bodyMed™ Insurance Program

liability insurance coverage for cosmetic laser & medispa businesses

Marine Agency Corp

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Toll Free 800-763-4775 | Facsimile 973-763-1635
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APPLICANT INFORMATION

1. Name of Corporation or LLC (include "Inc", "Corp", "LLC", etc.): _____
2. Name of Business (your "dba" or "t/a" name): _____
3. Name of business owner(s): _____
4. Mailing address: _____

   City: _____ State: _____ Zip Code: _____
5. Phone: _____ Facsimile: _____

   Website: _____ Email Address: _____
6. FEIN (Federal Employer Identification Number) or Social Security Number: _____
7. Type of Entity: ☐ Corporation ☐ Partnership or Joint Venture ☐ Sole Proprietor (individual)

   ☐ Limited Liability Company ☐ Other (describe): _____
8. Year started in this business/industry (if new, describe business experience): _____
9. List any professional associations in which the applicant is a member: _____

   _____

INSURANCE INFORMATION

10 Previous insurance carrier (last five years):

Carrier Name	Policy Number	Policy Dates	Coverage Form	
_____	_____	_____	☐ Claims-Made	☐ Occurrence Form
_____	_____	_____	☐ Claims-Made	☐ Occurrence Form
_____	_____	_____	☐ Claims-Made	☐ Occurrence Form
_____	_____	_____	☐ Claims-Made	☐ Occurrence Form

If previous policy was written on a claims-made basis, attach a copy of the prior policy declarations and provide the policy "retroactive date": _____

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Coverholder at LLOYD'S

11. Have there been any claims in the last five years (whether or not insured)? ☐ Yes ☐ No

    If yes, describe: _____

12. Has any previous carrier cancelled or not renewed a policy? ☐ Yes ☐ No

    If yes, describe: _____

COVERAGE INFORMATION

13. Professional Liability Coverage Limits (check one):
    - ☐ $1,000,000 per claim / $2,000,000 annual aggregate
    - ☐ $1,000,000 per claim / $3,000,000 annual aggregate
    - ☐ $2,000,000 per claim / $4,000,000 annual aggregate

14. Abusive Acts SubLimits (check one):
    - ☐ $100,000 per claim / $100,000 annual aggregate
    - ☐ EXCLUDE abusive acts liability

15. Policy Deductible (check one):
    - ☐ $0 (zero) per claim
    - ☐ $1,000 per claim
    - ☐ $2,500 per claim
    - ☐ $5,000 per claim

16. Defense Coverage Options (check one):
    - ☐ include coverage for defense in limits above
    - ☐ $100,000 per claim / $100,000 annual aggregate
    - ☐ $250,000 per claim / $250,000 annual aggregate
    - ☐ $1,000,000 per claim / $1,000,000 annual aggregate

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EXPOSURE INFORMATION

17. Indicate the professional services performed at your business. Please note:
→ Any professional services for which you do not provide such information will not be covered under this policy.
→ Checking a professional service does not obligate us to insure it.

- ☐ Aromatherapy
- ☐ Body Massage
- ☐ Body Piercing
- ☐ Chemical Peels – Aesthetician Grade ☐ Chemical Peels – Medical Grade
- ☐ Colon Hydrotherapy
- ☐ Cosmetics/Make-up Application
- ☐ Dermaplaning
- ☐ Ear Piercing
- ☐ Electrolysis
- ☐ Endermology
- ☐ Facial & Scalp Massage
- ☐ Facial & Skin Cleansing
- ☐ Hair Cutting/Styling/Coloring
- ☐ Hormone Therapy (injected or otherwise)
- ☐ Hydrotherapy
- ☐ Injections – Botox
- ☐ Injections – Dermal Fillers
- ☐ Injections – PRP (Platelet -rich Plasma)
- ☐ Ionic Foot Detox
- ☐ Laser/Intense Pulsed Light ("IPL")
- ☐ Manicure/Pedicure
- ☐ Mesotherapy
- ☐ Microdermabrasion
- ☐ Micropigmentation / Cosmetic Tattooing
- ☐ Nutritional Counseling / Consultation
- ☐ Personal Training / Yoga Instruction
- ☐ Pigment Removal – Injectable Solution
- ☐ Pigment Removal – Laser
- ☐ Radio Frequency ("RF") Skin Treatments
- ☐ Sclerotherapy
- ☐ Tanning Beds / Booths / Units
- ☐ Tattoo
- ☐ Ultrasonic / Ultrasound Skin Treatments
- ☐ PRP (Platelet -rich Plasma)
- ☐ Vitamin Therapy (injected or otherwise)
- ☐ Waxing
- ☐ Weight Loss

☐ Other (describe): _____

18. Indicate the number of people performing professional services for you or on behalf of your business.

_____ Supervising Physicians that do not render services
(if your supervising physician is also a service provider at the business, include below)

_____ Laser/MediSpa service providers
(those who perform laser/IPL treatments, medical treatments, or treatments that penetrate the skin)

_____ All other service providers
(non-medical cosmetology, masssage, skincare)

19. Are you and your staff properly licensed (where required by law)? ☐ Yes ☐ No

20. Have all service providers received training in the covered services? ☐ Yes ☐ No

21. Can all service providers document or attest to at least one year professional experience in the covered services? ☐ Yes ☐ No

22. Are any services performed by students? ☐ Yes ☐ No

    a. If yes, are all such services performed under direct supervision? ☐ Yes ☐ No

23. Have any service providers been the subject of a license revocation suspension, or sanction related to the covered services in the last five years? ☐ Yes ☐ No

APPLICANT WARRANTY

By signing the Application the Applicant warrants the use of certain forms of client documentation on all customers receiving professional services that are the subject of this Application for insurance. Failure to obtain and keep documentation of same will be grounds for denial of coverage. These forms are as follows:

- Signed consent/release form
- Completed/signed medical history form
- Distribution of written post-treatment ("aftercare") instructions
- Written consent of parent/guardian where required by law when providing services to a minor (under age 18)

We agree and confirm that written consent/release forms, medical history, and post-treatment instructions are not required for adjunct salon services including cosmetology (hair/nails/cosmetics), skincare (non-medical, non-laser/IPL), or bodywork (massage and/or body wrap).

ATTESTATION

By signing the Application the undersigned agrees that he/she is not aware of any fact or circumstance which reasonably might give rise to a future claim that would fall within the scope of the proposed coverage.

Receipt and review of this Application does not bind the insurer to provide this insurance.

If the Applicant has concealed or misrepresented any material fact, circumstance or fraud concering this insurance resulting in deception to us which existed at the time of loss/claim and contributed to such loss/claim, this policy may be canceled and/or coverage denied as long as the deception was material; was made knowingly and with the intent to deceive; was relied and acted upon by the Insurer; and deceived the Insurance to the Insurer's injury.

STATEMENT FROM APPLICANT & SIGNATURE

I hereby represent and confirm that the above information, to the best of my knowledge, is true and correct and further certify that I have read all of the questions and answers of this insurance application.

APPLICANT

Signature: _____ Date: _____

Principal, Partner or President

Print Name: _____ Title: _____

BROKER

Signature: _____ Date: _____
Agent/Broker

Print Name: _____ License #: _____

Return completed/signed application materials and any requested attachments to coverholder for quotation to:

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