

## MEDICAL MALPRACTICE PUBLIC & PRODUCTS LIABILITY INSURANCE APPLICATION Beauty Therapists

### Section 1 - The Insured Details

If you are a member of the APAA, please provide Membership No:

Name of Proprietor:

Business Name:

Operated As:  Sole Trader  Partnership  Individual  Company  Independant Contractor

Business Phone:  Mobile:

Fax Number:  Home Phone:

Email:  ABN:

Business Location:  State:  Postcode:

Mobile Business

Postal Address:  State:  Postcode:

### Section 2 – Business Operation

Note: Policy only covers 100% Private Practice Work, unless referred to us and agreed by the insurer.

	Number of Staff
Principals/Partners/Directors:	<input type="text"/>
Full-Time Qualified Staff:	<input type="text"/>
Part-Time Qualified Staff:	<input type="text"/>
Other:	<input type="text"/>
TOTAL:	<input type="text"/>

Turnover for last 12 months? \$   
(If a new business, state an estimate)

What percentage of this turnover is from the sale of products?  %

Do you provide Private Label Products for sale?  Yes  No

(Private label products are any Products that you sell under your own brand name, be they Manufactured by you or not)

If yes, please advise the income derived from the sale of Private Label Products: \$

There is NO COVER provided for Private Label Products under this policy.

### Section 3 – Staff Qualifications & Experience

Note: In signing this form, you agree to and must provide evidence of qualifications within 7 days at any time requested.

Full Name	Date of Birth	Qualifications	Date Qualified

Were the above qualifications obtained in Australia?  Yes  No

If not, please advise where the qualifications were obtained & provide copies for referral to the insurer.

**Section 3 – Customer Care**

- 1) Do you use a Medical History/Client Information form on every client?  Yes  No
- 2) Do you use a 'Hold Harmless' or 'Informed Consent' for all your activities?  Yes  No
- 3) Do you ensure that all treatments provided to clients under the age of 18 are only undertaken where such consent is given by the parent or legal guardian?  Yes  No
- 4) Are you fully aware of manufactures requirements &/or guidelines for each activity performed and agree that you will strictly follow such requirements/guidelines?  Yes  No

**Section 4 – Salon Equipment**

**Please list all salon equipment/machinery used in the provision of your treatments.**

Please note this policy does not cover the actual equipment/machinery itself (for damage, fire, theft etc), this list is purely for the insurer to assess the type of beauty equipment you are using in the provision of your treatments.

Type of Equipment/Machine	Quantity

**Section 5 – Insurance History**

- 1) Do you currently have a Medical Malpractice Public & Products Liability Insurance policy?  Yes  No  
If yes, please advise the following details:

Insurer	Policy No	Liability Limit	Premium	Expiry Date
		\$	\$	

- 2) Has any application or policy for similar insurance ever been declined, cancelled or voided, renewal refused or special terms imposed at any time?  Yes  No  
If yes, please advise details:


- 3) Do you plan any material changes to your business activities in the next 12 months?  Yes  No  
If yes, please advise details:


- 4) Have you had any claims (even if the event was not insured)?  Yes  No  
If yes, please advise details:

Year of Claim	Nature of Injury/Event	Equipment Used	Amount Paid	Date Finalised

- 5) Do you have any knowledge of any event, circumstance or occurrence (other than listed above), prior to the effective date of the proposed policy, which could result in a claim being bought against you?  Yes  No  
If yes, please provide full details on a separate attachment.

- 6) Have any complaints or investigations ever been made or undertaken against you or against any director, partner, employee or students under supervision?  Yes  No  
If yes, please provide full details on a separate attachment.

## Section 6 – Treatments Provided

Please tell us which services you provide, and what estimated percentage of your business is subject to each treatment. For those treatments marked with an asterisk (\*) you must use a 'Hold Harmless' or 'Informed Consent' form for these specific activities.

TYPE OF TREATMENT	Yes / No	% of your total Activities
<b>Band "A"</b>		
Acid Peels – Up to 30% strength *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Acupuncture *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Aromatherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Body Wrapping	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Caci (Facial Technique)	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Counselling ( <i>excluding Drug &amp; Alcohol</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Crystal Healing	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Ear Candling	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Ear Piercing	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Electrolysis *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Electrotherapy *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Endermologie	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Epidermal Levelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Eyebrow Tinting/Perming	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Eyelash Extension *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Facials	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Hairdressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Hydrotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Hypnotherapy *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Infrared Sauna	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Ionzyme DF Machine *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Kinesiology *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Lash Tinting & Eyebrow Shaping	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Life Coaching	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Light Treatments / LHE ( <i>excluding IPL/VPL Laser</i> ) *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Lymphatic Massage *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Manicure	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Make-up (Non-Permanent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Massage including all techniques & Baby Massage	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Microcurrent *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Microdermabrasion *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Muscle Manipulation Therapy *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Nail Extensions	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Non-Surgical Facelift	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Oxygen Therapy *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Pedicure	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Photo-Thermal Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Red Vein Treatment (Non-Surgical) *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Reflexology	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Reiki (minimum Reiki II qualified)	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Spa Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Spray Tanning	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Stone Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Sugaring	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Vocational Rehabilitation Counselling	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Waxing	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Weight Loss Management *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
<b>Band "B"</b>		
Acid Peels – 31% to 50% strength *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Acid Peels – Over 50% strength *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Body Piercing ( <i>Excluding piercing of genitalia or tongue</i> ) *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Cosmetic Tattoo/Micropigmentation *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Laser Therapy ( <i>up to 3b</i> ) *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Laser Therapy ( <i>4b and over</i> ) *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
IPL / VPL Treatment *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Sclerotherapy *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Skin Needling *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Solarium *	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
		<b>TOTAL 100%</b>

**Do you perform any activities other than those disclosed above?**  
(If Yes please advise in the below table)

Yes  No

TYPE OF OTHER TREATMENT / ACTIVITY	Yes / No	% of your total Activities
Training	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Injectables	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	%

**Section 7 – Specific Treatment / Activity Additional Questions**

**TANNING**

If you have Sun Beds, please describe type of machine/s below:


**ACID PEELS** Have you had specific training on the Acid Peels you are using?

Yes  No

Please list all products you use and their percentage of Acids:

Product	% of Acid
	%
	%
	%
	%

**TRAINING** Are you a registered College, School or Training organisation?

Yes  No

Please provide a complete list of all activities/treatments you provide training in. If they are the same as per Section 6 of this application, please state "As Above".


**INJECTABLES**

Injectables must be performed by a fully qualified and registered Doctor, Nurse, Dentist or Dermatologist.

They must hold their own separate Medical Malpractice Insurance in place for their relevant qualifications and hold the relevant licences.

Do you ensure they hold their own separate Medical Malpractice Public & Products Liability Insurance?

Yes  No

Do you ensure they hold the relevant licences?

Yes  No

Please advise who will be performing the Injectables and if cover is required under this policy?

Name	Qualification	Cover Required?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide full details of all injectable products, name of supplier & if approved by the ATGA?

Injectable Product Name	Name of Supplier	ATGA Approved?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

