Braishfield
a division of Hull & Company, LLC

Anti-Aging Services
Mainform Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone number:

4. Website: Email:

5. Date established:

6. Applicant's practice is a:

☐ Solo practitioner (unincorporated)	☐ Solo practitioner (incorporated)
☐ Corporation (for-profit)	☐ Corporation (non-profit)
☐ Professional Association	
☐ Other (please describe):	

7. Please state sources and amounts of total revenue:

	Amount last 12 months	Estimated next 12 months
Fee for services	$	$
Product sales	$	$
Other (explain)	$	$
TOTAL gross revenue:	$	$

Operations, Activities, & Staffing

If applicant has a training school, complete questions 8 and 9 below:

8.

Profession for which students are being trained	Max No. of students per session	No. of sessions per year	Number of faculty per session	Qualification of faculty (e.g. MD RN)

9. What is the total number of faculty members?

10. List all manufactured equipment and drugs used in the applicant's practice and the purpose for which each is used:

11. a. Indicate the number of applicant's staff:

	Employed	Contracted
Aesthetician		
Electrologist		
Laser technician		
Massage therapist		
Medical Assistant		
Nurse Practitioner		
Physician		
Physician Assistant		
Registered Nurse		
Other (specify)		

b. Are all of the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐

If No, please attach explanation.

c. i. Do you require contracted staff to carry their own Professional Liability Insurance? Yes ☐ No ☐

ii. If Yes, do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

d. Has the applicant or have any of the above employees: (Attach detailed explanation for any 'Yes" answers)

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

12. Do you operate any of the following equipment on your premises?

Infrared sauna Yes ☐ No ☐ Steam room Yes ☐ No ☐

Float tank Yes ☐ No ☐ Tanning bed Yes ☐ No ☐

13. Are any mergers, acquisitions, divestitures, or a complete sale of your business planned in the next 12 months? Yes ☐ No ☐

If Yes, please explain:

14. a. Provide the following information for all procedures performed, include proof of training/certification, informed consent forms, and client selection protocols:

Procedure Name	Performed By	Number of Procedures (performed annually)
DAY SPA		
Massage		
Facial		
Chemical peels		
Cosmetology (hair/nails/waxing)		
Microdermabrasion		
Teeth whitening		
Colon hydrotherapy		
Permanent makeup (incl. microblading)		
INJECTIONS		
Botox injections		
Dermal fillers: Specify type:		
Sclerotherapy		
Mesotherapy		
Platelet Rich Plasma		
Stem cell therapy: Specify type:		
LASER & LIGHT & RF		
Class III		
Intense Pulsed Light		
Class IV: Specify type & use:		
Radiofrequency: Specify type & use:		
Plasma pen		
HORMONE THERAPY		
Bio-identical hormone replacement therapy		
HCG therapy for weight loss		
Other (describe):		
SURGICAL		
Liposuction: Specify type:		
Plastic surgery: Specify type:		
Thread-lifts		
Hair transplants		
Other (describe):		
OTHER		
Cryotherapy		
Ultrasound cellulite reduction		
IV therapy: Specify type:		
Other (describe):		

b. Are any of the above procedures performed by a physician or dentist? Yes ☐ No ☐

If Yes, does the physician(s) or dentist(s) have Medical Malpractice Liability Insurance for this activity? Yes ☐ No ☐
If No, please submit a Physician Supplemental application and C.V. for each physician or dentist to be included.

Risk Management

15. Are informed patient consent forms outlining the risks and benefits of, and alternatives to, treatment required to be signed and dated by all patients receiving laser, injection, hormone therapy, or surgical treatments? Yes ☐ No ☐ Do not perform ☐

16. Is patient skin typing performed prior to all class IV laser or IPL treatments? Yes ☐ No ☐ Do not perform ☐

17. Is formal (not in-house), hands-on training required for anyone performing laser or injection treatments? Yes ☐ No ☐ Do not perform ☐

18. Do you require background checks for all staff that will be in closed-door treatment rooms with clients? Yes ☐ No ☐ Do not perform ☐

19. Do you have formal, written sexual misconduct policies and procedures outlining appropriate staff-client interactions? Yes ☐ No ☐ Do not perform ☐

20. Do you train staff on how to appropriately drape a client during massage therapy? Yes ☐ No ☐ Do not perform ☐

21. Is a licensed physician medical director onsite or readily available for consult when performing any class IV laser, IPL, or injection treatments? Yes ☐ No ☐ Do not perform ☐

Insurance and Claims History

22. List prior professional liability insurers for the past 5 years (if none, check here ☐):

Insurer	Dates Covered (From-To) mm/dd/yyyy	Limits of Liability per Claim/Aggregate	Deductible	Premium	Coverage Type: Occurrence or Claims-Made
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	

23. If the current/expiring policy is on a Claims-Made form, what is the retroactive date? mm/dd/yyyy

24. Is the applicant currently insured under a commercial general liability policy, including products and completed operations coverage? Yes ☐ No ☐

If Yes, please list below, if none, check here ☐:

Insurer	Dates Covered: (From-To) mm/dd/yyyy	Limits of Liability per Claim/Aggregate	Deductible	Premium	Coverage Type: Occurrence or Claims-Made
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	

25. If the current/expiring policy is on a Claims-Made form, what is the retroactive date? mm/dd/yyyy

26. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please attach an explanation.

27. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐
If Yes, please attach complete details including a description of the indicent(s).

28. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐

If Yes, please complete a Supplemental Claims Information Form for each claim.

29. How many claims have been made in the last five (5) years?

APPLICATION DISCLOSURES:

If there is any material change in the answers to the questions in this Application before the proposed policy inception date, you must notify us in writing and any outstanding quote for insurance coverage may be modified or withdrawn.

Your submission of this Application does not obligate us to issue, or you to purchase, a policy. You authorize us to make any inquiry in connection with this Application.

All written statements and materials furnished to us in conjunction with this Application are incorporated into this Application and made a part of it.

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 containing any false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime.

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:	
Signature of person authorized to execute on behalf of the applicant:	
Name/title of person authorized to execute on behalf of the applicant:	
Date:	

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated.
Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.