Minnesota Medical Malpractice Joint Underwriting Association
Minnesota Joint Underwriting Association
12400 Portland Avenue S, SUITE 190
Burnsville, MN 55337
Phone: (952) 641-0260 or (800) 552-0013
Fax: (952) 641-0274

INSTITUTIONAL CARE/ LIVING FACILITIES APPLICATION

1. Name of applicant: _____

2. Mailing address:
_____City_____State_____Zip_____

3. Contact_____Phone: _____

4. Email:_____Web address: _____

5. Federal ID#_____State Unemployment #_____

6. Type of Enterprise: ☐ Individual ☐ Corp. ☐ Partnership ☐ Joint Venture
☐ For Profit ☐ Non-Profit

7. Full Name of Owners or Partners:
_____ SSN: _____
_____ SSN: _____

8. Is applicant engaged in, owned by, associated with or involved with anyother enterprise? _____
If yes, provide details:_____

9. Has applicant had previous insurance for this enterprise: Yes☐ No☐ If yes, complete:

Insurance Company _____
Policy Period _____
Limits of Liability _____
Occurrence or Claims-Made _____
Type of Coverage_____

Insurance Company _____
Policy Period _____
Limits of Liability _____
Occurrence or Claims-Made _____
Type of Coverage_____

10. Provide details of licensing or certification needed for this operations:
_____

11. List any professional associations in which you are a member:
_____

12. Type of Facility

☐ Nursing Home

Level of Care provided:
_____ Licensed Skilled Care Beds _____Licensed Intermediate Care Beds
_____ Licensed Independent Living Beds

Patient Break Down by Age Group:

Under 18 years _____ 36 – 50 years _____ Over 65 years _____
18 – 35 years _____ 51 – 65 years_____

☐ Assisted Living Facility ☐ Licensed Beds

☐ Group Home ☐ Licensed Beds

☐ Home Health Care Provider

Indicate number of personnel:

_____ MDs _____RNs _____LPNs _____PCAs _____Therapists _____Counselors

13. Are patients allowed to leave premises unattended? ☐ Yes ☐ No

14. Are restraints used? ☐ Yes ☐ No

15. Is physician evaluation and written notice from physician (except in an emergency) required for use of chemical or physical restraints? ☐ Yes ☐ No

16. Is patient's legal guardian/representative required to approve use of chemical or physical restraints in writing? ☐ Yes ☐ No

17. What precautions are taken to keep track of patients? _____

18. Sign out procedures? ☐ Yes ☐ No

19. Alarms on doors to prevent clients from wandering from the home? ☐ Yes ☐ No

20. Electronic monitoring of patients with senility or alzheimers? ☐ Yes ☐ No

21. Does patient control the possession of smoking materials? ☐ Yes ☐ No

22. Are any other services provided, either by staff or independent contractor, such as beautician services, podiatrist, dentist, etc? Provide details _____

23. Do you required and maintain certificates of insurance from all independent contractors? ☐ Yes ☐ No

24. Prior Claim Information: During the past (3) three years, have any claims been presented to your current or prior insurance carrier? ☐ Yes ☐ No If yes, give full details, include description of claim, amount paid, and reserves.

25. Is applicant or any other person for whom insurance is being requested aware of any circumstance which may result in a claim? ☐ Yes ☐ No If yes, provide full details.

26. Has applicant or any other person for whom coverage is being requested had any liability application denied, policy cancelled, or policy not renewed in the past (3) three years? ☐ Yes ☐ No If yes, provide full details.

27. Limits of liability sought: _____

28. Proposed effective date of coverage: _____

29. Is the insured a building owner ☐ tenant ☐ general lessee ☐

30. Does applicant have workers compensation coverage in force? ☐ Yes ☐ No

---

Intentionally left blank for additional comment space.

COMPLETE A SEPARATE SHEET FOR EACH LOCATION

Address of location:

Street: _____

City_____State_____Zip Code: _____

Contact Name_____Phone at location _____

31. Number of licensed beds at this location:_____Current occupancy _____

32. Number of fire escapes_____ Number of fire extinguishers _____

33. Local fire alarm?_____Yes_____No Central fire station alarm?_____Yes_____No

34. Distance to nearest fire station: _____

35. Are handrails provided in bedrooms and hallways?_____Yes_____No

36. Temperature of hot water? _____

37. Swimming pool or hot tub?_____Yes _____No If yes, fenced with self-locking gate?_____Yes _____ No
Slide?_____Yes _____No

38. Is there an emergency written evacuation plan in place?_____ Yes_____No

AGENCY CONTACT INFORMATION

Agent Name: _____

Agency: _____

Agency Address _____

City/State/ZIP _____

Phone: _____

Employer Identification Number _____

REQUIREMENTS FOR QUOTE

1. **Fully completed application**
2. **Copy of ALL licenses for each location**
3. **Copy of state department of health survey and responses/certificates of correction**
4. **Prior company loss runs for previous (5) five year period**
5. **Copy of client incident report form used**

Applicant Name: _____

Title: _____

Applicant's Signature: _____

Date: _____