SUPPLEMENTARY APPLICATION
ERRORS & OMISSIONS LIABILITY INSURANCE

ELECTROLYSIS/ELECTROLOGISTS

1. Name of Applicant

2. What method do you use for electrolysis treatment?

	Yes	No
Electrolysis	☐	☐
Thermolysis	☐	☐
Blend	☐	☐

3. Do you use disposable needles? ☐ Yes ☐ No

If no, describe method used for sterilization of needles:

Is the sterilization machine C.S.A. approved? ☐ Yes ☐ No

4. Do you perform any treatment on warts, moles, growths or other type of surgery? ☐ Yes ☐ No

If yes, provide details:

Do you obtain written authorization for this treatment? ☐ Yes ☐ No

If yes,what are the qualifications:

Where are procedures performed? ☐ Hospital ☐ Office

5. Do you have clients complete a health questionnaire prior to providing treatment? ☐ Yes ☐ No

DECLARATION

The undersigned declares that all statements made in the Supplementary Application are true. Signing of this document does not bind the Applicant to complete the insurance, but it is agreed that the Application and Supplementary Application shall be the basis of the contract, should a policy be issued.

Signature

Title or Position

Date

Must be signed by a Principal, Partner, Controller, Executive Officer or Director.

55104 (Rev. 98)