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Health & wellness

| Application form

| [United States](#)



INSURANCE FOR HEALTH AND WELLNESS ORGANIZATIONS

APPLICATION FORM

INTRODUCTION

The purpose of this application form is for us to find out who you are and to obtain information relevant to the cover provided by the H&W policy. Completion of this application form does not oblige either party to enter into a contract of insurance.

Insurance is a contract of utmost good faith. This means that the information you provide in this application form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your application for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed. If a contract of insurance is agreed between you and us this application form will form the basis of the contract.

Important: Some Insuring Clauses of this Policy provide cover on a claims made and reported basis. Under these Insuring Clauses a claim must be first made against the Insured and notified to us during the period of the policy to be covered. These Insuring Clauses do not cover any claim arising out of any actual or alleged wrongful act occurring, in whole or in part, before the Retroactive Date which we will specify if we make an offer to enter into a contract of insurance with you and you accept our terms and conditions.

HOW TO COMPLETE THIS FORM

Whoever fills out the form must be a principal, partner or director of the applicant firm and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered. If you require any extra room to complete the answers to questions contained within this application form please continue your response in the Additional Information section at the back of the form. Once you have completed the form please return it directly to your insurance broker.

SECTION I: APPLICANT DETAILS

- 1.1 Please state the name and address of the individual or company for whom this insurance is required. Where the applicant is a company, cover is also provided for all of the company's subsidiaries, but only if the data for all the subsidiaries is included in the answers to the questions contained in this form:

Name of individual or company:	

Address:	

City:	State:
_____	_____
Zip code:	

Website:	

- 1.2 Please state the legal status of the company (tick as appropriate):

Corporation: Partnership: Sole Proprietorship:

LLC: Other:

If other, please provide details:

- 1.3 Please state when your business was established:

MM / DD / YY

- 1.4 Please state the number of your employees and independent contactors in the following categories:

Professionals: Clerical: Other:

2.3 Do you ensure that all of your employees and independent contractors are certified in cardio-pulmonary resuscitation (CPR) and first aid? Yes No

If no, please explain why:

2.4 Please state whether you:

a) conduct criminal background checks on all applicants prior to their employment and on all independent contractors prior to their engagement: N/A Yes No

If yes, please indicate which criminal background checks are conducted:

Drug Screening: Fingerprints: Sexual Offender Registry:

b) automatically decline to employ any applicant or engage any independent contractor who tests positive to a drugs screening, has a criminal record or is on the sexual offenders register: Yes No

c) verify the professional qualifications of all applicants prior to their employment or any independent contractors prior their engagement: Yes No

d) obtain confirmation from any applicant for employment or independent contractor that they have not had any claim made against them at any time: Yes No

e) obtain confirmation that all independent contractors maintain their own medical malpractice liability insurance: Yes No

If you have answered no to any of b), c) , d) or e), please explain why:

2.5 a) Do you hold an appropriate and valid licence for each of the services that you provide? Yes No

If yes, please state the licences that you hold, if no, please explain why:

b) Have you ever had any restriction or limitation imposed upon any licence that you hold or been the subject of any disciplinary action by any licensing body? Yes No

If yes, please provide full details:

2.6 In the event that your product or service failed or delivery was delayed please describe the worst case scenario. Consider the potential for loss of life, injury to people, damage to buildings or other tangible property, or financial loss (consequential or otherwise) for your clients:

SECTION 3: COVER FOR MEDICAL SPA

Only complete this section if you are a medical spa

- 3.1 Do you maintain records of the services that you provide to your clients? Yes No

If yes, please state how long you maintain the records for; if no, please explain why:

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- 3.2 Do you provide any treatment to minors? Yes No

If yes, do you require a signed written parental agreement? Yes No

- 3.3 Do you provide any non-certified or unlicensed aesthetic services? Yes No

- 3.4 Do you provide any services away from your premises? Yes No

If yes, please provide full details:

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- 3.5 Do you ensure that all employees and independent contractors wear surgical gloves and protective eyewear whilst they are providing treatment? Yes No

If 'no', please explain why:

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- 3.6 Please state that where it is necessary and appropriate you use sterile devices: Yes No

If no, please explain why:

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- 3.7 Do you ensure that your clients sign a waiver containing a 'hold harmless' clause in your favor and is this held on file for at least 5 years? Yes No

If no, please explain why:

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3.8 Please provide the following information for each of your licensed employees and independent contractors:

If you need more room, please complete the ADDITIONAL LICENSED STAFF list at the end of this form

Name	Services performed	Qualifications	Years of experience
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3.9 If you have declared in Q2.2 that you provide chemical peel or teeth whitening services, please complete the following table:

Service category	Performed during the past 12 months	Estimated number for the next 12 months
Chemical peel strength <30%:	_____	_____
Chemical peel strength >30%:	_____	_____
Teeth whitening >10% hydrogen peroxide:	_____	_____
Teeth whitening >25% hydrogen peroxide:	_____	_____

3.10 Please provide a percentage breakdown of your clients over the past 12 months who fall into the following categories:

Fitzpatrick scale skin type:	%	Fitzpatrick scale skin type:	%
I	_____ %	IV	_____ %
II	_____ %	V	_____ %
III	_____ %	VI	_____ %

3.11 Please state whether you conduct a skin patch test on all of your clients prior to any type of laser treatment: Yes No

If yes, please state whether:

a) the equipment is used in accordance with the manufacturer’s guidelines: Yes No

b) the employees and independent contractors are trained by the manufacturer to use the equipment before they perform any treatment on a client: Yes No

3.12 Do you regularly calibrate your laser equipment? Yes No

If yes, please state the frequency, if no, please explain why:

SECTION 4: COVER FOR FITNESS CLUBS

Only complete this section if you are a fitness club

4.1 Are you the holder of an appropriate licence for your club?

Yes No

If yes, please state what licenses you hold:

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4.2 If automated external defibrillators (AEDs) are used at your facility, do you ensure your employees are suitably trained to operate them?

Yes No

If no, please explain why:

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4.3 Please state the percentage of your revenues that relate to the following:

Membership fees:	_____	%
Initiation fees:	_____	%
Refreshments bar:	_____	%
Liquor:	_____	%
Pro shop sales:	_____	%

4.4 What is the minimum age requirement to use the club facilities?

4.5 Do you ensure each member of the club signs a membership agreement containing a 'hold harmless' clause in your favor for the use of your facilities, including to the member's guests?

Yes No

If no, please explain why:

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4.6 Is the facility staffed at all times during hours of business?

Yes No

If no, please explain why:

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4.7 Are crèche services offered at the facility?

Yes No

If yes, are these offered by you or by a third party?

4.8 Do you have any tanning beds at the facility?

Yes No

If yes, please state how many:

- 4.9 Do you have a swimming pool? Yes No
 If yes, is there a lifeguard on duty at all times? Yes No
 If no, please explain why:

- 4.10 Do you have a sauna or steam room? Yes No
 4.11 Do you have a maintenance contract in place for the servicing of all of your equipment and facilities? Yes No
 If yes, how often is the equipment and facilities serviced (tick as appropriate):
 Annually Half yearly Quarterly Monthly

SECTION 5: NON-OWNED AND HIRED AUTO

Only complete this section if you require non-owned and hired automobile cover

- 5.1 Do you own or lease any vehicles? Yes No
 If yes, please provide full details:

- 5.2 Do you obtain a motor vehicle report (MVR) for all of your employees or independent contractors? Yes No
 If no, please explain why:

- 5.3 Please state how often you request an MVR for an employee or an independent contractor?

- 5.4 Please state whether you obtain confirmation that your employees and independent contractors maintain their own automobile insurance: Yes No

- 5.5 Please state the minimum limit of automobile insurance that must be purchased by your employees and independent contractors:

SECTION 6: CYBER & PRIVACY

Only complete this section if you require cyber & privacy cover

- 6.1 Do you have anti-virus software installed and enabled on all desktops, laptops and servers (excluding database servers) and it is updated on a regular basis? Yes No
- 6.2 Do you have firewalls installed on all external gateways? Yes No
- 6.3 Do you take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fire-proof safe, or does your outsourced service provider meet this requirements? Yes No
- 6.4 Have you conducted a review of the business to ensure compliance with all relevant HIPAA legislation? Yes No
- 6.5 Do you ensure that all Protected Health Information (PHI) transmitted over open networks or stored on portable devices is encrypted? Yes No
- 6.6 Do you process or store credit card information? Yes No
- If yes, have you been certified as being PCI compliant during the past 12 months, or have you successfully completed a self-assessment audit? Yes No

SECTION 7: DIRECTORS & OFFICERS

Only complete this section if you require directors and officers liability cover

- 7.1 Is the company listed on any stock exchange or other securities market? Yes No
- If yes, does the company file the statutory File 20-f to the Securities and Exchange Commission? Yes No
- If yes, please provide a copy of your most recent completed statutory File 20-f
- 7.2 Please advise the:
- a) Number of shares issued:
- b) Number of shareholders:
- c) Name and percentage of shares owned by shareholders owning more than 10% of all voting rights (both direct and indirect):

Name	Percentage ownership:	Represented on the board:
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

- 7.3 Have you in the past 3 years, or do you during the next 12 months, have plans to:
- a) Sell the company? Yes No
- b) Be involved in any mergers, acquisitions or divestments? Yes No
- c) Change your capital structure? Yes No
- d) Raise any new equity capital? Yes No

If you have answered yes to any of the above questions then please give further details:

SECTION 8: EMPLOYMENT PRACTICES LIABILITY

Only complete this section if you require employment practices liability cover

8.1 Do you have a human resources department?

Yes No

a) If yes, how many employees are in this department?

b) If no, how is this function handled?

8.2 Are your employees issued with an employee handbook?

Yes No

If yes, please provide a copy

8.3 Do you have written management guidelines for the following:

a) Disciplinary procedures?

Yes No

b) Termination of employment?

Yes No

c) Preventing discrimination?

Yes No

d) Preventing harassment?

Yes No

e) Any complaint of discrimination or harassment?

Yes No

f) Grievance procedures?

Yes No

g) Compliance with (i) the Americans with Disabilities Act 1990, as amended,
(ii) The Civil Rights Act 1964, as amended and (iii) the Family and Medical and Leave
Act, as amended?

Yes No

8.4 Do you provide anti-discrimination and anti-harassment training for all of your employees?

Yes No

If no, please explain why:

8.5 Do you have written procedures for any complaint of discrimination or harassment from any person who is not an employee of the company?

Yes No

If no, please explain why:

8.6 Do the areas of your premises which are accessible to the public comply with the Americans with Disabilities Act 1990, as amended?

Yes No

If no, please explain why:

8.7 In the past 24 months has there been or, in the next 12 months is it anticipated there will be, any reduction in force or systematic lay-off?

Yes No

If yes, please provide full details:

SECTION 9: COMMERCIAL PROPERTY & BUSINESS INTERRUPTION INSURANCE

9.1 Please provide below details of your premises:

PREMISES I

Address: _____

Zip code: _____

Please state:

a) the purpose of the premises (e.g. office, warehouse, etc):

b) when approximately the premises was

 i) built:

 ii) last renovated:

c) how the premises is constructed:

Brick veneer: <input type="checkbox"/>	EIFS: <input type="checkbox"/>	Fire resistive: <input type="checkbox"/>	Frame: <input type="checkbox"/>	Heavy timber: <input type="checkbox"/>
Joisted masonry: <input type="checkbox"/>	Masonry non-combustible: <input type="checkbox"/>	Non-combustible: <input type="checkbox"/>	Semi-fire resistive: <input type="checkbox"/>	Stucco: <input type="checkbox"/>

d) when approximately the roof of the premises was last renovated?

e) how the roof of the premises is constructed:

Concrete/Clay tiles: <input type="checkbox"/>	Membrane: <input type="checkbox"/>	Metal sheathing: <input type="checkbox"/>	Shingles: <input type="checkbox"/>	Wind resistive singles: <input type="checkbox"/>
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Wood shakes: Other (please explain):

f) the class rating issued by the Public Classification (PPC) program for the premises (1-10):

PREMISES 2

Address: _____

Zip code: _____

Please state:

a) the purpose of the premises (e.g. office, warehouse, etc): _____

b) when approximately the premises was

 i) built: _____

 ii) last renovated: _____

c) how the premises is constructed:

Brick veneer: EIFS: Fire resistive: Frame: Heavy timber:

Joisted masonry: Masonry non-combustible: Non-combustible: Semi-fire resistive: Stucco:

d) when approximately the roof of the premises was last renovated _____

e) how the roof of the premises is constructed:

Concrete/Clay tiles: Membrane: Metal sheathing: Shingles: Wind resistive singles:

Wood shakes: Other (please explain): _____

f) the class rating issued by the Public Classification (PPC) program for the premises (1-10): _____

Please continue on a separate sheet if more than 2 premises are to be insured.

9.2 Please state whether the premises:

- a) is detached: Yes No
- If no, please state what measures are in place to protect the premises from damage if there is a fire in a neighbouring property:

- b) is self contained with a lockable entrance door: Yes No
- If yes, please state the type of locking system:
- Key operated multi-point locking system with at least 3 locking bolts: Rim automatic deadloc: Mortice deadlock:
- c) contain other external doors: Yes No
- If yes, please state the type of locking systems
- A key operated security bolt: A panic bar locking system:
- d) has lockable opening windows on all levels: Yes No
- If yes, please state the type of locking system:
- Secured by a key operated locking device: N/A (i.e. permanently sealed shut):
- e) is protected by fire and control action intruder alarm systems which are connected to all windows and doors and is subject to an annual maintenance Contract: Yes No
- f) is protected by interior and exterior cameras: Yes No
- g) is overseen by 24 hour security guards: Yes No

NOTE: We may refuse to pay a claim if all of the devices for the security of your premises (including locks and the intruder alarm) are not in full and effective operation whenever the premises are closed for business or otherwise left unattended.

- h) is free from cracks or other signs of damage that may be due to subsidence, landslip or heave and have not previously suffered damage by any of these causes: Yes No
- i) is in an area free from flooding and not near the vicinity of any rivers, streams or tidal waters: Yes No
- j) is self contained with a lockable entrance door: Yes No
- k) is heated by one of the following methods: conventional electric, gas, oil or solid fuel heating system: Yes No
- l) is fitted with electrical installations which are inspected at least every 5 years by a qualified electrician and any defect remedied: Yes No
- m) has lifts, boilers, steam and pressure vessels inspected and approved to comply with all of the statutory requirements: Yes No
- n) is fitted with sprinklers throughout: Yes No
- o) has a back up system for the electrical supply: Yes No

NOTE: Assuming you have answered yes to questions l) and m) above, it is importance to keep records of all relevant inspections as we may ask for evidence of these before paying a claim

If you have answered no to any of the above questions then please give further details:

9.3 Do any of the latest premises contain composite or sandwich panels? Yes No

If yes, please provide details:

9.4 Do any of the listed premises contain aluminium wiring? Yes No

If yes, please provide details.

9.5 Do you maintain written and electronic records of all stock? Yes No

If no, please explain why:

9.6 Would you like a quotation for the "Named windstorms" extension? Yes No

9.7 Please detail the amounts to be insured below for each premises:

NOTE: The amounts insured you state below should be the full rebuilding or replacement cost in each of the categories. If you understate these amounts you will be under-insuring and we may not pay the full amount of your claim. It is therefore essential that these amounts are as close to the true values of the insured items as possible.

ITEM	PREMISES 1	PREMISES 2
Building coverage:	_____	_____
Loss of income:	_____	_____
Indemnity period:	_____	_____
Loss of rent:	_____	_____
Indemnity period:	_____	_____
Inventory / Stock:	_____	_____
Business personal property:	_____	_____
Tenants improvements:	_____	_____
Portable equipment at home/ away from the premises:	_____	_____

SECTION 10: INSURANCE REQUIREMENTS

10.1 Please provide details of your current insurance or the cover you require if this is the first time you are applying for insurance:

	Limit:	Excess	Prior and Pending or Retroactive Date:
Errors and Omissions:	_____	_____	_____
Commercial General Liability:	_____	_____	_____
Cyber and Privacy:	_____	_____	_____
Directors and Officers:	_____	_____	_____
Employment Practices Liability:	_____	_____	_____

SECTION 11: CLAIMS EXPERIENCE

11.1 Regarding all of the types of insurance to which this application form relates AFTER FULL ENQUIRY:

- are you aware of any circumstances which may give rise to a claim against any of the organizations to be insured or their directors, trustees or employees, or
- have any directors or trustees of the company to be insured, or the company itself, been found guilty of any criminal, dishonest or fraudulent activity or been investigated by any regulatory body, or
- are you aware of any loss or damage, whether insured or not, that has occurred to any of the company to be insured within the last 5 years, or
- have you ever suffered a loss of data that has resulted in a privacy breach?

With reference to questions a, b, c, and d above:

Yes No

If the answer to the above is yes then please attach full details including an explanation of the background of events, the maximum amount involved or claimed, the status of the claims or circumstances and any reserves or payments made by you or by insurers, and the dates of all developments and payments.

SECTION 12: DECLARATION

- I declare that after proper inquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact.
- I agree that this Application Form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon.
- I undertake to inform Underwriters of any material alteration to these facts occurring before the completion of the contract.

Signed: _____		Full name: _____	
Position held at insured: _____		Date: MM / DD / YY	

ADDITIONAL INFORMATION: