Allied Healthcare Professional Package Product

DAY SPA SERVICES/MASSAGE THERAPIST SUPPLEMENTAL APPLICATION

1. Name of applicant: _____

2. 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. 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

____ Ablative laser resurfacing	____ Botox/Restylane/Filler injections	____ Dental spa services
____ Dermal fillers	____ Ear/Body piercing	____ Electrolysis
____ Laser and intense pulsed light procedures	____ Laser skin rejuvenation	____ Medical peels
____ Other surgical procedures	____ Oxygen bar	____ Thermage
____ Fraxel/Laser removal of wrinkles, scars, age spots/tattoo removal		____ Infared body wraps
____ Insertion of permanent makeup/pigment in or under the skin		____ Medical spa services

4. Does the applicant provide waxing services? ○ Yes ○ No

5. Does the applicant provide massage therapy services? ○ Yes ○ No

6 Does the applicant provide chemical peel services? ○ Yes ○ No

If yes,

Are all chemical peels performed by a licensed Aesthetician? ○ Yes ○ No

Percentages of chemical peel services:

Overall spa services consisting of chemical peels? _____ %

Chemical peels that are "light" (superficial, use Aha's/salicylic acids) _____ %

Chemical peels that are "medium" (TCA's) using solution strength: under 20% _____ %

over 20% _____ %

Chemical peels that are "deep" (Phenol) _____ %

7. Percentage of services provided to minors: _____ %

8. Percentage of services involving pregnancy massage _____ %

6a. Percentage of pregnancy massage in 1st or 3rd trimester _____ %

9. Does the applicant provide tanning services? ○ Yes ○ No

If yes,, what % of overall spa services involving tanning? _____ %

10. Does the applicant have waterless massage machine(s)? ○ Yes ○ No

11. Does the applicant have saltwater flotation chamber(s)? ○ Yes ○ No

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 _____

Agent's signature: _____

(Required in New Hampshire)