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. __________________

-______________________________

-______________________________

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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_________

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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.

MINNESOTA JOINT UNDERWRITING ASSOCIATION

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.

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-____

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Signature of applicant:___________________________________Date completed: __________________

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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: ___________________________________