

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

INDIVIDUAL HEALTH CARE PROVIDER
PROFESSIONAL LIABILITY INSURANCE APPLICATION

This application should be completed by applicants engaged in health care or related services. This application does not apply to corporations, hospitals or nursing homes.

- Name: _____
Address: _____
- _____
Date of birth: _____
Phone No: (____) _____
Social Security No: _____

- Give a name or title of your specific job occupation and a brief description of your duties.
(Supplemental information or advertising material available explaining duties should be included.)
- _____
- _____
- _____
- How long have you been practicing in each health care or related service activity you perform?
Describe _____ Years/Months _____
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- Are you self-employed? Yes _____ No _____ No. of hours worked per week? _____
Are you employed by others, or a partner in a partnership? Yes _____ No _____
If yes, indicate which type: Employed _____ Partner _____
Give name of employer or partners: _____
Show type of health care or related service provided: _____
Does your employer provide Professional Liability Coverage for you? Yes _____ No _____
- Are you an owner, operator, officer, partner, administrator, or have a similar capacity in any health care or related services organization? Yes _____ No _____
If yes, identify and explain: _____

6. If you have been named as a defendant in a law suit or if any claims have been made against you with a previous or current insurer, give dates, allegations, and disposition of each claim or suit arising out of any occurrence within the last five years. _____

- _____

7. If you have knowledge of any past activities or incidents that might give rise to a claim not yet presented, please explain: _____

- _____

8. List the state or municipal licensing requirements you currently company with to practice in your field.

None required _____

- _____

- _____

YOU MUST ATTACH A COPY OF YOUR LICENSE/CERTIFICATE AND INDICATE THE EXPIRATION/RENEWAL DATE IF NOT SHOWN.

9. List the educational requirements you have met as a prerequisite to practice in your field.

None required _____

- _____

- _____

10. List any professional associations or organizations of which you are a member. Please show complete name.

None _____

- _____ Date of initial membership: _____

- _____ Date of initial membership: _____

11. List any professional designations you have and the date for each. Please show complete name.

None _____

- _____

- _____

12. Have you been subjected to any disciplinary actions by any licensing or certifying authority, hospital, or other institution or professional association? Yes____ No____

If yes, provide details below. Attach additional explanation if necessary. _____

- _____

- _____

SECTION III – To be completed by the applicant and the agent.

Effective date of coverage requested: _____

Professional Liability limits requested: Each Claim \$ _____

Aggregate \$ _____

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

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

The applicant agrees that signing this application does not bind the Association to complete the insurance, however, this application will be the basis of the contract should a policy be issued. The applicant certifies that reasonable inquiry has been made to obtain the answers given in this application and that this application has been completed in a true, correct and complete manner to the best of the applicants knowledge and belief.

Date this application was completed: * _____

Signature of Applicant (_____) Telephone Number

Agent Name: _____

Agency Name: _____

Street Address: _____

City, State, Zip: _____

Telephone No: (_____) _____

Agency Fed ID No: _____ OR Agent Social Security No: _____

* Coverage can be bound at 12:01 a.m. of the day following receipt by the Association of the application, other required documentation and the required deposit premium, or on any subsequent date specified by the applicant.