MINNESOTA JOINT UNDERWRITING ASSOCIATION
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BURNSVILLE, MN 55337
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2020-2021 RENEWAL APPLICATION

INDIVIDUAL PHYSICIANS OR SURGEONS
PROFESSIONAL LIABILITY INSURANCE RENWAL APPLICATION

I. Name: .....

2. Date of birth: .....

3. Home Address: .....

4. Business Address: .....

5. County: _____

6. Type of practice

☐ Individual ☐ Professional Corporation ☐ Professional Association ☐ Partnership

☐ Resident/Intern ☐ Other _____

7. If Employed, Name of Employer: _____

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

_____

9. List Names of Partners or members of corporation or association: _____

_____

Are they also insured by the association ☐ Yes ☐ No

If yes, a separate renewal application must be submitted for each partner or member. Ifno, provide the name of the insurance company and policy number for each partner or member.

10. What is your medical specialty?

_____

11. Are you certified by an Approved Specialty Board? ☐ yes ☐ no
If yes, name: _____

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

%		%	
_	Aerospace Medicine	_	Neoplastic Diseases
_	Allergy	_	Anesthesiology
_	Neurology Nuclear Medicine	_	Brocho-Esophagology
	Nutrition		Cardiovascular Disease
_	Occupational Medicine	_	Dermatology
_	Ophthalmology		Diabetes
_	Otology	_	Emergency Medicine
_	Otorhinolaryngology	_	Endocrinology
_	Pathology	_	Family of Gen. Practice
	Forensic Medicine		Pediatrics
	Gastroenterology	_	Pharmacology-Clinical
	General Preventative Medicine	_	Physiatry
	Geriatrics	_	Phy. Medicine and Rehab.
_	Psychiatry	_	Gynecology
_	Psychoanalysis	_	Hematology
_	Psychosomatic Medicine	_	Hypnosis
	Public Health		Infectious Diseases
	Pulmonary Diseases		Intensive Care Medicine
	Radiology		Internal Medicine
_	Rheumatology	_	Laryngology
_	Rhinology	_	Legal Medicine
		_	Nephrology

% Surgery		% Surgery	
	Abdominal		Cardiovascular
	Colon and Rectal		General
	Geriatrics	_	Gynecology
	Hand		Head and Neck
_	Neurology	_	Obstetrics/Gynecology
_	Ophthalmology	_	Orthopedic
_	Otorhinolaryngology		Plastic
	Thoracic	_	Plastic Otorhinolaryngology
	Traumatic	_	Urological
	Vascular		Cardiac
	Obstetrics		

13. 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 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

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

_ Acupuncture - other than acupuncture anesthesia
_ Angiography
_ Arteriography
_ Catheterization - Arterial, cardiac or diagnostic, **other than:**

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

Colposcopy
_ 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 dilation (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

15. Do you normally staff an emergency room? ☐ yes ☐ no

16. Do you practice in or staff an urgi-center or similar minor emergency clinic ☐ yes ☐ no

17. Are you employed full time by the Federal Government or are you in military service ☐ yes ☐ no

18. Are you engaged in any "moonlighting" activities ☐ yes ☐ no

19. Do you own or operate a hospital, sanitarium or clinic with regular bed/board facilities? ☐ yes ☐ no

20. Do you own or operate a surgi-center, emergency service facility or similar out patient Facility? ☐ yes ☐ no

21. Has any hospital ever restricted, suspended or revoked your privileges or has probation Been invoked? ☐ yes ☐ no

22. Has your narcotics or medical license ever been suspended, revoked or involuntarily Surrendered, or has probation been invoked? ☐ yes ☐ no

23. Have you ever been denied a medical license or been denied certification by a Specialty board? ☐ yes ☐ no

24. Are you currently a member of a PPO or HMO? ☐ yes ☐ no
If yes, indicate name of PPO or HMO: _____

25. Have you signed a contract to supervise any department within a hospital ☐ yes ☐ no

26. 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

27. Have any claims ever been made against you ☐ yes ☐ no

28. 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? ☐ ☐

29. Explain any "yes" answers to questions 21, 22, 26, 27,28.

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% ofmy 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: _____