MINNESOTA JOINT UNDERWRITING ASSOCIATION
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BURNSVILLE, MN 55337
1(800) 552-0013 OR 952-641-0260 FAX: 952-641-0274

2023-2024 RENEWAL APPLICATION

INDIVIDUAL HEALTH CARE PROVIDER PROFESSIONAL LIABILITY INSURANCE APPLICATION

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

1. Name: _____

Address: _____

Business address: _____

Date of birth: _____

Phone No: ( )_____

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.)

-_____

-_____

-_____

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

Describe_____ Years/Months _____
Describe_____ Years/Months_____

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☐

Are you an owner, operator, officer, partner, administrator, or have a similar capacity in any health care or related services organization? Yes☐ No☐

If yes, identify and explain: _____

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. _____
_____

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

-_____

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.

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

None required ☐
-_____
-_____

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:_____

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

None ☐
-_____
-_____

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. _____
-_____
-_____

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

-_____
-_____

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

-_____
-_____

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

-_____
-_____

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.

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

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

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.

-_____
-_____
-_____

Are all anesthetic machines that you use equipped with "fail-safe" devices which will prevent an unconscious patient state? Yes ☐ No ☐ None are used ☐

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 applicant's 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: _____