

MINNESOTA JOINT UNDERWRITING ASSOCIATION
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INDIVIDUAL PHYSICIANS OR SURGEONS
PROFESSIONAL LIABILITY INSURANCE APPLICATION

This application should be completed by physicians or surgeons only. This application does not apply to corporations, hospitals, nursing homes, or to other health care providers.

1. Name: _____ Date of birth: _____

Phone No: (____) _____ Social Security No: _____

2. Business Address: _____

- _____

- _____

County: _____

3. Current form of insurance: claims-made occurrence

4. Retroactive date: _____ 5. Previous Carrier: _____

6. Effective date of coverage requested: _____

7. Limits of liability requested—Claims-Made Coverage

Each claim: \$ _____ Aggregate: \$ _____

8. Type of practice

Individual Professional Corporation Professional Association Partnership

Resident/Intern Other _____

9. If Employed, Name of Employer: _____

10. Name of Professional Corporation, Professional Association, or Partnership: _____

11. List names of partners or members of corporation or association: _____

- _____

Are they also insured by the association? yes no

If yes, a separate application must be submitted for each partner or member. If no, provide name of insurance company and policy number for each partner or member.

12. What professional organizations are you a member of?

AMA AOA State Medical County Medical Other _____

13. What is your medical specialty? _____

14. Are you certified by an Approved Specialty Board? yes no

If yes, name: _____

15. Indicate percentage of time devoted to the following medical and/or surgical activities:

- | | |
|--|--|
| <input type="checkbox"/> Aerospace Medicine | <input type="checkbox"/> Neoplastic Diseases |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Anesthesiology |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Brocho-Esophagology |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Dermatology |
| <input type="checkbox"/> Occupational Medicine | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Opthamology | <input type="checkbox"/> Emergency Medicine |
| <input type="checkbox"/> Otology | <input type="checkbox"/> Endochrinology |
| <input type="checkbox"/> Otorhinolaryngology | <input type="checkbox"/> Family of Gen. Practice |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Forensic Medicine | <input type="checkbox"/> Pharmacology-Clinical |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Physiatry |
| <input type="checkbox"/> General Preventative Medicine | <input type="checkbox"/> Phy. Medicine and Rehab. |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Gynecology |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Hematology |
| <input type="checkbox"/> Psychoanalysis | <input type="checkbox"/> Hyponosis |
| <input type="checkbox"/> Psychosomatic Medicine | <input type="checkbox"/> Infectious Diseases |
| <input type="checkbox"/> Public Health | <input type="checkbox"/> Intensive Care Medicine |
| <input type="checkbox"/> Pulmonary Diseases | <input type="checkbox"/> Internal Medicine |
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Laryngology |
| <input type="checkbox"/> Rheumatology | <input type="checkbox"/> Legal Medicine |
| <input type="checkbox"/> Rhinology | <input type="checkbox"/> Nephrology |
| | |
| <input type="checkbox"/> % Surgery | <input type="checkbox"/> % Surgery |
| <input type="checkbox"/> Abdominal | <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> Colon and Rectal | <input type="checkbox"/> General |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Gynecology |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Head and Neck |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Obstetrics/Gynecology |
| <input type="checkbox"/> Opthamology | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Otorhinolaryngology | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> Thoracic | <input type="checkbox"/> Plastic Otorhinolaryngology |
| <input type="checkbox"/> Traumatic | <input type="checkbox"/> Urological |
| <input type="checkbox"/> Vascular | <input type="checkbox"/> Cardiac |
| <input type="checkbox"/> Obstetrics | |

16. Do you perform: (Please indicate "YES" or "NO".)

_____ **Obstetrical Procedures** – Not constituting major surgery. **Caesarian sections shall be considered major surgery.**

_____ **No Surgery** – Other than incisions of boils and superficial abscess, or suturing of skin or superficial fascia.

_____ **Minor Surgery** – Including assisting in major surgery on your own patients. **Tonsillectomies and adenoidectomies shall be considered major surgery.**

_____ **Major Surgery** – Includes operations in or upon any body cavity included but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard of life. **It also includes: removal of tumors, open bone fractures, amputations, abortions, the removal of any gland or organ, plastic surgery, and any operation done using general anesthesia.**

17. Please check the following medical techniques or procedures you perform:

___ Acupuncture – other than acupuncture anesthesia

___ Angiography

___ Arteriography

___ Catheterization – Arterial, cardiac or diagnostic, **other than:**

- a. Occasional emergency insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers.
- b. Urethral Catheterization
- c. Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen.

___ Colonoscopy

___ Cryosurgery – other than use on benign or pre-malignant dermatological lesions.

___ Discograms

___ ERCP (Endoscopic retrograde cholangiopancreatography)

___ Lasers – used in therapy

___ Lymphangiography

___ Myelography

___ Needle biopsy – including lung and prostate but not including liver, kidney or bone marrow biopsy

___ Phlebography

___ Pneumatic or mechanical esophageal dialation (not with bougie or olive)

___ Pneumoencephalography

___ Radiation Therapy

___ Radiopaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae

___ Shock Therapy

___ None of the above

18. School of Graduation: _____

Degree: _____ Year: _____

a. If a foreign medical school graduate, are you certified by the educational council for foreign medical graduates? [] yes [] no Year Certified: _____

b. Name and location internship served: _____

c. Name and location residency served: _____

19. Name all places where you have practiced your profession in the last five years:

Location	During Years
- _____	_____
- _____	_____
- _____	_____

20. List all states where you are licensed to practice and your license numbers. ATTACH CURRENT COPIES OF ALL LICENSES.

- _____
- _____

21. Has there been any change in your practice or specialty in the last five years? yes no

If yes, describe: _____

- _____

22. How many continuing medical education credits did you achieve last year? _____

23. Name and locations of all hospitals where you hold staff or courtesy privileges:

Name	Location	JHAC Approved
- _____		<input type="checkbox"/> yes <input type="checkbox"/> no
- _____		<input type="checkbox"/> yes <input type="checkbox"/> no
- _____		<input type="checkbox"/> yes <input type="checkbox"/> no

24. Explain any "yes" answers under #27.

- a. Do you normally staff an emergency room? yes no
- b. Do you practice in or staff an urgi-center or similar minor emergency clinic? yes no
- c. Are you employed full time by the Federal Government or are you in military service? yes no
- d. Are you engaged in any "moonlighting" activities? yes no
- e. Do you own or operate a hospital, sanitarium or clinic with regular bed/board facilities? yes no
- f. Do you own or operate a surgi-center, emergency service facility or similar out patient facility? yes no
- g. Has any hospital ever restricted, suspended or revoked your privileges or has probation been invoked? yes no
- h. Has your narcotics or medical license ever been suspended, revoked or involuntarily surrendered, or has probation been invoked? yes no
- i. Have you ever been denied a medical license or been denied certification by a specialty board? yes no
- j. Are you currently a member of a PPO or HMO? yes no
If yes, indicate name of PPO or HMO: _____
- k. Have you signed a contract to supervise any department within a hospital? yes no

1. Have you signed a contractual agreement where you have agreed to indemnify (hold harmless) others? If yes, attached a copy of the agreement. [] yes [] no
25. Have any claims ever been made against you? [] yes [] no
26. Do you have knowledge of any pending claims or activities (including requests for medical records) that might give rise to a claim in the future? [] yes [] no
27. Explain any "yes" answers to questions 24, 25 and 26.

I, the undersigned, certify and attest that I am unable to obtain this insurance through ordinary methods.

I, the undersigned, certify and attest that at least 60% of my revenue is received from patients residing in Minnesota.

Signing this application does not bind the Association to complete the insurance. All information requested in this application is considered material and important. If the Association agrees to be bound under the terms of this application, your policy is void if you hide any important information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

Date this application was completed: _____

Signature of Applicant (_____)_____
Telephone Number

Agent Name: _____

Agency Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: (_____)_____

Agency Federal ID No: _____ or Agent Soc. Sec. No: _____