

MINNESOTA JOINT UNDERWRITING ASSOCIATION  
12400 PORTLAND AVE S, STE 190  
BURNSVILLE, MN 55337  
1(800) 552-0013 OR 952-641-0260 FAX: 952-641-0274

2026-2027 RENEWAL APPLICATION

**COMPLETE SEPARATE FORM FOR EACH LOCATION. ATTACH CURRENT LICENSE(S) AND INSPECTIONS(S) (if applicable).**

NAME AND MAILING ADDRESS OF INSURED \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

\_\_\_\_\_  
COUNTY: \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL: \_\_\_\_\_ WEBSITE: \_\_\_\_\_

ADDRESS OF LOCATION (attach additional pages if necessary.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

1. TYPE OF OPERATION FOR THIS LOCATION

NURSING HOME/SKILLED CARE	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
INTERMEDIATE CARE	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
RESIDENTIAL/ASSISTED LIVING	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
INDEPENDENT LIVING	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
OTHER: _____	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
ADULT DAY CARE	# OF CLIENTS _____	
FOSTER CARE HOME	# OF CLIENTS _____	Adult Home or Child Home (circle one)
HOME HEALTH CARE	# OF PCA COMPLETE BELOW	

2. TOTAL SQUARE FOOTAGE OF BUILDING FOR THIS LOCATION \_\_\_\_\_

3. IF THIS IS A HOME HEALTH CARE/NURSING SERVICES FACILITY PLEASE COMPLETE THE FOLLOWING:

INDICATE THE NUMBER OF PERSONNEL

MD'S	DAY _____	NIGHT _____
RN'S	DAY _____	NIGHT _____
LPN'S	DAY _____	NIGHT _____
PCA'S	DAY _____	NIGHT _____

PSYCHOLOGISTS \_\_\_\_\_  
THERAPISTS' \_\_\_\_\_  
COUNSELOR'S \_\_\_\_\_

4. HAVE YOU OR YOUR COMPANY BEEN SUBJECT TO ANY DISCIPLINARY ACTIONS BY ANY LICENSING OR CERTIFYING AUTHORITY? PLEASE PROVIDE DETAILS BELOW

5. HAVE ANY CLAIMS BEEN PRESENTED TO YOU OR YOUR COMPANY IN THE LAST 3 YEARS? IF YES PLEASE PROVIDE DETAILS BELOW.

6. YOU MUST ATTACH A COPY OF YOUR LICENSE/ CERTIFICATE AND ANY SURVEYS THAT HAVE BEEN COMPLETED IN THE LAST 5 YEAS.

**SIGNATURES**

I declare to the best of my knowledge that all statements herein are true and no material facts have been suppressed or misstated. I am also aware that my operation may be inspected by the insurance company.

Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Agent: \_\_\_\_\_ Date: \_\_\_\_\_

Agent: \_\_\_\_\_ Agency: \_\_\_\_\_

Agency Address: Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Agent Phone: \_\_\_\_\_ Agent Fax: \_\_\_\_\_

Agent Email: \_\_\_\_\_ Agency Fed Tax ID: \_\_\_\_\_