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.

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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: _____