

MINNESOTA JOINT UNDERWRITING ASSOCIATION

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Phone: (952)641-0260 - Toll Free: (800)552-0013 - Fax: (952)641-0274

Application for Claims Made Coverage Home and Community-Based Waiver Services (HCBS) - General Liability Insurance

1. Name of Applicant: _____

2. Address of Applicant: _____

Key Contact: _____

Key Contact E-Mail Address: _____

Phone: _____ Fax: _____

Agent/Broker: _____ Agent/Broker Phone: _____

Agent/Broker Address: _____

3. Applicant Type (Check all that apply).

Business Corporation Nonprofit Corporation Limited Liability Corporation (LLC)

Limited Partnership Limited Liability Partnership (LLP) Government Entity

Individual

4. Date of HCBS – 245D Licensure: _____

5. Number of 245D Clients:

Current Number of Clients _____ Maximum Number Allowed Under Current License _____

6. Staff Size:

Client Contact Full Time Employees _____ Client Contact Part Time Employees _____

Other non-Client Contact Employees _____ Independent Contractors _____ Volunteers _____

Total _____

7. Services Provided (Check all that apply).

Companion Services Homemaker Services Night Supervision Respite Care

Behavioral Support Crisis Respite Independent Living Skills Training

Foster Care Services Day Training and Habilitation Supported Employment

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8. Limit of Liability Requested: Per Occurrence \$ _____ Aggregate \$ _____

9. Retention/Deductible Requested: \$ _____

10. Does the applicant currently carry similar HCBS General Liability Insurance? ___ Yes ___ No

Name of Company: _____

Expiration Date: _____ Limits (Occ/Agg): \$ _____ / \$ _____

Retention/Deductible: \$ _____ Annual Premium: \$ _____

11. Has similar HCBS general liability insurance ever been declined, cancelled or non-renewed?
___ Yes ___ No

If "Yes", please attach explanation.

12. Itemize and fully describe the circumstances surrounding, and the outcome of, any claim made during the last five years which would come within the scope of the insurance now being applied for. Attach additional pages if necessary.

Date of Loss: _____ Type of Loss: _____

Amount Paid: _____ Reserve: _____

Description: _____

Date of Loss: _____ Type of Loss: _____

Amount Paid: _____ Reserve: _____

Description: _____

13. Does applicant have any knowledge of any negligent act, error or omission that could reasonably be expected to give rise to a claim(s), suit(s), investigation(s) or action(s) under the proposed policy?
___ Yes ___ No

If yes, fully describe. Attach additional pages if necessary.

I, the undersigned, certify and attest that I have been unable to obtain through ordinary methods, the insurance I am applying for with this application and the information contained in this application is true and complete.

Signed: _____ Title: _____

Date: _____