

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 HEALTH CARE PROVIDER
PROFESSIONAL LIABILITY INSURANCE APPLICATION

This application should be completed by applicants engaged in health care or related services. This application does not apply to corporations, hospitals or nursing homes.

1. Name: _____

Address: _____

- _____

Date of birth: _____

Phone No: (____) _____

Social Security No: _____

2. Give a name or title of your specific job occupation and a brief description of your duties.
(Supplemental information or advertising material available explaining duties should be included.)

- _____
- _____
- _____

3. How long have you been practicing in each health care or related service activity you perform?

Describe _____ Years/Months _____

Describe _____ Years/Months _____

4. Are you self-employed? Yes _____ No _____ No. of hours worked per week? _____

Are you employed by others, or a partner in a partnership? Yes ___ No ___

If yes, indicate which type: Employed ___ Partner _____

Give name of employer or partners: _____

Show type of health care or related service provided: _____

Does your employer provide Professional Liability Coverage for you? Yes ___ No ___

5. Are you an owner, operator, officer, partner, administrator, or have a similar capacity in any healthcare or related services organization? Yes ___ No ___

If yes, identify and explain: _____

6. If you have been named as a defendant in a law suit or if any claims have been made against you with a previous or current insurer, give dates, allegations, and disposition of each claim or suit arising out of any occurrence within the last five years. _____

7. If you have knowledge of any past activities or incidents that might give rise to a claim not yet presented, please explain: _____

8. List the state or municipal licensing requirements you currently company with to practice in your field.

None required _____

YOU MUST ATTACH A COPY OF YOUR LICENSE/CERTIFICATE AND INDICATE THE EXPIRATION/RENEWAL DATE IF NOT SHOWN.

9. List the educational requirements you have met as a prerequisite to practice in your field.

None required _____

10. List any professional associations or organizations of which you are a member. Please show complete name.

None _____

_____ Date of initial membership: _____

_____ Date of initial membership: _____

11. List any professional designations you have and the date for each. Please show complete name.

None _____

12. Have you been subjected to any disciplinary actions by any licensing or certifying authority, hospital, or other institution or professional association? Yes____No_____

If yes, provide details below. Attach additional explanation if necessary. _____

12. If you have any independent contractors working for you, please describe, including type and in what capacity independent contractor is working. None: _____

13. If you have completed or participated in any continuing education within the last five years, please describe. None _____

14. If you administer or assist in administering any radiation or shock therapy, please describe. None _____

15. Are you aware of any professional services that you will perform outside of the United States? If so, please describe. None _____

SECTION II – IF YOU ADMINISTER OR ASSIST IN ADMINISTERING ANY ANESTHETIC, COMPLETE THIS SECTION.

16. Do you perform or assist in general anesthesia procedures where patients are rendered unconscious?

_____ % in hospital only _____ % in office only _____ % in hospital or office

17. If you use nitrous oxide or any other anesthetic or anesthetic procedure where patients are not rendered unconscious, please describe type of anesthetics used and methods of administration.

18. Are all anesthetic machines that you use equipped with “fail-safe” devices which will prevent an unconscious patient state? Yes _____ No _____ None are used _____

SECTION III – To be completed by the applicant and the agent.

Effective date of coverage requested: _____

Professional Liability limits requested: Each Claim \$ _____

Aggregate \$ _____

I, the undersigned, certify and attest that I have been unable to obtain this insurance through ordinary methods.

I, the undersigned, certify and attest that at least 60% of my revenues are received from patients residing in Minnesota.

The applicant agrees that signing this application does not bind the Association to complete the insurance, however, this application will be the basis of the contract should a policy be issued. The applicant certifies that reasonable inquiry has been made to obtain the answers given in this application and that this application has been completed in a true, correct and complete manner to the best of the applicants knowledge and belief.

Date this application was completed: * _____

Signature of Applicant (_____) Telephone Number

Agent Name: _____

Agency Name: _____

Street Address: _____

City, State, Zip: _____

Telephone No: (_____) _____

Agency Fed ID No: _____ OR Agent Social Security No: _____

* Coverage can be bound at 12:01 a.m. of the day following receipt by the Association of the application, other required documentation and the required deposit premium, or on any subsequent date specified by the applicant.

PRIOR CLAIM/SUIT INFORMATION ADDENDUM (Please type all information).

One of these forms must be completed by the Applicant relative to each prior claim presented against the applicant. Please make additional copies of the blank form as needed to report on each prior claim.

Name of applicant _____

1. Name, age and sex of patient/claimant: _____

2. Dates of treatment and/or surgery which led to the allegations against you: _____
Month/Year

3. Nature of the allegations in the claim/suit: _____
-

4. Specify if a suit was ever filed: yes no If yes, state when: _____
Month/Year

5. Name of other doctor(s) and hospital(s), if any, involved in claim/suit: _____
-

6. Disposition or current status of claim/suit:
 OPEN – Indicate case value established by carrier if known: _____

CLOSED – Was payment made? yes no
If no, was claim or suit withdrawn? yes no

If payment was made, indicate amount of settlement or award: _____

Total settlement or award: _____ On Your behalf: _____

7. Name of insurance carrier defending you: _____

8. Narrative description or the medical facts (must include, but not limited to the type of treatment and/or surgery; your involvement). PLEASE GIVE AS COMPLETE A NARRATIVE DESCRIPTION AS POSSIBLE. YOU MAY ATTACH ADDITIONAL PAGES, IF REQUIRED. THIS PORTION MUST BE COMPLETED AND SIGNED BY THE APPLICANT.

Signature of applicant: _____ Date completed: _____

**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: _____

MJUA

12400 Portland Avenue S, Suite 190, Burnsville, Minnesota 55337

email: info@mjua.org | office: 952-641-0260 | fax: 952-641-0274 | www.mjua.org