LEVELFIRST
An Independent Insurance Agents of Texas Company

PROFESSIONAL LIABILITY APPLICATION FOR CRYOTHERAPY CENTERS

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Applicant Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. Telephone Number: Office:_____ Fax:_____

5. Person to Contact for Survey: Name:_____ Title:_____

6. Date Established:_____

7. The applicant is:
   [ ] Sole Practitioner
   [ ] Sole Proprietorship
   [ ] Partnership
   [ ] Corporation
   [ ] Other; Describe:_____
   _____

8. Gross Annual Receipts: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

9. Entity is: [ ] For Profit [ ] Non-Profit
   Describe source of funds:_____

PART II. EXPOSURES

1. Describe the nature of insured's operation including types of services rendered and activities conducted:

_____

_____

2. Do you have any ancillary operations not stated above? [ ] Yes [ ] No
   If yes, provide details

_____

_____

Estimated next year? _____

4. Do you work with professional athletes and/or high-profile individuals? [ ] Yes [ ] No

   If yes, provide details:

   _____

   _____

5. Do you treat minors? [ ] Yes [ ] No

   If yes, what percentage of you clientele is underage? _____

6. Are patients/clients screened prior to use to ensure that they do not have any of the following conditions?

   High Blood Pressure [ ] Yes [ ] No

   Diabetes [ ] Yes [ ] No

   Pregnancy [ ] Yes [ ] No

   Bleeding Disorders [ ] Yes [ ] No

   Uncontrolled Seizures [ ] Yes [ ] No

   Cardiovascular Disease, Pacemakers or any other cardiac issues [ ] Yes [ ] No

   Severe Anemia [ ] Yes [ ] No

   Claustrophobia [ ] Yes [ ] No

   Acute Kidney &/or Urinary Tract Diseases [ ] Yes [ ] No

7. Are informed consent forms used in all cases prior to treatment (including minors)? [ ] Yes [ ] No

   If yes, please provide a copy.

8. Is the applicant/facility and all professional employees licensed and certified as required by state and federal laws? [ ] Yes [ ] No

   If no, explain: _____

9. Do you use single-person booths only? [ ] Yes [ ] No

   If no, explain: _____

10. Is the head elevated outside of the chamber in normal temperature at all times? [ ] Yes [ ] No

    If no, explain: _____

11. Please confirm that all patients are provided with appropriate protective clothing to prevent rapid freezing due to moisture (i.e. wet/damp socks) [ ] Yes [ ] No

12. How long do treatment sessions last? _____

13. Are services 'prescribed' by a third party physician? [ ] Yes [ ] No

1. Do you require staff to report all incidents (accidents)? [ ] Yes [ ] No

   Are records of such reports kept on file by you? [ ] Yes [ ] No

   If not, explain:_____

2. Explain arrangements for medical emergencies (e.g., physician on call, transfer arrangement with hospital, etc.):_____

   _____

3. Complete the following for all employees (including any professional designations):

Professional Designation	Employee Count	E, C, or I (E = Employee C = Contract I = Independent)	Copy of Certification(s) Obtained (Y/N)

4. Has the applicant or have any of the above employees:

   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

   If Yes to any of the above, please explain.

5. Name, qualification, and number of years of experience of the Medical Director, all managers, and supervisors:

   Name Title Experience/Training Association Membership

   _____

   _____

   _____

PART IV. HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Limit of Liability	Premium	Effective Dates	Claims-made or Occurence

What is the most recent PL retroactive date?_____

2. List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Limit of liability	Premium	Effective Dates	Claims-made or Occurrence

What is the most recent GL retroactive date?_____

3. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] Yes [ ] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

_____

_____

_____

_____

4. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [ ] Yes [ ] No

If yes, describe the event and indicate the reason for anticipation of a claim:_____

_____

_____

_____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the

foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and JaVA Underwriting, LLC, any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

_____
Applicant Signature

_____
Title

_____
Date