MASSAGE COUNCIL APPLICATION

An FSMTA Endorsed Massage Coverage Program

1. CONTACT & PRACTICE INFORMATION

Full Name (First, Middle, Last) _____ Practice / Establishment Name _____

Establishment or Mailing Address (Include Suite #) _____ City _____ State _____ Zip _____

Office Phone _____ Cell Phone _____ Fax _____ Email _____

Massage School Attended _____ Program Hours _____ State Licensed _____ License Number _____ Initial License Date _____ License current? Yes No

List any Additional Insured you require: _____

If you provide Hot Stone Massage you must complete the enclosed addendum for coverage to apply.
If you practice Colonics or any Other Speciality, contact Customer Service, as additional documentation is required for coverage to apply.

2. CHOOSE COVERAGE

Choose Limit [1]

$1,000,000 / $3,000,000 @ **$ 99.00** _____

$2,000,000 / $6,000,000 @ **$109.00** _____

Optional $10K of Property Coverage [2]

Business Personal Property @ **$103.25** _____

Total Payment Due: _____

1 Coverage will be effective on the date app is received or, for new licensees, the date license is active, whichever is later.

2 Property Policy is through Lloyd's of London. Covers mobile practice, plus Establishment address indicated above.

3. PAYMENT METHOD (Complete applicable section.)

Credit Card Type: Visa MasterCard American Express

Name on Card: _____

Card #: _____

Expires: _____

ACH Payments from: Personal Account Business Account

Account #: _____

Bank Name: _____

Bank Routing #: _____

Bank City: _____

4. DECLARATION AND SIGNATURE

I, the APPLICANT, hereby apply for Membership and Massage Professional Liability Coverage and DECLARE that:

- I have no knowledge of any incident, pending claim, suit, license suspension or revocation hearing or ethics violation, nor have any been filed against me in the past, pertaining to my practice as a massage therapist or any other health or wellness designation I hold. In addition, I have never been the subject of any investigation, in connection with any sexual act, conduct, molestation and/or assault.
- The information contained in this application, including the above statements are true, and that I have not misstated or suppressed any facts. I understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my policy. I understand that if coverage is granted, I shall have the duty to report in writing, as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written client complaints, or threats or filings of lawsuits. I hereby authorize release of information for any underwriting or claim-related inquiry, from any massage therapy professional association, licensing board or health care organization. I understand that there is no guarantee that coverage will be renewed.
- I signed/typed my name below, and if membership is approved, you are authorized to process payment as indicated above, in accordance with applicable issuer agreements. You are authorized to communicate with me regarding my coverage via text, or email.

Sign here: _____ **Date:** _____

5. SUBMIT APPLICATION:

By Email: Info@massagecouncil.com **By Fax**: 714-571-1863

If the link does not open your email client, please copy/paste address into your email client .

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