MINNESOTA JOINT UNDERWRITING ASSOCIATION
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Burnsville, MN 55337
(952) 641-0260 or (800) 552-0013 fax: (952) 641-0274

INDIVIDUAL PHYSICIANS OR SURGEONS PROFESSIONAL LIABILITY INSURANCE APPLICATION

This application should be completed by physicians or surgeons only. This application does not apply to corporations, hospitals, nursing homes, or to other health care providers.

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1. Name: _____ Date of birth: _____

   Phone No: (_____)_____ Social Security No:_____

2. Business Address: _____

   -_____

   -_____

   County: _____

3. Current form of insurance: [ ] claims-made [ ] occurrence

4. Retroactive date: _____ 5. Previous Carrier: _____

6. Effective date of coverage requested: _____

7. Limits of liability requested—Claims-Made Coverage

   Each claim: $_____ Aggregate: $_____

8. Type of practice

   [ ] Individual [ ] Professional Corporation [ ] Professional Association [ ] Partnership

   [ ] Resident/Intern [ ] Other _____

9. If Employed, Name of Employer: _____

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

11. List names of partners or members of corporation or association: _____

    -_____

    Are they also insured by the association? [ ] yes [ ] no

    If yes, a separate application must be submitted for each partner or member. If no, provide name of insurance company and policy number for each partner or member.

12. What professional organizations are you a member of?

    [ ] AMA [ ] AOA [ ] State Medical [ ] County Medical [ ] Other _____

13. What is your medical specialty? _____

14. Are you certified by an Approved Specialty Board? [ ] yes [ ] no

    If yes, name: _____

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

%	%
___ Aerospace Medicine	___ Neoplastic Diseases
___ Allergy	___ Anethesiology
___Neurology	___ Brocho-Esophagology
___Nuclear Medicine	___ Cardiovascular Disease
___Nutrition	___ Dermatology
___ Occupational Medicine	___ Diabetes
___ Opthamology	___ Emergency Medicine
___ Otology	___ Endochrinology
___ Otorhinolaryngology	___ Family of Gen. Practice
___ Pathology	___ Pediatrics
___ Forensic Medicine	___ Pharmacology-Clinical
___ Gastroenterology	___ Physiatry
___ General Preventative Medicine	___ Phy. Medicine and Rehab.
___ Geriatrics	___ Gynecology
___ Psychiatry	___ Hematology
___ Psychoanalysis	___ Hyponosis
___ Psychosomatic Medicine	___ Infectious Diseases
___ Public Health	___ Intensive Care Medicine
___ Pulmonary Diseases	___ Internal Medicine
___ Radiology	___ Laryngology
___ Rheumatology	___ Legal Medicine
___ Rhinology	___ Nephrology

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

16. 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 abcess, 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 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.**

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

___ Acupuncture – other than acupuncture anesthesia
___ Angiography
___ Arteriography
___ Catheterization – Arterial, cardiac or diagnostic, **other than:**
   a. Occasional emergency insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers.
   b. Urethral Catheterization
   c. Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen.

___ Coloscopy
___ Cryosurgery – other than use on benign or pre-malignant dermatological lesions.
___ Discograms
___ ERCP (Endoscopic retrograde choloangiopancreatography)
___ 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 dialation (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

18. School of Graduation: _____

Degree: _____ Year: _____

a. If a foreign medical school graduate, are you certified by the educational council for foreign medical graduates? [ ] yes [ ] no Year Certified: _____

b. Name and location internship served: _____

c. Name and location residency served: _____

19. Name all places where you have practiced your profession in the last five years:

Location	During Years
-_____	_____
-_____	_____
-_____	_____

20. List all states where you are licensed to practice and your license numbers. ATTACH CURRENT COPIES OF ALL LICENSES.

-_____

-_____

21. Has there been any change in your practice or specialty in the last five years? [ ] yes [ ] no

If yes, describe: _____

-_____

22. How many continuing medical education credits did you achieve last year? _____

23. Name and locations of all hospitals where you hold staff or courtesy privileges:

Name	Location	JHAC Approved
-_____		[ ] yes [ ] no
-_____		[ ] yes [ ] no
-_____		[ ] yes [ ] no

24. Explain any "yes" answers under #27.

a. Do you normally staff an emergency room? [ ] yes [ ] no
b. Do you practice in or staff an urgi-center or similar minor emergency clinic? [ ] yes [ ] no
c. Are you employed full time by the Federal Government or are you in military service? [ ] yes [ ] no
d. Are you engaged in any "moonlighting" activities? [ ] yes [ ] no
e. Do you own or operate a hospital, sanitarium or clinic with regular bed/board facilities? [ ] yes [ ] no
f. Do you own or operate a surgi-center, emergency service facility or similar out patient facility? [ ] yes [ ] no
g. Has any hospital ever restricted, suspended or revoked your privileges or has probation been invoked? [ ] yes [ ] no
h. Has your narcotics or medical license ever been suspended, revoked or involuntarily surrendered, or has probation been invoked? [ ] yes [ ] no
i. Have you ever been denied a medical license or been denied certification by a specialty board? [ ] yes [ ] no
j. Are you currently a member of a PPO or HMO? [ ] yes [ ] no
If yes, indicate name of PPO or HMO: _____
k. Have you signed a contract to supervise any department within a hospital? [ ] yes [ ] no

l. 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

25. Have any claims ever been made against you? [ ] yes [ ] no

26. 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? [ ] yes [ ] no

27. Explain any "yes" answers to questions 24, 25 and 26.

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: _____