

Minnesota Joint Underwriting Association
12400 Portland Ave S, Suite 190
Burnsville, MN 55337
1-800-552-0013 or 952-641-0260
Fax: 952-641-0274
www.mjua.org

SEPTIC INSPECTORS APPLICATION
General & Professional Liability
Claims-Made Form

APPLICANT INFORMATION

1. Proposed insured: _____

Mailing address: _____

City, State, Zip: _____ County: _____

Phone: _____ Email: _____

2. The proposed named insured is:

Individual Partnership Joint Venture Corporation Other

3. Proposed: Effective date _____ End date July 1st (Common Renewal Date)

4. Limits offered (select desired limits)

\$250,000 per occurrence/ \$500,000 annual aggregate

\$300,000 per occurrence/ \$1,000,000 annual aggregate

5. Years in Business: _____ Number of full time staff: _____ Part time: _____

Nature of business – including gross receipts, total payroll, number of units inspected
In each of the last three years (attach most recent financial statement and other
Supporting documents. Be as detailed as possible).

6. Anticipated number of septic inspections to be performed in the next year: _____

7. Charge per inspection _____

8. Is the applicant a licensed septic inspector? Please attach a copy of the
license/certification.

No Yes

9. Does the applicant engage in any kind of professional service other than septic inspections?

_____ No _____ Yes

10. Does the applicant design septic systems?

_____ No _____ Yes

11. Anticipated number of septic designs to be performed in the next year: _____

12. Charge per design _____

PRIOR CARRIER INFORMATION (Attach copy of most recent policy and application)

Year	Carrier	Policy Number	Limits BI/PD	Annual Premium
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LOSS AND CLAIM HISTORY (Attach further sheets if needed)

Enter all losses and claims for the prior 5 years. If aggregates are provided, please indicate the number of claims and explain all claims exceeding \$5,000.

Date of loss: _____ Type of loss: _____

Amount paid: _____ Reserve: _____

Description: _____

Date of loss: _____ Type of loss: _____

Amount paid: _____ Reserve: _____

Description: _____

APPLICATION REQUIREMENT

AS PART OF YOUR APPLICATION, YOU ARE REQUIRED TO SUBMIT ONE REJECTION OF COVERAGE FROM A STANDARD INSURANCE CARRIER.

A WRITTEN QUOTE PROVIDED BY AN INSURER AT A RATE IN EXCESS OF 110% OF PLAN RATES FOR SIMILAR COVERAGE IS DEEMED TO BE A WRITTEN REJECTION.

Does the applicant conduct any activities outside the state of Minnesota for which the applicant is applying for insurance from MJUA?

_____ No _____ Yes

If Yes, identify the percentage amount of the applicant's activities conducted outside the state of Minnesota; the states in which those activities are conducted; and describe such activities.

Is the insurance for which the applicant is applying for from MJUA required by statute, ordinance, or otherwise required by Minnesota law?

_____ No _____ Yes

If Yes, identify the statute, ordinance, or Minnesota law requiring such insurance.

THE FOLLOWING QUESTIONS MUST BE ANSWERED BY ALL APPLICANTS.
("Yes" answers do not require explanation)

Does the applicant understand that the insurance being applied for does not cover, and will not indemnify, the applicant for any liability or loss arising from the applicant's activities that are conducted substantially outside the state of Minnesota, unless required by statute, ordinance, or otherwise required by Minnesota law.

_____ No _____ Yes

I, the undersigned, certify and attest on behalf of the applicant that I have been unable to obtain through ordinary methods, the insurance I am applying for with this application and the information contained in this application is true and complete.

_____ No _____ Yes

Please identify the name of the insurance company who has refused to provide coverage to the applicant and the date of the refusal.

Was the refusal to provide coverage by another insurer based on an offer of coverage at a rate in excess of the rate that would be charged by the MJUA for similar coverage and risk?

_____ No _____ Yes

If Yes, and the rate for coverage offered is more than 10% in excess of the MJUA's rates for similar coverage and risk, or 20% in excess of the MJUA's rates for liquor liability coverages, attach a copy of such written offer to this application. *NOTE that pursuant to Minn. Stat. 62I.13, Subd. 2, "[i]t shall not be deemed to be a written notice of refusal if the rate for coverage offered is less than ten percent in excess of the joint underwriting association rates for similar coverage and risk or 20 percent in excess of the Joint Underwriting Association rates for liquor liability coverages."*

If No, provide further explanation.

The applicant agrees, represents and warrants that the statements and information contained in the application for insurance, including all statements, information and documents accompanying or relating to the application are accurate and complete and no facts have been suppressed, omitted or misstated. Failure to fully disclose the information requested in the application for insurance, whether by omission or suppression, or any misrepresentation in the statements, information and documents accompanying or relating to the application renders coverage for any claim(s) null and void and entitles us to rescind the policy from its inception.

Signature of applicant: _____ Date: _____

Signature of Agent: _____ Date: _____

Agent: _____ Agency: _____

Agency Address: Street: _____

City, State, Zip: _____

Agent Phone: _____ Agent Fax: _____

Agent Email: _____ Agency Fed Tax ID: _____

MINNESOTA JOINT UNDERWRITING ASSOCIATION

POLICYHOLDER DISCLOSURE

NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended, you have a right to purchase insurance coverage for losses resulting from acts of terrorism. As defined in *Section 102(1) of the Act*: The term "act of terrorism" means any act or acts that are certified by the Secretary of 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 of the United States in the case of certain air carriers or vessels or the premises of the 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 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 AND 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 IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. 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 0%, 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.

Applicant Name (Print)

Policyholder/Applicant Signature

Named Insured

Policy Number, if applicable

Date