Wellness Medical Protection Group

Insurance Questionnaire

Integrative Medicine

Complete legal name and D/B/A of Applicant: _____

Principal Business Address: _____

Additional Locations: _____

Years in Operation: _____ | Phone: _____ Email: _____

If Liability Coverage is currently in force, please specify:

Carrier: _____ | Limit: _____ Retroactive Date: (mm/dd/yyyy) _____

Questionnaire

INTEGRATIVE MEDICINE

	Yes	No
Does your current professional liability cover integrative treatments like anti-aging and aesthetic procedures, hormone replacement therapies, IVs, adrenal and other supplements, and HCG medical weight loss?	○	○
Are you forming a separate entity contained within your existing corporate structure to facilitate the delivery of the cash-based procedures? If "Yes" what is the name under which you will operate? _____	○	○
Would you like us to perform a comprehensive review of your existing insurance liability programs to be performed by a licensed insurance agent at no cost to you?	○	○
Are you interested in obtaining information regarding our risk management services, including security, compliance and HIPAA privacy/cyber liability insurance?	○	○
Are you interested in receiving information regarding General Liability/Business Owners Policy? (Covers "Slip and Fall", Business Interruption, Business Personal Property)	○	○
Are you interested in receiving information about our portfolio of supplements, nutrition and diagnostic products offered through our affiliated companies?	○	○

Are there any other insurance or financial planning products we can help or guide your growing practice with?

_____

_____

_____

Name of Requester _____

Date: (mm/dd/yyyy) _____

Best Method of Contact
(Please provide an email address or telephone number) _____

Submit