Aesthetisure
A division of Palomar Insurance Corporation

Application for Coverage

A. APPLICANT (PLASTIC SURGEON) INFORMATION – PLEASE PRINT

1. Full Name: _____

2. Desired Effective Date: _____ **3. Policy Selection (*required*):** ☐ **CHOICE** ☐ **PREMIER**

B. OFFICE INFORMATION – PLEASE PRINT

1. Office Manager _____ Email _____

   Patient Registration _____ Email _____

   Accounting (to receive monthly invoices): _____ Email _____

2. Business Name _____

3. Primary Business Address _____

4. Billing Address (if different) _____

5. Office Phone _____ Fax _____

   Office Email _____ Web Address _____

6. Type of Practice: ☐ Solo Practitioner ☐ Group (2-4 Surgeons) ☐ Group (5 or more

   ☐ Multi-Specialty Group ☐ Academic Practice ☐ Other

8. Are you Board Certified by an ABMS Member Board? ☐ Yes ☐ No

   Name of Board(s) _____ Date Certified _____

9. If you answered NO to Question #8, are you ABMS Board Eligible? ☐ Yes ☐ No

   Name of Board _____ Status _____ Est. Date of Certification _____

C. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please attach a current copy of your Medical Malpractice Insurance certificate.

1. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit for alleged malpractice? ☐ Yes ☐ No If yes have these been reported to your insurer? ☐ Yes ☐ No

   NOTE: Please email or fax any claims information provided by your Medical Malpractice Insurance Company

2. Has your Medical Malpractice coverage ever been non-renewed or cancelled due to claims or nonpayment of premium? ☐ Yes ☐ No ***If Yes, please attach an explanation.***

TERMS AND CONDITIONS

As an applicant to be a Participating Aesthetisure Surgeon, I ratify and affirm that I understand and agree that:

1. Only the below procedures are covered under the Aesthetisure policy unless the policy is endorsed by the insurance carrier:

List of Covered Procedures

Abdominoplasty	Buttock Lift	Face Lift	Neck Lift
Arm Contouring	Calf Implants	Facial Rejuvenation	Otoplasty
Breast Augmentation	Capsulectomy	Labiaplasty	Rhinoplasty
Revisional Breast Implant	Cheek Implants	Liposuction	Thigh Lift
Breast Lift	Chin Augmentation	Lower Body Lift	Upper Body Lift
Breast Reduction	Chin Reduction	Male Breast Surgery	Hair transplants
Brow Lift	Cosmetic Eyelid Surgery	Mandibular Implant	Hand Rejuvenation

2. Representatives of the insurer have the right to review and audit any records and/or records of the policyholder that may have a bearing on this insurance. This would include but is not limited to any individual patient file and/or a CPT-4 report and/or similar type of report.

3. The above-mentioned audit is to ensure there is compliance with the Aesthetisure program policy provisions.

4. Patients not covered by Aesthetisure are not eligible for Aesthetisure benefits.

5. There is no coverage in effect prior to the policy's effective date.

PLEASE READ AND SIGN. I hereby declare that the above statements are true and that I have not knowingly suppressed or misstated any material facts. I authorize the Company to conduct any investigation to substantiate this information. I hereby agree that this questionnaire including my attachments thereto shall be the basis of any insurance contract issued.

I agree to notify Aesthetisure if there is any future material change in any answer to this questionnaire, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician, firm or professional association.

I understand and agree that the completion of this questionnaire does not bind the Company to issue, nor me to purchase, a contract of insurance, provided however, if I am issued insurance by the Company and I purchase such contract of insurance, I understand and agree that any material misrepresentation or omission by me in this questionnaire may act to void such contract of insurance and may give the Company a right to rescind such contract.

I understand and agree to abide by the aforementioned Aesthetisure Terms and Conditions.

Surgeon Signature _____ Date Signed _____

Print Name _____