

MINNESOTA JOINT UNDERWRITING ASSOCIATION  
12400 Portland Avenue S, Suite 190  
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.

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:

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

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 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 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.

\_\_\_ Colonoscopy

\_\_\_ 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 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? \_\_\_\_\_

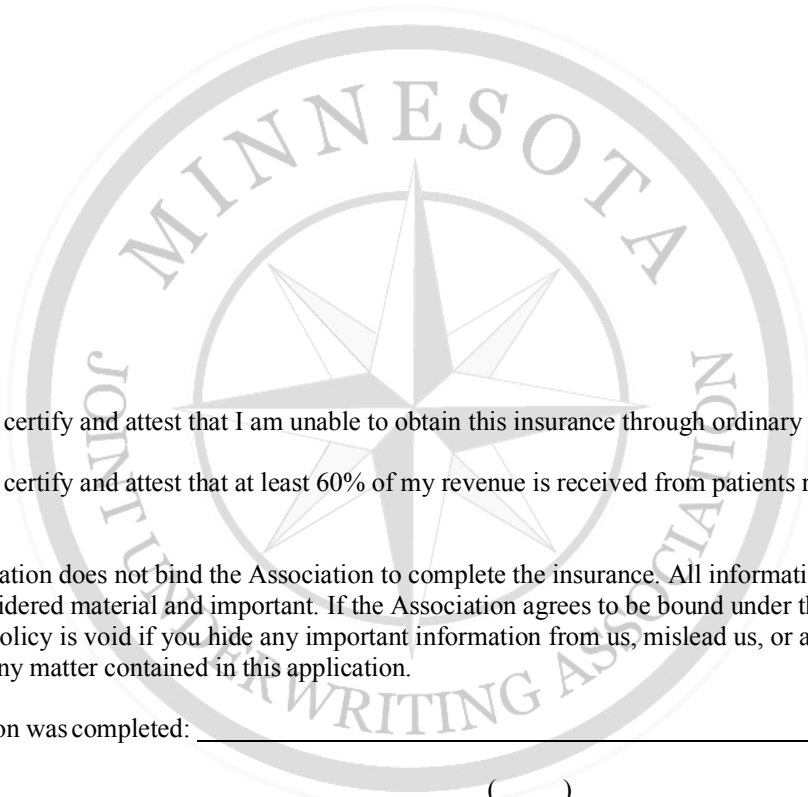
23. Name and locations of all hospitals where you hold staff or courtesy privileges:

Name	Location	JHAC Approved
_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> 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 urgent-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

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

## 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: \_\_\_\_\_