor (**IC**) staff working in your Clinic/Spa:

Professional License/Status *** Must be scheduled on policy to be covered.**	**Number Employed Staff**	**Number IC/1099 Staff**	**Should all Staff be INCLUDED on the Policy?**
1) Physician/Surgeon (MD/DO)*****			☐ **Y** ☐ **N**
2) Doctor - DDS/DC./DPM./etc.*****			☐ **Y** ☐ **N**
3) Nurse Anesthetist (CRNA)*****			☐ **Y** ☐ **N**
4) Nurse Practitioner (NP)*****			☐ **Y** ☐ **N**
5) Physician Assistant (PA)*****			☐ **Y** ☐ **N**
6) Medical Director, With Patient Care*			☐ **Y** ☐ **N**
7) Medical Director, No Patient Care			☐ **Y** ☐ **N**
8) Nurse – RN/LPN/etc.			☐ **Y** ☐ **N**
9) Massage Therapist			☐ **Y** ☐ **N**
10) Medical Aesthetician/Esthetician			☐ **Y** ☐ **N**
11) Medical/Laser Technician			☐ **Y** ☐ **N**
12) Other (describe):			☐ **Y** ☐ **N**

b) **Do you confirm excluded employees & ICs have their own policy? (Proof of Coverage is required)** ☐ Y ☐ N

c) List all employees and their specialty that are to be excluded from this policy: _____

_____

_____

d) No coverage is afforded to certain Professional Employees unless specifically requested. As such, list all professional "employed staff" addressed in 1. a) 1-6 above that should be covered/scheduled on your policy. Answer all subsequent columns for their work performed only on behalf of the clinic/spa.

Name	**Medical License**	**Clinic or Spa Hours Per Week**	**What Percentage of Practice for Clinic/Spa is Aesthetic, Anti-Aging or Weight Loss?**	**If Prior Column is not 100%, list other Specialty & Percentage**

2. Do you periodically and consistently confirm the licensing requirements needed by you and any employed or independent staff to ensure each person can perform the procedures or treatments they offer through your clinic/spa? ☐ Yes ☐ No

SECTION 7: GENERAL PRACTICE INFORMATION

Answer each of the following questions as it applies to your Anti-Aging Clinic/Medical Spa/Weight Loss Clinic.

Surgical Services

1. a) Do you offer any surgical procedures? **If No, proceed to question 2.** Yes No

   b) If **Yes**, what is the most complex surgical procedure offered at your location? _____

   c) What is the maximum scheduled length of surgical time you will spend on any patient undergoing one or more surgical procedures in your location's operating suite? _____ hours / _____ minutes

   d) Is appropriate medical/nursing staff on premises during patient preparation and recovery periods? Yes No

Anesthesia Services

2. a) Do your patients receive any form of anesthetic agents/drugs? **If No, proceed to question 3.** Yes No

   b) Do any of your patients receive general anesthesia for any medi-spa/cosmetic surgery procedures? Yes No

   c) Are anesthetic agents/drugs ever allowed or used off premises? (i.e. patient's home, office or hotel) Yes No

   d) Is Propofol or a similar anesthesia agent/drug ever administered to any patient? Yes No

   e) Do you have an emergency management and transport plan for adverse reactions to anesthesia? Yes No

Weight Loss Services

3. a) Do you prescribe any weight loss medication? **If No, proceed to question 4.** Yes No

   b) If **Yes**, describe your weight loss services and products: _____

   c) When you prescribe weight loss medications, are regular follow-up visits required? Yes No

   d) If **Yes**, how often do you see such patients: ☐ Weekly ☐ Monthly ☐ Other: _____

   e) Are any of your patients placed on a diet regimen of 750 (known as VLCD) or fewer calories? Yes No

   f) What is the maximum number of days a patient is allowed to be on a VLCD regimen? _____

   g) Do you mandate that VLCD patients take a nutritional supplement? Yes No

   h) If you offer an hCG Diet regimen, do your patients only receive <u>prescription grade</u> hCG products? Yes No

   i) Do you offer hCG injections? **Attach hCG Injection Protocols** Yes No

Risk Management

4. Do you have a credentialing process in place to verify the education, licensure and other qualifications of <u>all</u> medical staff employees and independent contractors? Yes No
5. Does your clinic/spa practice within the *Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008* published by the Centers for Disease Control and Prevention (CDC)? Yes No
6. a) Do you have a quality assessment/improvement plan or risk management plan in place? Yes No

   b) If **Yes**, who directs such activities and what is their specialty? _____

Informed Consent and Patient History/Documentation

7. Do you secure a signed Informed Consent document for each new procedure offered to a patient? Yes No
8. Does your Informed Consent disclose to a patient applicable FDA off label use of drugs or equipment? Yes No
9. Does your Informed Consent address consuming alcohol and/or illicit drugs prior to procedures? Yes No
10. Do you secure a fully completed and signed medical history from each new patient? Yes No
11. a) Do you or any staff perform any procedures on patients younger than age 18? Yes No

    b) If **Yes**, do you secure a signed and dated parental/guardian consent form for all procedures? Yes No
12. a) Do you take and store digital "Before" pictures for every new patient? Yes No

    b) If **Yes**, do you utilize "Before" pictures for <u>new</u> procedures on return patients? Yes No

Other Clinic/Spa Practice Exposures

13. a) Do you sell or distribute herbal supplements, homeopathic remedies, nutraceuticals or vitamins? Yes No
    b) If **Yes**, list each and the annual revenue: _____
14. Do you compound, manufacture or repackage anything that is then sold to your patients/clients? Yes No
15. a) Do you or any staff perform procedures or treatments offsite? **If No, proceed to question 16.** Yes No
    b) If Yes, where? ☐ Patient's Home/Work ☐ Hotel ☐ Mall ☐ Other: _____ Yes No
    c) How many offsite procedures or treatments do you perform annually? _____
16. a) Do you maintain any beds or rooms designed for overnight occupancy at your facility? Yes No
    b) If **Yes**, describe the occupant's treatment: _____

SECTION 8: UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, complete the Supplemental Claim Information Form.

1. Within the past 10 years, has any insurance carrier declined, cancelled, refused to renew, restricted, or surcharged any professional liability insurance policy issued to your clinic/spa or any owner/officer? Yes No
2. Within the past 10 years, have you, your clinic/spa or any health care professional rendering services on your behalf been notified of an involvement in a malpractice claim, suit, or incident, either directly or indirectly? If **Yes**, how many claims, suits or incidents have been brought to your attention? (Complete a Supplemental Claim Information Form for each) _____ Yes No
3. Within the past 10 years, have you, your clinic/spa or any health care professional rendering services on your behalf been investigated or audited by a governmental or regulatory agency? Yes No
4. Within the past 10 years, has any healthcare practitioner, patient, or insurance plan filed a complaint of any kind against you or your clinic/spa with a medical society, foundation or state/federal agency? Yes No
5. Within the past 10 years, has any healthcare professional working in your clinic/spa had their admitting privileges to any hospital or other healthcare facility restricted, revoked or placed on probation? Yes No
6. Are you or any health care professional rendering services on your clinic/spa's behalf aware of any conduct, circumstance, occurrence, incident or accident that is likely to or reasonably could be expected to give rise to a claim **<u>that has not yet been reported</u>** to your current and/or prior insurance carrier? Yes No
7. Does any healthcare professional working in your clinic/spa currently have or in the past had a probationary, restricted or suspended license? Yes No
8. Do the principal owners of your clinic/spa own, operate, or control any specialized, medically related business, such as a pharmacy, laboratory, physical therapy center, free-standing surgery center, etc. that has not been previously named and described in this application? Yes No
9. Does the applicant or any of its practitioners provide services to professional athletes or celebrities? Yes No

COMMENTS / EXPLANATIONS

NOTICE

To All Prospective Insureds: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

Notice to California Applicants: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia and Louisiana Applicants: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Oklahoma Applicants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Notice to Kansas Applicants: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Notice to Maine, Tennessee, Virginia and Washington Applications: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Hampshire Applicants: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Notice to New York Applicants (Fire insurance applications): 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, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Notice to New York Applicants (Automobile): Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation."

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Pennsylvania Applicants (Automobile): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information, shall, upon conviction, be subject to imprisonment for up to seven (7) years and the payment of a fine of up to $15,000.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

This application is for insurance to be placed on a surplus lines basis with Breckenridge Insurance.

_____ _____

Signature **Date**

Print Name/Title

BRECKENRIDGE
Supplemental Claim Information Form

1. Full name of applicant: _____

2. Full name of claimant: _____

3. Indicate whether: ☐ Claim ☐ Suit ☐ Incident Report

4. Date of incident: _____ 5. Date claim was reported to Carrier: _____

6. Additional defendants: _____

7. If closed:
   Total loss paid including deductible: $ _____ Defense costs: $ _____

   Check One: ☐ Court judgment ☐ Out of court settlement
   Date closed: _____

8. If pending:
   Claimant's settlement demand: $ _____

   Defendant's offer for settlement: $ _____

   Insurer's loss reserve: $ _____

   Deductible amount: $ _____

   Is claim in suit? ☐ Yes ☐ No
   If **Yes**, amount asked in summons: $ _____

9. Insurance carrier:_____

10. Description: (Provide enough information to allow evaluation. Use reverse side or additional sheet if required.)

A. Alleged act, error or omission upon which Claimant bases claim:

_____

_____

B. Description of case and events:

_____

_____

C. Description of the type and extent of injury or damage allegedly sustained:

_____

_____

_____ _____
Signature of applicant Date