

**CRYOTHERAPY INSURANCE POLICY APPLICATION**

**NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE AND REPORTED POLICY SUBJECT TO ITS TERMS. THE POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE UNDERWRITERS DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. THE UNDERWRITERS ARE NOT LIABLE FOR CLAIMS EXPENSES OR DAMAGES ONCE THE LIMIT OF LIABILITY IS EXHAUSTED. PLEASE READ THIS POLICY CAREFULLY.**

Please fully answer all questions and submit all requested information. Terms appearing in bold face in this **Application** are defined in the Policy and have the same meaning in this **Application** as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker.

**General Information**

1. Legal Name of Entity: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Website: \_\_\_\_\_ Facebook Instagram Snapchat Twitter Other  
 FEIN: \_\_\_\_\_  
 Hours of Operation: \_\_\_\_\_

If additional locations, please add on page 6 of application.

2. Are clientele given remote access or allowed to use equipment/treatments without a trained employee supervising the treatments? Yes No  
 If yes, please provide details. \_\_\_\_\_

3. The Entity has continuously been in existence since \_\_\_\_\_ and is a  
 Corporation Partnership Individual Other: \_\_\_\_\_

4. Is the Applicant controlled or owned by, associated or affiliated with, or does it own, any other business enterprise? Yes No  
 If yes, please explain: \_\_\_\_\_

5. Limits of Liability Desired \$500K/\$500K \$500K/\$1MM \$1MM/\$3MM \$2MM/\$4MM

6. Are any significant changes in the nature or size of the Applicant's business anticipated over the next twelve (12) months? Or have there been any such changes in the past twelve (12) months? Yes No

7. Total Gross Annual revenue for ALL services offered for last fiscal year (12 mos) \_\_\_\_\_ Anticipated  
 current fiscal year \_\_\_\_\_ projected next fiscal year \_\_\_\_\_

8. Do you provide any services to animals? Yes No

If yes, please provide the following:

- a. Equine (please complete equine supplemental) no of treatments \_\_\_\_\_ % of total revenues \_\_\_\_\_
- b. Canine - no of treatments \_\_\_\_\_ % of total revenues \_\_\_\_\_
- c. Other (please provide full details) \_\_\_\_\_

9. Please describe in detail the types of service the Applicant is engaged in and indicate the **Gross Revenues** derived from each:

Service	Past Fiscal Yr. Ending / / . (or Projected of applicant is a new entity)	No. of total Treatments
<u>Cryotherapy – Whole Body/Sauna</u>	\$ _____	_____
<u>IV Therapy (complete supplemental)</u>	\$ _____	_____
<u>Infrared Sauna</u>	\$ _____	_____
<u>Massage Therapy</u>	\$ _____	_____
<u>Cryotherapy – Local</u>	\$ _____	_____
<u>Float Tanks</u>	\$ _____	_____
<u>Weight Loss Services</u>	\$ _____	_____
<u>MediSpa Treatments</u>	\$ _____	_____
<u>Other:</u>	\$ _____	_____

Other: \_\_\_\_\_ \$ \_\_\_\_\_

Please provide the percentage of local treatments by type (must total 100%):

Rehabilitative/Pain Management: \_\_\_\_\_ Weight Loss & Body Contouring \_\_\_\_\_

Aesthetic/Facials \_\_\_\_\_ Other (explain) \_\_\_\_\_ Details \_\_\_\_\_

If more space is needed, please list on page 6 of the application: \_\_\_\_\_

10. Do you sell any products? Yes No

Gross receipts (excluding private label): \$ \_\_\_\_\_

a. Do you private label products for sale? Yes No

b. Do you sell or distribute herbal supplements, homeopathic remedies or nutraceuticals, drugs without FDA approval or products requiring a physician's prescription? Yes No

If Yes, please give details \_\_\_\_\_

c. Do any of these products contain cannabis, THC or other marijuana derivatives/related products? Yes No

11. Do you want to include General Liability? Yes No

12. Do you want Business Personal Property and/or Business Income Insurance? Yes No

13. Do you provide any mobile services or services at locations other than your own? Yes No

a. Please break down the percentage of mobile services by location performed (must equal 100%):

1. Nursing Homes/Hospitals \_\_\_\_\_

2. Private Residences \_\_\_\_\_

3. Offices/Other businesses (not your own) \_\_\_\_\_

4. Trade Shows/Business Expo \_\_\_\_\_

5. Fairs \_\_\_\_\_ Please provide average daily attendance \_\_\_\_\_

6. Rodeos, Ranches, etc. \_\_\_\_\_ Will you be treating Equine/Bovine or other livestock? Yes No

If yes, how many treatments \_\_\_\_\_

7. Sporting Events \_\_\_\_\_

a. Please provide full details including services you will be providing, type of sporting event, level (i.e. youth, select, collegiate, semi-pro, pro), date(s) and average attendance: \_\_\_\_\_

8. Music & Film Festivals \_\_\_\_\_

a. If any Music/Film Festivals, are any above 1000 attendees daily? Yes No

If yes, please provide full details including name of festival, website of festival, dates, and what services you will be performing there \_\_\_\_\_

9. Other? \_\_\_\_\_ Please provide full details: \_\_\_\_\_

10. Please list the mobile services that you provide (i.e. IV Therapy, massage therapy, cryotherapy, etc.) and the annual number each: \_\_\_\_\_

14. List the make and model of each Cryotherapy or other device and the number of each in use:

Device Make and Model:	Number	Inflatable:		Electric Cryo		Nitro Cryo	
		Yes	No	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No	Yes	No

If additional room is needed, please attach a schedule of equipment.

15. Do you assess/treat scarring, stretchmarks, burns, etc.? Yes No  
If Yes:

Which machine(s)/treatment(s) do you use? \_\_\_\_\_

Do you obtain a written referral from a doctor (MD) prior to performing treatments? Yes No

Do you retain the medical referral in the client's permanent file? Yes No

Do you have the client sign additional waivers acknowledging that there are no guarantees of results and/or that the fading may be only temporary? Yes No

16. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

Independent Certified and/or

	Employee	Contractor	State Licensed		Own Insurance	
			Yes	No	Yes	No
Certified Cryo Technicians	_____	_____	Yes	No	Yes	No
Massage Therapists	_____	_____	Yes	No	Yes	No
Medical Assistants	_____	_____	Yes	No	Yes	No
Other:	_____	_____	Yes	No	Yes	No

17. Do you have a medical director? If yes, please provide name \_\_\_\_\_

18. Are you aware of, advertise for or otherwise promote Cryo services to professional /collegiate athletes, celebrity or other high profile clients? Yes No

If Yes, please give

a) Associated revenues: \$ \_\_\_\_\_ Annual treatments: \_\_\_\_\_

b) Type of Athletes (i.e. pro/collegiate football, MMA, actor/actress, politician, etc.) \_\_\_\_\_

c) List these clients by name (if more space is needed please use page 5) : \_\_\_\_\_

19. What is the minimum temperature you use in Cryo treatments? \_\_\_\_\_ °F

20. How long have they been working with Cryo devices? \_\_\_\_\_

21. What training do the operators receive? \_\_\_\_\_

22. How many employees are trained to use the Cryo devices? \_\_\_\_\_

23. Do you have an operating protocol in place that requires supervision at all times whilst the device is in use? Yes No

24. Does the application provide **dry** hand and foot protection prior to use of cryotherapy equipment? Yes No

25. If the Applicant provides completely enclosed cryochambers, is **dry** head protection provided? Yes No N/A

26. Does the Applicant screen for medical conditions that may not be suitable for cryotherapy? Yes No

27. Does the Applicant use nitrogen monitors in cryotherapy rooms? (Electric Cryo Chamber. Nitrogen for Local Cryo only) Yes No

28. Does the Applicant limit cryotherapy sessions to the manufacturer recommended time limit? Yes No

29. Does the Applicant ensure that patients are able to exit cryotherapy machines without assistance? Yes No

30. Does the Applicant require all patients to sign an informed consent form? Yes No

31. Does the Applicant regularly inspect and calibrate cryotherapy machines as recommended by the manufacturer? Yes No

32. Are staff trained to provide first aid or CPR? Yes No

33. Does the Applicant allow staff or patients to provide cryotherapy to themselves? Yes No

34. Do you operate under a Franchise Agreement? Yes No

If Yes, Franchisor Name: \_\_\_\_\_

a. Do you own or rent/lease equipment from them? \_\_\_\_\_

b. Do you have a current service agreement for equipment maintenance with them? Yes No

35. Do you have a written procedure to document incidents and adverse reactions? Yes No

36. Has any applicant, employee or independent contractor of the applicant, or any owner or office ever been convicted of a criminal act other than a traffic offense? Yes No
37. Has any applicant, employee or independent contractor of the applicant, or any owner or office ever been treated for alcoholism or drug addiction (if yes, please attach details)? Yes No
38. Has any applicant, employee or independent contractor of the applicant, or any owner or office ever had any state professional license or license to prescribe narcotics suspended, revoked, renewal refused, or restricted or ever voluntarily surrendered a license? (if yes, please attach details) Yes No
39. Do you have all clients sign waivers of liability and/or informed consent forms prior to treatment in your facility and retain these forms in the clients' files? Yes No
40. Do you require a Physician signed prescription which will be kept on file for a minimum of 5 years for all Cryotherapy treatments? Yes No
41. Is there a medical director? Yes No  
 If yes, do they have their own medical malpractice? \_\_\_\_\_
42. Have you in the past, or do you plan to begin in the future, provide or offer services to anyone under the age of 18? Yes No  
 If Yes, please provide a breakdown of the age of minors treated by percent (must total 100% of minor services):
- Under 5 years old \_\_\_\_\_%
  - 5 years – 9 years old \_\_\_\_\_%
  - 10 years -13 years old \_\_\_\_\_%
  - 14 years – 18 years old \_\_\_\_\_%
- a. Please state the average number of monthly visits for clients under 18 \_\_\_\_\_
- b. Are employees in the same room as clients under 18 when they are undressing? Yes No
- c. Are there cameras in the treatment rooms? Yes No
- d. Do parents always remain present with minors under 14 during treatment? Yes No
- e. Does the insured follow all manufacturer's guidelines for all machines, modalities, treatments and services, including but not limited to any age restrictions? Yes No
- f. Does the insured require an expanded waiver, signed by the parent/guardian that lists any additional risks of treatments based on age? Yes No
- g. What specific services, modalities, and treatments are minors under the age of 14 allowed to receive?  
 Please list all services for minors under 14 \_\_\_\_\_

**Insurance History**

43. Please provide history of professional liability insurance for past five years (if none, state none)
- Carrier: \_\_\_\_\_ Limit: \_\_\_\_\_ Premium: \_\_\_\_\_ Term \_\_\_\_\_
- Carrier: \_\_\_\_\_ Limit: \_\_\_\_\_ Premium: \_\_\_\_\_ Term \_\_\_\_\_
- Carrier: \_\_\_\_\_ Limit: \_\_\_\_\_ Premium: \_\_\_\_\_ Term \_\_\_\_\_
- Carrier: \_\_\_\_\_ Limit: \_\_\_\_\_ Premium: \_\_\_\_\_ Term \_\_\_\_\_
- Carrier: \_\_\_\_\_ Limit: \_\_\_\_\_ Premium: \_\_\_\_\_ Term \_\_\_\_\_

44. Do you offer any childcare or are any other business operations taking place on your premises? If yes, please attach details    Yes    No
45. Who is your nitrogen provider? \_\_\_\_\_
46. Has any professional liability or general liability insurance ever been declined or cancelled?    Yes    No
47. Have any of the Applicant's current professional liability or general liability Underwriters formally indicated intent not to offer renewal terms?    Yes    No  
If Yes, please explain: \_\_\_\_\_
48. Has the Applicant or any director, officer, partner or principal been a party to any lawsuit or other legal proceeding or been the subject of a disciplinary action as a result of their professional activities?    Yes    No
49. Is the Applicant aware of any errors, omissions or claims (including any circumstances reported to previous Underwriters which have not developed into claims) during the last five (5) years?    Yes    No
50. Has the Applicant or any director, officer, employee or other proposed Insured given written notice under the provisions of any prior or current errors or omissions or professional liability policy of specific facts or circumstances which might give rise to a Claim being made against any proposed Insured?    Yes    No
51. List additional insured needed: \_\_\_\_\_  
Name/Address of AI \_\_\_\_\_ Relationship of AI \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The undersigned declares that the statements set forth herein are true and include all material information. For New Hampshire applicants, the foregoing statement is limited to the best of the undersigned's knowledge, after reasonable inquiry. The undersigned agrees that if the information supplied in this Application changes between the date of this Application and the effective date of the insurance, he/she will, in order for the information to be accurate on the effective date of the insurance, immediately notify the Underwriters of such changes, and the Underwriters may withdraw or modify any outstanding quotations or authorizations or agreements to bind the insurance.

Signing of this Application does not bind the Applicant or the Underwriters to complete the insurance, but it is represented that the statements contained in this Application and the materials submitted herewith are the basis of the contract should a Policy be issued and have been relied upon by the Underwriters in issuing any Policy. The Underwriters is authorized to make any investigation and inquiry in connection with this Application as it deems necessary.

All written statements and materials furnished to the Underwriters in conjunction with this Application are hereby incorporated by reference into this Application and made a part hereof. This Application and materials submitted with it shall be retained on file with the Underwriters and shall be deemed attached to and become part of the Policy if issued. For North Carolina, Utah, and Wisconsin Applicants, such Application and materials are part of the policy, if issued, only if attached at issuance.

**NOTICE TO NEW YORK APPLICANTS:** THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE POLICY SUBJECT TO ITS TERMS. UPON TERMINATION OF COVERAGE FOR ANY REASON, A 60-DAY AUTOMATIC EXTENSION PERIOD WILL APPLY. FOR AN ADDITIONAL PREMIUM, AN OPTIONAL EXTENSION PERIOD CAN BE PURCHASED AS INDICATED IN ITEM 8. OF THE DECLARATIONS. EXCEPT AS OTHERWISE PROVIDED HEREIN, THIS POLICY ONLY APPLIES TO CLAIMS FIRST MADE DURING THE POLICY PERIOD, THE AUTOMATIC EXTENSION PERIOD OR, IF APPLICABLE, THE OPTIONAL EXTENSION PERIOD. NO COVERAGE EXISTS FOR OCCURRENCES WHICH TAKE PLACE PRIOR TO THE RETROACTIVE DATE STATED IN THE POLICY. NO COVERAGE EXISTS FOR CLAIMS MADE AFTER THE END OF THE POLICY PERIOD AND THE AUTOMATIC EXTENSION PERIOD UNLESS, AND TO THE EXTENT, THE OPTIONAL EXTENSION PERIOD APPLIES. NO COVERAGE WILL EXIST AFTER THE EXPIRATION OF THE AUTOMATIC EXTENSION PERIOD OR, IF PURCHASED, THE OPTIONAL EXTENSION PERIOD, WHICH MAY RESULT IN A POTENTIAL COVERAGE GAP IF PRIOR ACTS COVERAGE IS NOT SUBSEQUENTLY PROVIDED BY ANOTHER UNDERWRITER. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY CLAIMS EXPENSES AND CLAIMS EXPENSES SHALL BE APPLIED TO THE DEDUCTIBLE. THE UNDERWRITERS ARE NOT OBLIGATED TO PAY CLAIMS EXPENSES OR ANY SETTLEMENTS OR JUDGMENTS AFTER THE LIMIT OF LIABILITY HAS BEEN EXHAUSTED. DURING THE FIRST SEVERAL YEARS OF A CLAIMS-MADE RELATIONSHIP, CLAIMS-MADE RATES ARE COMPARATIVELY LOWER THAN OCCURRENCE RATES, AND THE INSURED CAN EXPECT SUBSTANTIAL ANNUAL PREMIUM INCREASES, INDEPENDENT OF OVERALL RATE INCREASES, UNTIL THE CLAIMS-MADE RELATIONSHIP REACHES MATURITY.

**NOTICE TO MINNESOTA APPLICANTS:** THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE AND REPORTED POLICY SUBJECT TO ITS TERMS. THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED TO THE UNDERWRITERS DURING THE POLICY PERIOD OR OPTIONAL EXTENSION PERIOD, IF APPLICABLE. THIS MEANS THAT ONLY CLAIMS ACTUALLY MADE DURING THE POLICY PERIOD ARE COVERED UNLESS COVERAGE FOR AN OPTIONAL EXTENSION PERIOD IS PURCHASED. IF AN OPTIONAL EXTENSION PERIOD IS NOT MADE AVAILABLE TO YOU, YOU RISK HAVING GAPS IN COVERAGE WHEN SWITCHING FROM ONE COMPANY TO ANOTHER. MOREOVER, EVEN IF SUCH A REPORTING PERIOD IS MADE AVAILABLE TO YOU, YOU MAY STILL BE PERSONALLY LIABLE FOR CLAIMS REPORTED AFTER THE PERIOD EXPIRES. CLAIMS MADE POLICIES MAY NOT PROVIDE COVERAGE FOR NEGLIGENT ACTS, ERRORS OR OMISSIONS OF THE INSURED IN RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES COMMITTED BEFORE A FIXED RETROACTIVE DATE. RATES FOR CLAIMS MADE POLICIES ARE DISCOUNTED IN THE EARLY YEARS OF A POLICY, BUT INCREASE STEADILY OVER TIME. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE.

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE INCLUDING ATTACHMENT "A" AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

#### **FRAUD WARNING DISCLOSURE**

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

**NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO AND RHODE ISLAND 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 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 CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NOTICE TO KANSAS APPLICANTS:** 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 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 COMMITS A FRAUDULENT INSURANCE ACT.

