HISCOX PRO™

Anti-Aging Services

Renewal 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. 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:	$	$

Staffing Information

6. 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 the same staff members from the prior policy year insured with Hiscox? Yes ☐ No ☐

If No, please attach training certificates for any new staff.

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. i. Do any physicians or dentists perform direct patient care services on behalf of the applicant? Yes ☐ No ☐

ii. Do all physicians or dentists performing direct patient care services maintain separate Medical Malpractice Liability Insurance extending to these services? Yes ☐ No ☐

If No, please submit a physician supplemental application and CV for each physician or dentist to be included.

Operations and Activities

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

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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):		

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	8.	Are any mergers, acquisitions, divestitures, or a complete sale of your business planned in the next 12 months? If Yes, please explain:	Yes ☐ No ☐
Insurance and claims history	9.	Has the applicant notified Hiscox Inc. of all matters that may result in a potential claim including any litigation, administrative proceedings, demand letters, formal or informal investigations, or inquiries which have occurred within the expiring policy period? If No, please attach a detailed explanation or explain in the comments section.	Yes ☐ No ☐ None to report ☐

Comments section

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 thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

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.