CapSpecialty
Capitol Specialty Insurance Corporation
A Stock Company
P. O. Box 5900
Madison, WI 53705-0900

Medical Spa Supplemental Application

I. APPLICANT INFORMATION

1.1	Applicant Name:	
1.2	Website(s):	

II. CRITICAL UNDERWRITING QUESTIONS

2.1	Do you provide any other services besides medical spa services?	☐ Yes ☐ No
	If yes, please provide details:	
2.2	Do you have a formalized employee verification program including background checks?	☐ Yes ☐ No
2.3	Who is your medical director?	
	a. What is their medical specialty?	
	b. Coverage you would like:	☐ Medical Director Administrative Duties only ☐ Medical Director Administrative & Direct Patient Care

III. RATING INFORMATION FOR MEDICAL PROFESSIONALS

The following information affects our pricing model and is critical for an accurate assessment of your exposure.

3.1 Indicate the number of the Applicants staff and whether they carry their own insurance:

	Employed		Contractor		
Staff Type	**Full Time**	**Part Time**	**Full Time**	**Part Time**	**Carry Own Med Mal Policy**
Aesthetician					☐ Yes ☐ No
Laser Technician					☐ Yes ☐ No
LPN / RN					☐ Yes ☐ No
Medical Assistant					☐ Yes ☐ No
Nurse Practitioner					☐ Yes ☐ No
Physician Assistant					☐ Yes ☐ No
Physician					☐ Yes ☐ No
Other, please describe: _____					☐ Yes ☐ No

3.2	Are all of the above individuals licensed in accordance with applicable state and federal regulations?	☐ Yes ☐ No
3.3	Has the Applicant or any of the above staff:	
	a. ever been under the investigation of a regulatory agency?	☐ Yes ☐ No
	If yes, please explain:	
	b. ever been treated for alcoholism or drug addiction?	☐ Yes ☐ No
	If yes, please explain:	
	c. ever had any state professional license to prescribe narcotics suspended, revoked, refused, restricted or voluntarily surrendered?	☐ Yes ☐ No
	If yes, please explain:	
	d. take before and after pictures for cosmetic procedures?	☐ Yes ☐ No
	If no, please explain:	

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	e. have all patients and minors with parental consent sign consent forms specific to procedures being performed?	☐ Yes ☐ No
	If no, please explain:	
	f. perform any services offsite?	☐ Yes ☐ No
	If yes, please explain:	
3.4	Please complete the following for procedure(s) you perform annually:	

Procedure(s)	Current #	Projected #	Professional performing procedure
Acne Blue Light			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Acupuncture			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
BHRT			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Body Wraps			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Botox			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Chelation Therapy			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Chemical Peels:			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
30% acidity or less:			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Over 30% acidity:			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Colonics			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Cool Sculpting			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Cryotherapy			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Day Spa services (waxing, hair, nails, reflexology, aromatherapy)			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Dermal Fillers			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Ear Candling			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Electrolysis			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Facials – Basic / Special			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Fat Injections			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Hair Transplant			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
HCG (for weight loss only)			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Hormone Therapy (NO BHRT), explain type:			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Invasive Lipolysis			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
IPL			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Laser Hair Removal			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Laser Skin Treatment			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:

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Procedure(s)	Current #	Projected #	Professional performing procedure
Laser Tattoo Removal			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Laser Vein up to 1.5 mm			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Latisse			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
LED Hair Stimulation			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Lipo-Dissolve			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Lipo Injections			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Lipolysis			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Liposuction			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Laser Assisted			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Tumescent			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Low T			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Mesotherapy			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Microdermabrasion			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Microneedling			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Non-surgical cellulite treatment (velashape, thermage & endermologie)			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
P - Shot			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Permanent Makeup			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Photo Therapy			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Plastic / Cosmetic Surgery, describe surgical procedures:			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
PRP Injections			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
O - Shot			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Sclerotherapy			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Skin Tag Removal			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Teeth Whitening			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Vitamin Injections			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Weight Loss Counseling			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:
Other, please describe:			☐ LPN ☐ NP ☐ Nurse ☐ PA ☐ Physician ☐ Other, please list:

3.5	Are there any procedures listed above and/or not listed above that you have performed but are no longer performing? If yes:	☐ Yes ☐ No
	a. What is the procedure?	
	b. When was the procedure first performed?	
	c. When was the procedure last performed?	
	d. How many procedures have been performed?	

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IV. DESIRED EFFECTIVE DATE / LIMITS / DEDUCTIBLE OPTIONS

4.1	Desired Effective Date:	(mm/dd/yyyy)
4.2	Desired Limits for Professional Liability:	
	Each Claim:	☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000 ☐ Other _____
	Aggregate Limit	☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000 ☐ Other _____
4.3	Desired Deductible:	☐ None ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Other _____
4.4	Would you like a Quotation with General Liability (limits will equal Professional Liability limits)?	☐ Yes ☐ No

V. PROFESSIONAL LIABILITY HISTORY

5.1	Do you have Professional Liability insurance? If yes:	☐ Yes ☐ No
	a. If current policy is Claims Made, what is your retroactive date?	
	b. Please complete the following:	

Policy Year	Carrier	Limits of Insurance	Deductible	Policy Effective Date (mm/dd/yyyy)	Annual Premium
Expiring Policy:					
One year prior:					
Two years prior:					
Three years prior:					
Four years prior:					

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS SUPPLEMENTAL APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY AND ARE MADE PART OF THE MISCELLANEOUS MEDICAL GENERAL APPLICATION.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued. I HAVE READ AND UNDERSTAND THE FRAUD WARNINGS CONTAINED IN THE MISCELLANEOUS MEDICAL GENERAL APPLICATION.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

Signature of authorized representative of Applicant	**Title**
Type / Print name of authorized representative	**Date**
Producer Signature	**Date**