

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

### INDIVIDUAL HEALTH CARE PROVIDER PROFESSIONAL LIABILITY INSURANCE APPLICATION

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

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Business address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Phone 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 \_\_\_\_\_

Describe \_\_\_\_\_ Years/Months \_\_\_\_\_

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: \_\_\_\_\_

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. \_\_\_\_\_

\_\_\_\_\_

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

- \_\_\_\_\_

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.**

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

None required \_\_\_\_\_

- \_\_\_\_\_

- \_\_\_\_\_

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: \_\_\_\_\_

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

None \_\_\_\_\_

- \_\_\_\_\_

- \_\_\_\_\_

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. \_\_\_\_\_

- \_\_\_\_\_

- \_\_\_\_\_

If you have any independent contractors working for you, please describe, including type and in what capacity independent contractor is working. None: \_\_\_\_\_

- \_\_\_\_\_  
- \_\_\_\_\_

If you have completed or participated in any continuing education within the last five years, please describe. None \_\_\_\_\_

- \_\_\_\_\_  
- \_\_\_\_\_

If you administer or assist in administering any radiation or shock therapy, please describe. None \_\_\_\_\_

- \_\_\_\_\_  
- \_\_\_\_\_

Are you aware of any professional services that you will perform outside of the United States? If so, please describe. None \_\_\_\_\_

- \_\_\_\_\_  
- \_\_\_\_\_

**SECTION II – IF YOU ADMINISTER OR ASSIST IN ADMINISTERING ANY ANESTHETIC, COMPLETE THIS SECTION.**

Do you perform or assist in general anesthesia procedures where patients are rendered unconscious?

\_\_\_\_\_ % in hospital only \_\_\_\_\_ % in office only \_\_\_\_\_ % in hospital or office

If you use nitrous oxide or any other anesthetic or anesthetic procedure where patients are not rendered unconscious, please describe type of anesthetics used and methods of administration.

- \_\_\_\_\_  
- \_\_\_\_\_  
- \_\_\_\_\_

Are all anesthetic machines that you use equipped with “fail-safe” devices which will prevent an unconscious patient state? Yes \_\_\_\_\_ No \_\_\_\_\_ None are used \_\_\_\_\_

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 applicant’s 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: \_\_\_\_\_