Minnesota Joint Underwriting Association
445 Minnesota St Suite 514
St. Paul, MN 55101
1-800-552-0013 or 651-222-0484
Fax: 651-222-7824

GUARDIAN AD LITEM INSURANCE APPLICATION FOR CLAIMS MADE COVERAGE

1. Name and mailing address: ____

   Phone: ___________________

   Agent : _____________________________ Phone: ________________________

2. The proposed named insured is:

   ___ Individual ___ Partnership ___ Joint Venture ___ Corporation ___ Other

3. List of officers, partners or the name of individual:

   1. ____

   2. ____

   3. ____

   4. ____

If the proposed name insured is not an individual, the total number of guardians ad litem employed in the organization: ______________

Important: If the proposed named insured is not an individual and employs more than one guardian ad litem, complete a supplemental application for each guardian ad litem and attach to this application.

4. Proposed: Effective date: ___________________ Ending date: ________________

   Limit per occurrence: $__________________

   Aggregate limit: $__________________

5. Years in service as a guardian ad litem: _____________________________________

6. Greatest number of guardian ad litem children that you will be representing at any one time: ____________

7. Total number of guardian ad litem cases in which you expect to serve as a guardian ad litem during the next twelve months: ________________

	Yes	No
8. Are you certified as a guardian ad litem?	_____	_____

In which countries? _______________________________

Please list name, address, and phone number of certifying Authority. _______________________________________

____

9. Will any of the children represented by you be involved in Court proceedings dealing with the following:

	Yes	No
Neglect	_____	_____
Dependency	_____	_____
Termination of parental rights	_____	_____
Custody	_____	_____
10. Will you be accountable to any program coordinator, peer supervisor, outside agency, or consultant? If yes, please specify names, titles, and phone numbers. ___________	_____	_____

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	Yes	No
11. Have you or any of your employees ever been convicted of a felony or gross misdemeanor? If yes, explain (include dates, locations, infractions and penalties).	_____	_____
12. Are you or any of your employees under investigation for or have a previous record of sexual abuse?	_____	_____
13. Are you or any of your employees a licensed attorney? If yes, specify company with whom you have lawyers professional liability coverage and policy number.	_____	_____

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PRIOR CARRIER INFORMATION

Year	Carrier	Policy Number	Limits BI/PD	Annual Premium

LOSS AND CLAIM HISTORY

Enter all losses and claims for the prior 5 years. Add separate sheets if necessary.

Date of loss: ______________ Type of loss:_______________________________________

Amount paid: _______________ Reserve: ____

Description: ____

Date of loss: ______________ Type of loss:_______________________________________

Amount paid: _______________ Reserve: ____

Description: ____

Date of loss: ______________ Type of loss:_______________________________________

Amount paid: _______________ Reserve: ____

Description: ____

Comments:

I, the undersigned, certify and attest that the information contained in this application is true and complete, and that I have been unable to obtain through ordinary methods the insurance applied for with this application.

______________________________________ ______________________
Signature of Applicant Date

ONE LETTER OF REJECTION OR REFUSAL TO WRITE YOUR COVERAGE WITH A STANDARD MARKET INSURANCE COMPANY MUST BE SUBMITTED WITH YOU APPLICATION BEFORE IT CAN BE CONSIDERED COMPLETE.