



## A YOUR DETAILS

1. Insured Entity:

2. ABN:

3. Web Address:

4. Address:

5. Contact Number:

6. Date of commencement of business:

## B STAFF TURNOVER

7. Actual last 12 months:

8. Estimated next 12 month:

## C PRINCIPALS

9. Please complete the table:

|                       |  |
|-----------------------|--|
| Number of Principals: |  |
| Number of Employees:  |  |
| Number Contractors:   |  |
| Total Staff Numbers:  |  |

10. Please provide the breakdown of income by State

| VIC | NSW | ACT | QLD | TAS | SA | NT | WA | Overseas | Total |
|-----|-----|-----|-----|-----|----|----|----|----------|-------|
|     |     |     |     |     |    |    |    |          |       |

11. Do you require contractors to carry their own health professional's policy?

YES

NO

**D****RISK INFORMATION**

12. (a) Do all practitioners carry the minimum qualification required?

YES

NO

(b) Do you provide any form of laser or intense pulse light treatments?

**If Yes, please complete the attached Laser/IPL Addendum**

YES

NO

(c) Do you obtain medical history or client information in all cases?

**If No, please list the activities you do not require this for**

YES

NO

(d) Does the client provide aftercare/post treatment instructions to all customers?

**If No, please list all the activities you do not require this for**

YES

NO

(e) Do you use informed consent?

YES

NO

(f) Do you manufacture, alter, repair, repackage, or import any products?

**Please note, cover is not automatically provided for importing or manufacturing products**

YES

NO

13. What percentage of your turnover is derived for the sale of products?

%

**If you or your contractors perform cosmetic injectables please answer Question 14 to 16. Otherwise please proceed to Question 17**

14. Are all injectables TGA approved?

YES

NO

15. Please provide a full list of injectables used (Botox, Juvéderm, Juvéderm Ultra XC, Dysport etc.)

16. Are all cosmetic injections performed by a qualified nurse or doctor?

YES

NO

**If No, please confirm who is prescribing them**

## E INSURER LIMIT OF INDEMNITY EXCESS EXPIRY DATE

17. Please tick beside each of the modalities undertaken by you or your contractors

|  |                          |  |                          |
|--|--------------------------|--|--------------------------|
| Acid or chemical peels up to strength of 40%             | <input type="checkbox"/> | Light Heat Therapy / Light Therapy           | <input type="checkbox"/> |
| Acid or chemical peels up to strength of 60%             | <input type="checkbox"/> | Make Up                                      | <input type="checkbox"/> |
| Body Piercing (Excl. Genitalia or Tongue)                | <input type="checkbox"/> | Manicure / Pedicure / Shellac / Ion Foot Spa | <input type="checkbox"/> |
| Body Wrapping  | <input type="checkbox"/> | Massage                                      | <input type="checkbox"/> |
| Calendula Eye Baths                                      | <input type="checkbox"/> | Mesotherapy                                  | <input type="checkbox"/> |
| Cosmecanique   | <input type="checkbox"/> | Microcurrent Treatment                       | <input type="checkbox"/> |
| Cosmetic Injectables (Botox, Juvéderm etc.) / IV Therapy | <input type="checkbox"/> | Microdermabrasion                            | <input type="checkbox"/> |
| Cosmetic Tattoo / Micropigmentation                      | <input type="checkbox"/> | Microsclerotherapy                           | <input type="checkbox"/> |
| Dermatherapy   | <input type="checkbox"/> | Milia Extractions                            | <input type="checkbox"/> |
| Dyathermy  | <input type="checkbox"/> | Non-Laser Tattoo Removal                     | <input type="checkbox"/> |
| Ear Candling   | <input type="checkbox"/> | Non-Surgical Facelift                        | <input type="checkbox"/> |
| Electrical Epilations                                    | <input type="checkbox"/> | Oxygen Therapy                               | <input type="checkbox"/> |
| Electro Collagen Therapy                                 | <input type="checkbox"/> | Paraffin Wax Treatment                       | <input type="checkbox"/> |
| Electro Proration Treatment                              | <input type="checkbox"/> | Plasma Skin Resurfacing                      | <input type="checkbox"/> |
| Electrolysis   | <input type="checkbox"/> | Radio & Ultrasonic Skin Treatments           | <input type="checkbox"/> |
| Epidermal Levelling                                      | <input type="checkbox"/> | Reflexology                                  | <input type="checkbox"/> |
| Eyebrow Shaping / Threading / Tinting                    | <input type="checkbox"/> | Sauna (including Infrared)                   | <input type="checkbox"/> |
| Eyelash Extensions / Tinting                             | <input type="checkbox"/> | Skin Needling                                | <input type="checkbox"/> |
| Facials  | <input type="checkbox"/> | Spray Tan                                    | <input type="checkbox"/> |
| Fat Freezing (Cryolipolysis)                             | <input type="checkbox"/> | Teeth Whitening                              | <input type="checkbox"/> |
| Fat Reduction Laser / Galvanic                           | <input type="checkbox"/> | Vibrosaun                                    | <input type="checkbox"/> |
| Gua Sha  | <input type="checkbox"/> | Waxing / Alkaline Hair Removal               | <input type="checkbox"/> |
| Hair Transplant Services                                 | <input type="checkbox"/> | Whole Body Vibration Therapy                 | <input type="checkbox"/> |
| High Frequency Facial                                    | <input type="checkbox"/> | Other:                                       | <input type="checkbox"/> |
| HIFU   | <input type="checkbox"/> | Other:                                       | <input type="checkbox"/> |
| Laser Hair Removal                                       | <input type="checkbox"/> | Other:                                       | <input type="checkbox"/> |
| Intense Pulse Light (IPL / VPL)                          | <input type="checkbox"/> | Other:                                       | <input type="checkbox"/> |
| Laser Tattoo Removal                                     | <input type="checkbox"/> | Other:                                       | <input type="checkbox"/> |

18. Do you offer any training for the above activities / services? **If Yes**, please provide details

YES  NO

19. Is all equipment used TGA approved / meet relevant Australian Standards and Compliance?

YES  NO

20. Is all equipment purchased from Local suppliers? **If No**, please confirm details

YES  NO

21. Is all equipment used and maintained according to the manufacturer's instructions?

YES  NO

## F INSURER LIMIT OF INDEMNITY EXCESS EXPIRY DATE

22. Please indicate the limit of Indemnity required

(a) Please advise limit(s) required for Coverage Section A (Civil Liability)

|             |  |                       |  |
|-------------|--|-----------------------|--|
| \$100,000   |  | \$5,000,000           |  |
| \$250,000   |  | \$10,000,000          |  |
| \$500,000   |  | \$15,000,000          |  |
| \$750,000   |  | \$20,000,000          |  |
| \$1,000,000 |  | Other Please Specify: |  |
| \$2,000,000 |  |                       |  |

(b) Please advise limit(s) required for Coverage Section B (Public & Products Liability)

|             |  |                         |  |
|-------------|--|-------------------------|--|
| \$100,000   |  | \$5,000,000             |  |
| \$250,000   |  | \$10,000,000            |  |
| \$500,000   |  | \$15,000,000            |  |
| \$750,000   |  | \$20,000,000            |  |
| \$1,000,000 |  | Other - Please Specify: |  |
| \$2,000,000 |  |                         |  |

(c) Please advise excess(es) required

|             |  |                         |  |
|-------------|--|-------------------------|--|
| \$1,000     |  | \$10,000                |  |
| \$2,000     |  | \$20,000                |  |
| \$5,000     |  | Other - Please Specify: |  |
| \$2,000,000 |  |                         |  |

## G INSURANCE HISTORY

23. Have you ever had an insurer:

YES  NO

(a) Decline your insurance proposal?

YES  NO

(b) Impose special terms or conditions?

YES  NO

(c) Cancel your insurance?

24. Have you ever:

(a) Been convicted of a criminal offence?

YES  NO

(b) Declared bankrupt?

YES  NO

25. In the past 10 years have any claims made against you, your principals, employees or contractors for Professional Liability or Public Liability, or have any circumstances been notified to the insurers that might give rise to a claim?

YES  NO

26. After making appropriate enquiries are there any facts or circumstances which you, your principals, employees or contractors are aware of that may give rise to a claim under this policy?

YES  NO

27. Have you, your principals, employees or contractors ever been subject to disciplinary proceedings for professional misconduct or unsatisfactory professional conduct by a professional society or statutory body?

YES  NO

28. Have you, your principals, employees or contractors ever been the subject of a complaint to a professional society or statutory registration board that required a response?

YES  NO

**If Yes to any of 23 to 28, please provide full details of the matter including the insurer, date of incident, whether the matter open is closed, amount paid/reserve and full details of the matter including any relevant correspondence**

## DECLARATION

**After making appropriate enquiries, I declare that:**

- I am authorised on behalf of the prospective Insured (s) to make this proposal.
- I have read and understood the Important Notices and accompanying this proposal
- I have provided information about another individual, I declare that the individual has been made aware of that fact and of the ProRisk Privacy Statement.
- I confirm that the contents of this proposal are true and complete.
- I understand that until a contract of insurance is entered in to, I am under continuing obligation to immediately inform ProRisk of any change to the information contained in this proposal.
- I acknowledge that if a contract of insurance is entered in to this proposal and any accompanying documents will form the basis of the contract.

Signature \_\_\_\_\_

Name \_\_\_\_\_

Position \_\_\_\_\_

Date \_\_\_\_\_