



**NEW BUSINESS APPLICATION**

**MISCELLANEOUS HEALTHCARE FACILITIES PROGRAM**

- General Star Indemnity Company
- General Star National Insurance Company

Wholesaler: \_\_\_\_\_ Location: \_\_\_\_\_  
City State

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-Mail : \_\_\_\_\_

*NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.*

**Instructions to the Applicant.**

- A. Please answer **all** the questions on this application and on applicable supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- C. The application must be signed and dated by an owner, partner, officer or director of your facility.
- D. Please attach the following to your completed application:
  - 1. brochures, pamphlets, advertisements or other descriptive literature of operations and services,
  - 2. copies of any surveys conducted by outside organizations within the past three years,
  - 3. copy of the current practice license(s),
  - 4. company loss runs, valued within the last 90 days, for past 5 years, or for as long as you have been in business if less than 5 years. **Losses should be provided on a report year basis**, and
  - 5. Current income statement and balance sheet.

**I. GENERAL INFORMATION**

Applicant's/Entity's Name: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

1. Mailing Address: \_\_\_\_\_  
Street/P.O. Box City County State Zip Code

2. Business Address: \_\_\_\_\_  
Street City County State Zip Code

3. Telephone Number: \_\_\_\_\_ Web Site: \_\_\_\_\_

4. Applicant is a:  Individual  Partnership  Corporation  Joint Venture  Other: \_\_\_\_\_  
 Applicant is:  For Profit  Not for Profit

5. Years in Business: \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

6. Description of Operation: (complete & attach the appropriate SUPPLEMENTAL APPLICATION)

- Blood / Donor Bank
- Home Health Care / Hospice Care
- Laboratory / Imaging
- Out-Patient Facility / Ambulatory Surgery Center
- Air or Ground Ambulance Service
- Durable Medical Equipment Supplier
- Birthing Center
- Other (describe) \_\_\_\_\_

Please provide additional details as necessary: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. List below all subsidiaries, date acquired, description of operation and percentage of ownership:

Subsidiaries	Date Acquired	Description of Operation	% of Ownership
			%
			%

8. Within the next 12 months, does the applicant plan to: (check all that apply and provide details)

- Purchase or acquire another operation or entity?
- Add any services?
- Expand the number of locations?
- Expand operation into other states?

Details: \_\_\_\_\_

9. Has the applicant sold, discontinued or acquired any operations since the retroactive date of your current policy? If yes, please provide details: \_\_\_\_\_  Yes  No

**II. OPERATIONS**

1. Provide applicant's total **gross** annual revenues:

Projected	\$ _____
Current Year	\$ _____
Past Year	\$ _____
2 <sup>nd</sup> Previous Year	\$ _____

2. If your operation is an outpatient facility, please provide the number of outpatient visits:

Projected	# _____
Current Year	# _____
Past Year	# _____
2 <sup>nd</sup> Previous Year	# _____

3. Is the applicant accredited by or a member of any professional organization or association?  Yes  No  
If yes, please name: \_\_\_\_\_

If accredited, please provide a copy of the accreditation report.

3. Is applicant certified for Medicare reimbursement?  Yes  No

4. Does the applicant maintain a current state license? If yes, please provide copy.  Yes  No

5. Has applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any state or federal licensing board or regulatory agency? This includes but is not limited to Medicare, Medicaid, or other reimbursement programs. If yes, please provide details: \_\_\_\_\_  Yes  No

6. Are all operations provided out of the main location? If no, please attach a listing of all locations including a description of services conducted at each location.  Yes  No

7. Are any services provided for or at Nursing Homes, Assisted Living Facilities, or Long Term Care Facilities? If yes, please describe. \_\_\_\_\_  Yes  No

8. a. Does applicant have any contractual agreements with independent contractors to provide services at applicant's facility?  Yes  No

b. Does contractual agreement contain a hold harmless or indemnification clause favorable to applicant?  Yes  No

c. Does applicant obtain certificates of insurance in the amount of \$1m/\$3m (minimum) from all Healthcare Professionals, e.g., Resident, intern, Physician, Surgeon, Dentist, Psychiatrist, Licensed or Certified Registered Nurse Anesthetist, Nurse, Midwife, Podiatrist and Chiropractor rendering professional services at the facility?  Yes  No

9. a. Does applicant provide services to others on a contractual agreement? If yes, please describe services provided: \_\_\_\_\_  Yes  No

b. Does the applicant agree to hold harmless or indemnify others under contract? If yes, please provide details: \_\_\_\_\_  Yes  No

10. Does applicant sell or lease any medical supplies and/or equipment to others? If yes, please complete and attach the Durable Medical Equipment Supplemental Application.  Yes  No
11. Does applicant provide any overnight bed facilities? If yes, advise number of beds: \_\_\_\_\_  Yes  No
12. Do you have written protocols and transfer agreements to transfer patients in the event of a life-threatening emergency? Please provide a copy of those documents and advise:  Yes  No

Name of the facility \_\_\_\_\_  
 Number of miles to the facility \_\_\_\_\_ Miles  
 Driving time to facility \_\_\_\_\_ Minutes

13. Please provide the following information for each medical director providing services at the applicant's facility:

Medical Director's Name	Specialty	Insurance Carrier & Policy Number	Limits	Employee/ Contractor	Hours per Month

Please note: Coverage for Medical Director is limited to administrative duties as described in the policy form.

14. Identify the number of other employed health care professionals providing services at the applicant's facility:

Type of Professional	# Full Time Employees	# Part Time Employees	# Full Time Contractors	# Part Time Contractors	Contractors Annual Hours
EMT	_____	_____	_____	_____	_____
Nurse	_____	_____	_____	_____	_____
Nurses Aid	_____	_____	_____	_____	_____
Nurse Practitioner	_____	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____	_____
Paramedic	_____	_____	_____	_____	_____
Pharmacist	_____	_____	_____	_____	_____
Phlebotomist	_____	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____	_____
Physician Assistant	_____	_____	_____	_____	_____
Radiation Technician	_____	_____	_____	_____	_____
Respiratory Therapist	_____	_____	_____	_____	_____
Social Worker	_____	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____	_____

### III. RISK MANAGEMENT/LOSS CONTROL

1. Does applicant utilize a formal written Risk Management Program?  Yes  No  
 If yes, attach a written summary of, the Table of Contents, or copy of the written policy/procedure document.
2. Who has the overall responsibility for Risk Management & Loss Control?  
 Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
4. Who is to be contacted for loss control survey, if different than above?  Same as #2  
 Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
4. a. Does applicant own any equipment used for diagnosis, monitoring or treatment purposes?  Yes  No
- b. Is there a written procedure followed for the inspection and maintenance of any equipment that is owned or leased?  Yes  No
- c. Who is responsible for inspecting and maintaining the equipment?  Employees  Independent Contractors
- d. If Independent Contractors are utilized, are certificates of Insurance obtained?  Yes  No
- e. Is inspection and maintenance performed according to the manufacturer's recommendations?  Yes  No

5. Indicate which hiring/screening procedures are used for employees and contractors: (check all that apply)
- References checked:  In writing  By telephone
  - Criminal records checked
  - Require information on any professional liability or work related claim or suit
  - Verify any pending license suspensions, revocations or pending disciplinary actions by other facilities
6. Are "INFORMED CONSENT" forms used? If yes, please provide a copy.  Yes  No
7. Is there a written policy or procedure document describing:
- a. Employee training?  N/A  Yes  No
  - b. Incident Reporting?  N/A  Yes  No
  - c. Medical equipment training?  N/A  Yes  No
  - d. Infection Control?  N/A  Yes  No
  - e. patient acceptance?  N/A  Yes  No
  - f. patient evaluations?  N/A  Yes  No
  - g. safety for workers in offsite locations?  N/A  Yes  No
  - h. lifting requirements?  N/A  Yes  No
  - i. drug administration procedures?  N/A  Yes  No
  - j. food preparation?  N/A  Yes  No
  - k. patient discharge procedures?  N/A  Yes  No
  - l. advance directives such as a "Living Will"?  N/A  Yes  No
8. Does applicant have written job descriptions in place for:
- a. all professionals?  Yes  No
  - b. all clinical support staff?  Yes  No

#### IV. BUILDING INFORMATION

1. Building Construction: \_\_\_\_\_ Year Built: \_\_\_\_\_
2. Number of Stories \_\_\_\_\_  
Number of Exits per Floor \_\_\_\_\_
3. Are there smoke detectors and fire extinguishers?  Yes  No
4. Is building completely sprinklered?  Yes  No
5. Are there fire alarms? If yes, advise number \_\_\_\_\_ and type \_\_\_\_\_  Yes  No
6. Fire Department is:  Paid  Volunteer
7. Are the electrical, heating and plumbing systems up to code and regularly inspected?  Yes  No

#### V. PRIOR POLICY AND LOSS INFORMATION

1. Please provide the following information pertaining to applicant's past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	

2. Has the applicant ever had any insurance company decline, cancel, rescind or non-renew any Professional and/or General Liability Insurance Policy? If yes, please provide details:  Yes  No
-

3. Is the applicant aware of any of the following:
- a. known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made?  Yes  No
  - b. knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that has not been reported to a prior insurance carrier?  Yes  No
  - c. knowledge of any request for medical records by a patient or his/her attorney which might result in a claim?  Yes  No
  - d. knowledge or information relating to service(s) on a Board which might result in a claim?  Yes  No
  - e. knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact?  Yes  No

If yes to any of the above, please provide details: \_\_\_\_\_  
 \_\_\_\_\_

**VI. COVERAGE REQUESTED**

**Effective Date:** \_\_\_\_\_ **Retroactive Date:** \_\_\_\_\_

*Important: Declarations Page of your current policy must be attached if a retroactive date is requested.*

**Primary Liability:** Professional Liability  Claims Made  
 General Liability  Claims Made  Occurrence

*Important: Limits for Professional Liability and General Liability must be the same when both provided, even though they apply separately.*

**Limits of Liability:**

- \$250,000/\$750,000
- \$500,000/\$1,500,000
- \$1,000,000/\$1,000,000
- \$1,000,000/\$3,000,000

- Deductible:**
- \$ 5,000 (minimum)
  - \$ 7,500
  - \$10,000
  - Other \$ \_\_\_\_\_

**Excess Limit of Liability:**

- \$1,000,000/\$1,000,000
- \$2,000,000/\$2,000,000
- \$3,000,000/\$3,000,000
- \$4,000,000/\$4,000,000
- \$5,000,000/\$5,000,000

**VII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE**

**PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.**

**By signing this Application, you represent and agree to each of the following five (5) items:**

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and
2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):
  - Ambulance Service Supplemental Application  Durable Medical Equipment Supplemental Application
  - Out-Patient / Ambulatory Surgery Center Supplementa Application  Laboratory & Imaging Supplemental Application
  - Blood / Donor Banks Supplemental Application  Home Health Care and Hospice Care Supplemental Application
  - Birthing Center Supplemental Application
  - Claim Information Supplemental Application  Other \_\_\_\_\_

3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:
  - a. Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
  - b. Representations you are making on behalf of all persons and entities proposed to be insured;
  - c. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy, and incorporated into the policy, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy, and regardless of whether any of the Supplemental Applications are signed or dated.
5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or in any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

**NEW YORK FRAUD WARNING: 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 insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

**FRAUD WARNING (not applicable in Nebraska, Vermont or Virginia): Any person who knowingly and with the 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.**

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where General Star National Insurance Company is "non-admitted or "surplus lines"), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

An authorized representative who is an active owner, officer, or partner of your organization must sign this Application within thirty (30) days prior to the policy inception date.

\_\_\_\_\_  
Signature of Owner, Officer or Partner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or Type Name and Title





**SUPPLEMENTAL APPLICATION FOR  
MEDICAL SPAS**

**MISCELLANEOUS HEALTHCARE FACILITIES  
PROGRAM**

*NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.*

**Instructions to the Applicant.**

- A. This supplemental application must be accompanied by the General Application for Miscellaneous Healthcare Facilities Program, form GSM-MHCF-06-01.
- B. Please answer **all** the questions on this supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- C. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- D. The application must be signed and dated by an owner, partner, officer or director of your facility.
- E. The following additional information is required. Any delay in providing this information will delay the company's decision to provide requested coverage:
  - 1. Sample Patient Informed Consent forms
  - 2. Brochures, pamphlets, advertisements, or other descriptive literature of operations and services
  - 3. Credentialing guidelines

**I. GENERAL INFORMATION**

This application has been formatted for ease of use based on the Applicant's core professional specialty. However, please answer each question as it relates to the professional services performed at the Applicant's facility.

Attach a separate page on the Applicant's letterhead if more space is required.

A. Applicant's / Entity's Name: \_\_\_\_\_

B. Indicate your Medical Director(s) and his/her medical specialty:

Who is providing the "good faith exam" at your facility? \_\_\_\_\_

C. Annual gross revenues: Current: \$ \_\_\_\_\_ Projected: \$ \_\_\_\_\_

D. Annual Outpatient/Client visits: Current: \_\_\_\_\_ Projected: \_\_\_\_\_

E. Total personnel working at your facility:

	Full Time	Part Time	Total
Employees*	_____	_____	_____
Contractors*	_____	_____	_____

\*Is a resume, curriculum vitae (CV), or training certificate attached for each individual indicated above?  Yes  No

**II. OPERATIONS**

A. Do you require that patients sign an Informed Consent form?  Yes  No

B. Do all physicians/dentists performing procedures at your facility carry professional liability insurance?  Yes  No

C. Are parent/guardian signatures required on Informed Consent forms for patents/clients under the age of 18?  Yes  No

D. Do you sell any products with the facility's name and/or label on them?  Yes  No  
If yes, attach complete product list and indicate annual sales: \$ \_\_\_\_\_

E. Do you ever hold off-site events?  Yes  No  
If yes, please describe:

- F. Are food and/or beverages served/sold on premises?  Yes  No  
 Is liquor served/sold on premises?  Yes  No  
 If yes to either of the above, please indicate annual sales:  
 Food / Beverages \$ \_\_\_\_\_ Liquor \$ \_\_\_\_\_
- G. Is any cooking/food preparation done on premises?  Yes  No  
 If yes, please describe: \_\_\_\_\_
- H. Please indicate the number of the following on your premises (if none, write "N/A"):
- |                         | Number |
|-------------------------|--------|
| Swimming Pool           | _____  |
| Sauna                   | _____  |
| Steam Room              | _____  |
| Whirlpool-type Spa      | _____  |
| Tanning Booths          | _____  |
| Other (describe): _____ |        |
- I. Do you operate a fitness club?  Yes  No  
 If yes, please describe: \_\_\_\_\_
- J. Do you provide daycare services solely for your patients/clients?  Yes  No  
 If yes, provide the following:  
 Maximum number of children at one time: \_\_\_\_\_  
 Do you accept infants < 3 months of age?  Yes  No  
 Ratio of Staff \_\_\_\_\_ to children \_\_\_\_\_  
 Activities provided: \_\_\_\_\_
- Are the parents/guardians allowed to leave the premises without their child(ren)?  Yes  No

### III. PROCEDURES AND PERSONNEL

A. Please check (✓) which of the following indicates your **core** professional specialty:

- \_\_\_\_\_ **Aesthetic / Cosmetic**  
 \_\_\_\_\_ **Preventative / Wellness**  
 \_\_\_\_\_ **Complementary / Alternative**

B. Please check (✓) **all** procedures performed at your facility:

Aesthetic / Cosmetic	Preventative / Wellness	Complementary / Alternative
<input type="checkbox"/> Acne Therapy	<input type="checkbox"/> Addiction Therapy	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Botox / Collagen	<input type="checkbox"/> Bone Density	<input type="checkbox"/> Ayurvedic Medicine
<input type="checkbox"/> Cellulite	<input type="checkbox"/> Cardiovascular Medicine	<input type="checkbox"/> Biofeedback
<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Chelation Therapy
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chinese Medicine
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Executive Health Screening	<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Laser Hair	<input type="checkbox"/> Imaging Tests	<input type="checkbox"/> Detoxification
<input type="checkbox"/> Laser Skin	<input type="checkbox"/> Lab Tests	<input type="checkbox"/> Homeopathy
<input type="checkbox"/> Liposuction	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Hormone Therapy
<input type="checkbox"/> Microdermabrasion	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Mesotherapy
<input type="checkbox"/> Permanent Makeup	<input type="checkbox"/> Physical Examinations	<input type="checkbox"/> Mind/Body Medicine
<input type="checkbox"/> Photo Rejuvenation	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Naturopathic Medicine
<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Pre- / Post- Natal	<input type="checkbox"/> Nutrition Therapy
<input type="checkbox"/> Pre- / Post- Operative	<input type="checkbox"/> Sexual Health	<input type="checkbox"/> Spirituality & Healing
<input type="checkbox"/> Sclerotherapy (veins)	<input type="checkbox"/> Sleep Health	<input type="checkbox"/> Thermal Waters
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Western Herbal Medicine
_____	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Other (specify)
_____	_____	_____

**C. AESTHETIC / COSMETIC - Number of Professionals performing these procedures: \_\_\_\_\_.**  
**Complete the information below.**

Name of Procedure	Designation of Professional(s) Performing Procedure	# of Procedures Performed Annually at Your Facility
1. Acne Phototherapy and/or Photo Rejuvenation (blue light)	_____	_____
2. Dental (specify Type) _____	_____	_____
3. Facial Peels:	_____	_____
a. Chemical	_____	_____
b. Mechanical (aka dermabrasion, microdermabrasion)	_____	_____
c. Laser application	_____	_____
4. Injections:	_____	_____
a. Botox	_____	_____
b. Collagen, Fat, Silicone	_____	_____
5. Hair Removal:	_____	_____
a. Electrolysis	_____	_____
b. Laser Application	_____	_____
6. Hair Transplant	_____	_____
7. Liposuction (specify type) _____	_____	_____
8. Permanent Makeup	_____	_____
9. Plastic Surgery (specify type) _____	_____	_____
10. Sclerotherapy (veins)	_____	_____
11. Other (specify type) _____	_____	_____

D. Do you take before and after pictures of patients involving the above (Item C) procedures?  Yes  No  
 If no, please explain:

\_\_\_\_\_

**E. PREVENTATIVE / WELLNESS – Number of Professionals performing these procedures: \_\_\_\_\_.**  
**Complete the information below.**

F. Is any methadone treatment administered?  Yes  No  
 If yes, indicate annual number of treatments: \_\_\_\_\_ and  
 attach description of treatment and controls used.

G. Is imaging performed at your facility? If yes, please indicate annual number of tests:  Yes  No

- Mammograms \_\_\_\_\_
- Ultrasounds \_\_\_\_\_
- Bone Density \_\_\_\_\_
- MRI/CT Scans \_\_\_\_\_
- Other (describe) \_\_\_\_\_

\_\_\_\_\_

H. Do you use drugs as part of weight treatment plan for patients/clients?  Yes  No  
 If yes, percent of practice devoted to weight reduction: \_\_\_\_\_; and attach list of drugs used and frequency and duration of prescriptions; and copy of screening protocols for patients undertaking a weight treatment plan.

I. Do you sell dietary supplements?  Yes  No  
 If yes, identify brand names \_\_\_\_\_  
 Annual sales: \$ \_\_\_\_\_

J. **COMPLEMENTARY / ALTERNATIVE** -- Number of Professionals performing these procedures: \_\_\_\_\_.  
 Complete the information below.

Name of Procedure	Designation of Professional(s) Performing Procedure	# of Procedures Performed Annually at Your Facility
1. Acupuncture a. Limited to analgesia Identify treatment use: _____	_____	_____
b. With laser or electro Identify treatment use: _____	_____	_____
c. With direct moxibustion Identify treatment use and indicate scarring or non-scarring: _____	_____	_____
2. Chelation Therapy as treatment for arteriosclerosis	_____	_____
3. Chiropractic Manipulation under anesthesia	_____	_____
4. Other (specify type): _____	_____	_____

**PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR FACILITY NOT SPECIFICALLY ADDRESSED HEREIN.**

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

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 fact material thereto, commits a fraudulent insurance act.

\_\_\_\_\_  
Signature of Owner, Officer or Partner

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Date