



Micropigment Implantation, Tattoo, Body Piercing Professional Liability Application

NOTICE: THE COVERAGE APPLIED FOR PROVIDES CLAIMS-MADE AND REPORTED COVERAGE WHICH PROVIDES LIABILITY COVERAGE ONLY IF A CLAIM IS MADE DURING THE POLICY PERIOD AND REPORTED IN WRITING TO US SUBSEQUENT TO THE EFFECTIVE DATE AND PRIOR TO THE EXPIRATION DATE OF THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.S.

ATTACH ADDITIONAL SHEETS AS NECESSARY. ANSWER ALL QUESTIONS. IF NOT APPLICABLE, INDICATE N/A

GENERAL INFORMATION

Name of Applicant:
Principal business premise address: Street: County:
City: State: Zip:
Website address: Email address:
Number of Employees: Full time Part time Seasonal Total
Date established:
Applicant is: Sole Proprietorship Partnership Professional Association
Corporation Employee of: (specify):

BUSINESS OPERATIONS

- 1. Annual number of client encounters:
2. Total Gross Revenues: This fiscal year: \$ Estimated next fiscal year:\$

If you answer YES to any of questions 3-6 below, please attach a detailed explanation and copies of all pertinent advertisements.

- 3. Do you own or operate any business other than that shown in the General Information above? Yes No
4. Are you employed by any individual or entity other than that shown in General Information above? Yes No
5. Are you under contract to any individual or entity? Yes No
6. Do you advertise professional services in any manner? Yes No

YOUR PRACTICE

- 1. Please provide a description of professional services:
2. Does your practice include piercings of the following? Check all that apply: Head Torso Hands/Feet Genitalia
3. Please describe the nature and duration of your professional training:
Institution name, if applicable:
Years of training:
Certification attained, if applicable:
4. Have you received training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? Yes No
If no, please explain:

5. Have you received training pertaining to the safe handling of blood-borne pathogens? Yes No
6. In what states are you licensed, certified or registered as a practitioner?

7. Do you practice as an independent contractor? Yes No
If yes, where do you practice? _____
8. Are you a member of: (check all that apply)
 American Academy of Micropigmentation Society of Permanent Cosmetic Professionals
 Alliance of Professional Tattooists Association of Professional Piercers
 Other (please specify): _____
9. In what setting(s) do you provide professional services: (check all that apply)
 Store/kiosk/mall Medical/Dental office Private office
 Home/Home office Spa/Salon Other (please specify): _____
10. Are you employed by, associated with or do you work for a physician or surgeon? Yes No
If yes, give details including name and specialty of physicians you work for:

11. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? Yes No
If yes, please describe in detail: _____
12. Are clients screened for existing and prior medical conditions prior to treatment? Yes No
13. Is signed and dated informed consent obtained from all patients prior to commencing treatment? Yes No
Please provide a copy of the informed consent form.
14. Are services performed on clients under the age of 18? Yes No
If yes, is written consent of the parent/legal guardian obtained before performing any procedure? Yes No
15. Are clients provided with written aftercare instructions? Yes No
Please provide a copy of the aftercare instructions.
16. Are patient treatment records kept? Yes No
If yes, how long are patient treatment records kept? _____
17. Are disposable needles and disposable gloves (latex or non-latex) used in your procedures? Yes No
18. For the categories listed below, please identify the method(s) of cleaning, disinfection or sterilization employed in your practice:

	Sterilized*	Disinfected**	Cleaned***	Disposable
Needles	Yes	Yes	Yes	Yes
	No	No	No	No
Equipment/Instruments/Articles intended to penetrate the skin	Yes	Yes	Yes	Yes
	No	No	No	No
Jewelry/Ornaments	Yes	Yes	Yes	Yes
	No	No	No	No
Patient Furniture/Floors	Yes	Yes	Yes	Yes
	No	No	No	No
Other _____	Yes	Yes	Yes	Yes
	No	No	No	No

* Subjected to a process that eliminates all forms of microorganisms, e.g. autoclave

** Subjected to a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects, e.g. use of alcohol, peroxide, bleach, etc.

*** Subjected to manual or mechanical removal of visible soil using water and detergent or other enzymatic product.

19. Do any tattoo inks utilized in your practice contain paraphenylenediamine (PPD) or black henna? Yes No
20. Is the ink utilized in your practice manufactured only with sterile water? Yes No
21. Is only sterile water used for the purpose of diluting tattoo ink? Yes No
22. Do you perform tattoo removal? Yes No
23. Are piercing instruments and implant jewelry/ornaments used in your practice only made of non-toxic metals? Yes No
24. Are any piercings performed with a piercing gun? Yes No
If yes, what body parts are pierced? _____
25. Do you use disposable sterile cassettes in your piercing gun? Yes No

INSURANCE AND CLAIMS HISTORY

1. Limits of Liability for Professional Liability requested: \$_____ / \$_____
2. Deductible requested: \$_____
3. Retroactive Date: _____
4. List prior Professional Liability Insurance carried for each of the last five years, including the current year.
If none, check here: _____

Ins. Co.	Limits of Liability	Deductible	Premium	Eff/Exp Dates	Claims Made or Occurrence	Retroactive Date

5. Is coverage requested for independent contractors? Yes No
If no, do independent contractors carry their own professional liability limits? Yes No
If yes, what limits of liability are maintained? \$_____ / \$_____
6. Has the Applicant or any employed or contracted healthcare providers:
- a. Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes No
 - b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
 - c. Ever been treated for alcoholism or drug addiction? Yes No
 - d. 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
 - e. Ever had any insurance company or Lloyds cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? Yes No
- If yes to a. - e., provide details by attachment.*
7. Is the Applicant or any employed or contracted healthcare provider aware of any act, error, omission, fact, circumstance, situation or incident which may result in a disciplinary or investigative proceeding by a governmental or administrative agency Yes No

8. Has any claim or suit for alleged malpractice been brought against the Applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant? Yes No
If yes, provide currently valued 5-year company loss runs or complete a copy of our Supplemental Claim form for each claim or suit.
9. Is the Applicant aware of any act, error, omission, fact, circumstance, situation or incident which may result in a malpractice claim or suit being made or brought against the Applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant organization? Yes No
If yes, completed a copy of our Medical Incident form for each incident.

GENERAL LIABILITY

Check if coverage NOT requested: _____

1. Please complete the following for each of the Applicant's facilities:

Loc #	Name of Facility	Address of Facility	Description (Yes/No)	Does the Applicant Maintain a Garage? (Yes/No)	Is there an Adjacent Exposure? (Yes/No)

2. Does the Applicant maintain office space at a host facility? Yes No
3. Does the Applicant have a written safety program in place? Yes No
If yes, attach a copy of the written safety program.
4. Does the Applicant have written procedures for incident reporting? Yes No
5. Does the Applicant want coverage for any additional insureds? Yes No
If yes, list any additional insureds that coverage is requested for and the relationship to the Applicant:
- _____

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 subjects that person to criminal and civil penalties (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.) **(Not applicable in AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OK, OR, PA, PR, RI, TN, VA, WA, WV)**

Applicable in Alabama, Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, and West Virginia: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

Applicable in California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Florida and Oklahoma: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony. (In FL, a person is guilty of a felony of the third degree.)

Applicable in Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit

pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Applicable in Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Applicable in Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

REPRESENTATIONS

Verus Specialty Insurance, a Berkley Company, is authorized to make any inquiry in connection with this application. Signing this application does not bind Verus Specialty Insurance or the Company to provide or the Applicant to purchase the insurance. This application, information submitted with this application, and all previous applications and material changes thereto of which Verus Specialty Insurance or the Company receives notice is on file with Verus Specialty Insurance and is considered physically attached to and part of the policy if issued. Verus Specialty Insurance and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Verus Specialty Insurance, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I/We warrant to Verus Specialty Insurance and the Company, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should Verus Specialty Insurance and the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Verus Specialty Insurance or the Company.

It is understood and agreed that prior to the inception date of the policy no applicant knew, nor could have reasonably foreseen, any negligent act, error or omission or breach of professional duty, or personal injury or other circumstances that reasonably might result in a Claim covered by this policy.

SIGNATURE

Name of Applicant:		
Signature of person authorized to execute on behalf of the applicant:		Date:
Print Name and Title of person authorized to execute on behalf of the applicant:		
Name and address of Broker:		

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

California residents: Please see our **CCPA Notice of Collection of Personal Information** available at <https://www.berkley.com/privacy#californiaConsumerPrivacyPolicy>