



Allied Healthcare Professional Liability and General Liability:

DAY SPA SERVICES/MESSAGE THERAPIST SUPPLEMENTAL APPLICATION

- Name of applicant: _____
- If massage therapy is performed, is the therapist or other staff currently certified in Cardio-Pulmonary Resuscitation (CPR)? N/A Yes No
- Does any person for whom coverage is sought, conduct blood analysis or stress testing now or expect to in next 12 months? Yes No

4. Please list all services the applicant currently provides or intends to provide over the next 12 months:

Type of service	Annual number of procedures	Name and job title of person performing procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5.. If any of the applicant's services involve the following, please note in the space provided the number of procedures over the past 12 months

- | | |
|--|--|
| <input type="checkbox"/> Ablative laser resurfacing | <input type="checkbox"/> Laser and intense pulsed light procedures |
| <input type="checkbox"/> Botox/restylane/filler injections | <input type="checkbox"/> Laser skin rejuvenation |
| <input type="checkbox"/> Dental spa services | <input type="checkbox"/> Medical peels |
| <input type="checkbox"/> Dermal fillers | <input type="checkbox"/> Medical spa services |
| <input type="checkbox"/> Ear/body piercing | <input type="checkbox"/> Microdermabrasions/chemical peels |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Other surgical procedures |
| <input type="checkbox"/> Fraxel/laser removal of wrinkles, scars, age spots/tattoo removal | <input type="checkbox"/> Oxygen bar |
| <input type="checkbox"/> Infrared body wraps | <input type="checkbox"/> Photo-facials |
| <input type="checkbox"/> Insertion of permanent makeup/pigment in or under the skin | <input type="checkbox"/> Tanning services |
| | <input type="checkbox"/> Thermage |

6. Percentage of services provided to minors: _____%

7. Percentage of services provided in the following specialties:

Cardiopulmonary/cardio related conditions _____%

Pregnancy massage _____%

Neurological conditions _____%

This supplemental application is incorporated into and is deemed a part of the other application(s) submitted in connection with the requested insurance. Any and all notices and representations included in such other application(s) are incorporated by reference in this supplemental application as though fully set forth herein.

Applicant's Signature _____ Title _____ Date _____
 (Principal, Partner or Officer)

Print Name _____

This document does not amend, extend or alter the coverage afforded by the policy. For a complete understanding of any insurance you purchase, you must first read your policy, declaration page and any endorsements and discuss them with your broker. A specimen policy is available from an agent of the company. Your actual policy conditions may be amended by endorsement or affected by state laws.