

Minnesota Joint Underwriting Association
Pioneer P.O. Box 1760
St. Paul, MN 55101
1-800-552-0013 or 651-222-0484
Fax: 651-222-7824

CAREER FIDUCIARY LIABILITY INSURANCE APPLICATION
FOR CLAIMS MADE COVERAGE

1. Name and mailing address: _____

Phone: _____

Agent : _____ Phone: _____

2. The proposed named insured is:

Individual Partnership Joint Venture Corporation Other

3. List of officers, partners or the name of individual:

1. _____

2. _____

3. _____

4. _____

If the proposed name insured is not an individual, the total number of career fiduciaries employed in the organization: _____

Important: If the proposed named insured is not an individual and employs more than one career fiduciary, complete a supplemental application for each career fiduciary and attach to this application.

4. Proposed: Effective date: _____ Ending date: _____

Limit per occurrence: \$ _____

Aggregate limit: \$ _____

5. Years in service as a career fiduciary : _____

6. Greatest number of career fiduciary clients that you will be representing at any one time: _____

7. Total number of cases in which you expect to serve as a career fiduciary during the next twelve months: _____

	Yes	No
8. Are you certified as a career fiduciary ?	_____	_____

In which counties? _____

Please list name, address, and phone number of certifying Authority. _____

9. Will any of the clients represented by you be involved in Court proceedings dealing with the following:

Neglect	_____	_____
Dependency	_____	_____
Termination of parental rights	_____	_____
Custody	_____	_____

10. Will you be accountable to any program coordinator, peer supervisor, outside agency, or consultant? If yes, please specify names, titles, and phone numbers. _____	_____	_____
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11. Have you or any of your employees ever been convicted of a felony or gross misdemeanor? If yes, explain (include dates, locations, infractions and penalties).	_____	_____
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12. Are you or any of your employees under investigation for or have a previous record of sexual abuse?	_____	_____
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13. Are you or any of your employees a licensed attorney? If yes, specify company with whom you have lawyers professional liability coverage and policy number.	_____	_____
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PRIOR CARRIER INFORMATION

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

LOSS AND CLAIM HISTORY

Enter all losses and claims for the prior 5 years. Add separate sheets if necessary.

Date of loss: _____ Type of loss: _____

Amount paid: _____ Reserve: _____

Description: _____

Date of loss: _____ Type of loss: _____

Amount paid: _____ Reserve: _____

Description: _____

Date of loss: _____ Type of loss: _____

Amount paid: _____ Reserve: _____

Description: _____

Comments:

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

Signature of Applicant

Date

ONE LETTER OF REJECTION OR REFUSAL TO WRITE YOUR COVERAGE WITH A STANDARD MARKET INSURANCE COMPANY MUST BE SUBMITTED WITH YOUR APPLICATION BEFORE IT CAN BE CONSIDERED COMPLETE.