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 any other 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

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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: _____