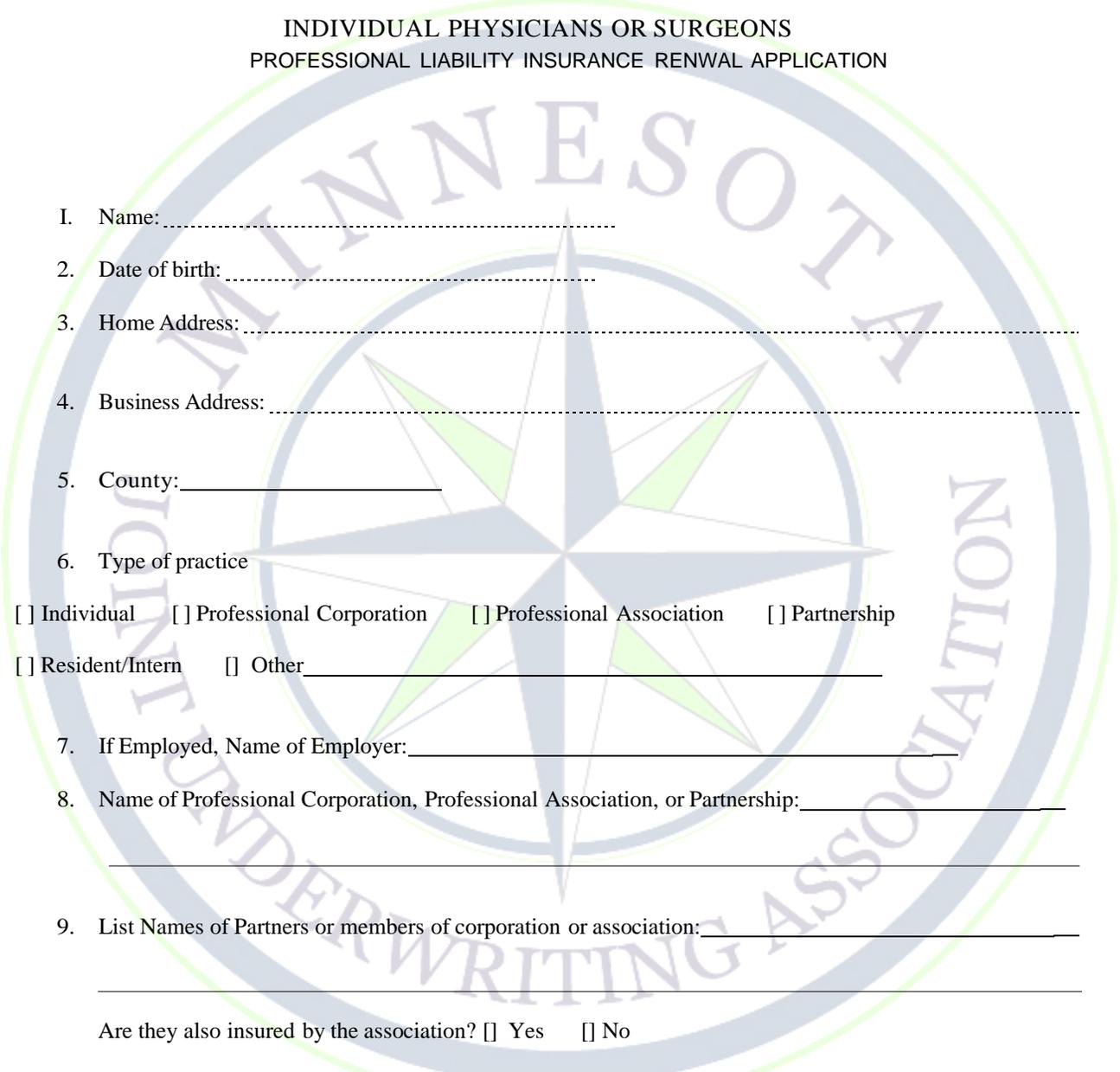


MINNESOTA JOINT UNDERWRITING ASSOCIATION
12400 PORTLAND AVES. STE 190
BURNSVILLE, MN 55337
1(800) 552-0013 OR 952-641-0260 FAX: 952-641-0274

2020-2021 RENEWAL APPLICATION

INDIVIDUAL PHYSICIANS OR SURGEONS PROFESSIONAL LIABILITY INSURANCE RENEWAL APPLICATION

- 
1. 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. If no, 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:

- | | |
|--|--|
| <input type="checkbox"/> % | <input type="checkbox"/> % |
| <input type="checkbox"/> Aerospace Medicine | <input type="checkbox"/> Neoplastic Diseases |
| <input type="checkbox"/> <u>Allergy</u> | <input type="checkbox"/> Anesthesiology |
| <input type="checkbox"/> <u>Neurology Nuclear</u> | <input type="checkbox"/> Brocho-Esophagology |
| <input type="checkbox"/> 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"/> Ophthalmology | <input type="checkbox"/> <u>Emergency Medicine</u> |
| <input type="checkbox"/> <u>Otology</u> | <input type="checkbox"/> Endocrinology |
| <input type="checkbox"/> Otorhinolaryngology | <input type="checkbox"/> Family of Gen. Practice |
| <input type="checkbox"/> <u>Pathology</u> | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Forensic Medicine | <input type="checkbox"/> Pharmacology-Clinical |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> <u>Physiatry</u> |
| <input type="checkbox"/> General Preventative Medicine | <input type="checkbox"/> <u>Phy. Medicine and Rehab.</u> |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Gynecology |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Hematology |
| <input type="checkbox"/> Psychoanalysis | <input type="checkbox"/> <u>Hypnosis</u> |
| <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"/> <u>Rhinology</u> | <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"/> <u>Neurology</u> | <input type="checkbox"/> Obstetrics/Gynecology |
| <input type="checkbox"/> Ophthalmology | <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 | |

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% 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: _____

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism is included in your policy. You are hereby notified that the Terrorism Risk Insurance Act, as amended in 2019, defines an act of terrorism in Section 102(1) of the Act: The term “act of terrorism” means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a \$100 billion cap that limits U.S. Government reimbursement as well as insurers’ liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds \$100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed \$100 billion, your coverage may be reduced. The portion of your annual premium that is attributable to coverage for acts of terrorism is, and does not include any charges for the portion of losses covered by the United States government under the Act.

I ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED THAT UNDER THE TERRORISM RISK INSURANCE ACT, AS AMENDED, ANY LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM UNDER MY POLICY COVERAGE MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT AND MAY BE SUBJECT TO A \$100 BILLION CAP THAT MAY REDUCE MY COVERAGE, AND I HAVE BEEN NOTIFIED OF THE PORTION OF MY PREMIUM ATTRIBUTABLE TO SUCH COVERAGE.

Policyholder/Applicant’s Signature

Print Name

Date

Name of Insurer: Minnesota Joint Underwriting Association

Policy Number: _____