Texas Medical Liability Insurance Underwriting Association (JUA)

1812 Centre Creek Drive, Suite 305 • Austin, Texas 78754
(512) 452-4370

APPLICATION FOR MEDICAL (PROFESSIONAL) LIABILITY INSURANCE
PHYSICIANS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

To the above designated Association:
As a licensed physician or other non-institutional health care provider entitled in good faith to medical liability insurance in Texas, the undersigned hereby makes application for such insurance in accordance with the provisions of Chapter 2203 of the Insurance Code of Texas, as amended, and the Plan of Operation of the Texas Medical Liability Insurance Underwriting Association ("ASSOCIATION") created in such Article. **THE UNDERSIGNED RECOGNIZES AND AGREES THAT IF HE OR SHE IS ISSUED A POLICY OF MEDICAL (PROFESSIONAL) LIABILITY INSURANCE PURSUANT TO THIS APPLICATION, HE OR SHE MAY BE ASSESSED IN AN AMOUNT NOT TO EXCEED ONE HUNDRED PERCENT (100%) OF THE PREMIUM PAID FOR THIS POLICY, AND THAT IF HE OR SHE SHOULD FAIL TO PAY SUCH ASSESSMENT WHEN LEVIED AGAINST HIM OR HER, THAT THIS POLICY AND ANY OTHER POLICY INSURING THE UNDERSIGNED WHICH IS WRITTEN THROUGH THE ASSOCIATION MAY BE CANCELLED, AND THE UNEARNED PREMIUM OTHERWISE REFUNDABLE ON SUCH POLICY (OR POLICIES) MAY BE OFFSET BY THE ASSOCIATION AGAINST THE AMOUNT OF SUCH UNPAID ASSESSMENT**. The undersigned further recognizes and agrees that such insurance as is applied for herewith is subject to such rates, premium modifications, surcharges and policyholder's stabilization reserve fund charges as are now or may hereafter be approved by the Texas Department of Insurance. The undersigned further agrees that the Producer of Record herein shown acts solely as the agent of the undersigned and is not an agent of or for the ASSOCIATION or of the company assigned to issue and service such insurance.

1. The insurance herewith applied for has currently been tendered to and rejected by two carriers, including licensed and engaged in writing the coverage applied for in Texas or self-insurance trust created under Insurance Code Chapter 2212. These rejections must be evidenced only by valid notification from the insurer or trust. This requirement applies to each and every application, whether new or renewal. **THIS IS A MANDATORY REQUIREMENT. COVERAGE CANNOT BE BOUND WITHOUT COPIES OF THESE WRITTEN REJECTIONS.**

   Name of Rejecting Carriers: (1) _____ (2) _____

   Date of Rejections: (1) _____ (2) _____

2. a. **APPLICANT'S FULL NAME**: _____ Date of Birth _____

   b. Mailing Address: _____ (Street) _____ (City) _____ (County) _____ (State) _____ (Zip)

   c. Practice Address: _____ (Street) _____ (City) _____ (County) _____ (State) _____ (Zip)

   d. Email address for insured: _____

   e. Email address for office manager: _____

   f. Provide name of **EACH** facility at which you have staff membership or privileges and **ATTACH** a copy of your clinical privileges approved at **EACH.** Attach addendum if additional space is needed. **THIS IS A MANDATORY REQUIREMENT. COVERAGE CANNOT BE BOUND WITHOUT THIS INFORMATION.**

   _____ _____

   _____ _____

   _____ _____

   _____ _____

3. Check the TYPE OF COVERAGE desired:

   ☐ Occurrence

   ☐ Claims-Made: Check one of the following:

   ☐ First Year

   ☐ Prior Acts Coverage (You must complete form JUA-82 and attach copy of your current/most recent declaration's page)
   Retro Date Desired: _____

4. Future EFFECTIVE DATE Desired: _____

5. **My Medical Professional Specialty is**: _____

IMPORTANT: You MUST check "✓" all areas which are included in your medical practice or profession even if performed infrequently.

SPECIALTY OR PROCEDURE	CLASS CODE
☐ Acupuncture	80437
☐ Aerospace Medicine	80230
☐ Allergy	80254
☐ Anesthesiology	80151
☐ Angiography	80422
☐ Arteriography	80422
☐ Bronchoesophagology	80101
☐ Cardiovascular Disease	
☐ No surgery	80255
☐ Minor surgery	80281
☐ Catheterization	80422
☐ Colonoscopy	80443
☐ Dentistry-excluding oral surgery	
☐ *or operative dentistry	80211
☐ Dentistry-including oral surgery	
☐ *or operative dentistry	80210
☐ Dermatology	
☐ No surgery	80256
☐ Minor surgery	80282
☐ Diabetes	
☐ No surgery	80237
☐ Minor surgery	80271
☐ Discograms	80428
☐ Emergency Medicine	
☐ No major surgery	80102
☐ Including major surgery	80157
☐ Endocrinology	
☐ No surgery	80238
☐ Minor surgery	80272
☐ ERCP	80443
☐ Family or General Practice	
☐ No surgery	80420
☐ Minor surgery	80421
☐ Forensic Medicine	80240
☐ Gastroenterology	
☐ No surgery	80241
☐ Minor surgery	80274
☐ General Preventive Medicine	80231
☐ Geriatrics	
☐ No surgery	80243
☐ Minor surgery	80276
☐ Gynecology	
☐ No surgery	80244
☐ Minor surgery	80277

SPECIALTY OR PROCEDURE	CLASS CODE
☐ Hematology/Oncology	
☐ No surgery	80245
☐ Minor surgery	80278
☐ Hypnosis	80232
☐ Infectious Diseases	
☐ No surgery	80246
☐ Minor surgery	80279
☐ Intensive Care Medicine	80283
☐ Internal Medicine	
☐ No surgery	80257
☐ Minor surgery	80284
☐ Laparoscopy	80440
☐ Laryngology	
☐ No surgery	80258
☐ Minor surgery	80285
☐ Lasers	80425
☐ Legal Medicine	80240
☐ Lymphangiography	80434
☐ Myelography	80428
☐ Needle Biopsy-lung or prostate	80446
☐ Neoplastic Diseases	
☐ No surgery	80259
☐ Minor surgery	80286
☐ Nephrology	
☐ No surgery	80260
☐ Minor surgery	80287
☐ Neurology	
☐ No surgery	80261
☐ Minor surgery	80288
☐ Nuclear Medicine	80262
☐ Nurse (Registered) Practitioner	80998P
☐ Nurse (Registered)	80998
☐ Nurse (CRNA)	80960
☐ Nurse (Certified)-Midwife	
☐ Births	80962
☐ Nurse (Certified)-Midwife	
☐ No Births	80963
☐ Nurse (Registered)-	
☐ X-Ray Therapists	80714
☐ Nutrition	80248
☐ Occupational Medicine	80233
☐ Ophthalmology	
☐ No surgery	80263
☐ Minor surgery	80289

5. Specialty or Procedure (continued)

SPECIALTY OR PROCEDURE	CLASS CODE	SPECIALTY OR PROCEDURE	CLASS CODE
☐ Otology		☐ Surgery-abdominal	80166
☐ No surgery	80264	☐ Surgery-bariatric	80166B
☐ Minor surgery	80290	☐ Surgery-cardiac	80141
☐ Otorhinolaryngology		☐ Surgery-cardiovascular	80150
☐ No surgery	80265	☐ Surgery-colon and rectal	80115
☐ Minor surgery	80291	☐ Surgery-endocrinology	80103
☐ Pathology		☐ Surgery-gastroenterology	80104
☐ No surgery	80266	☐ Surgery-Family or General Practice not primarily	
☐ Minor surgery	80292	engaged in major surgery	80117
☐ Pediatrics		☐ Surgery-general	80143
☐ No surgery	80267	☐ Surgery-geriatrics	80105
☐ Minor surgery	80293	☐ Surgery-gynecology	80167
☐ Perfusionist	P80151	☐ Surgery-hand	80169
☐ Phlebography	80434	☐ Surgery-head and neck	80170
☐ Physiatry	80235	☐ Surgery-laryngology	80106
☐ Physical Medicine & Rehabilitation	80235	☐ Surgery-maxillofacial	80155
☐ Pneumoencephalography	80428	☐ Surgery-neoplastic	80107
☐ Podiatry (No Surgery)	80993	☐ Surgery-nephrology	80108
☐ Podiatry (Surgery)	80993S	☐ Surgery-neurology	80152
☐ Psychiatry	80249	☐ Surgery-obstetrics	80168
☐ Psychoanalysis	80250	☐ Surgery-obstetrics-gynecology	80153
☐ Psychosomatic Medicine	80251	☐ Surgery-ophthalmology	80114
☐ Public Health	80236	☐ Surgery-orthopedic	80154
☐ Pulmonary Disease	80269	☐ Surgery-otology	80158
☐ Radiation Therapy	80425	☐ Surgery-otorhinolaryngology	80159
☐ Radiology		☐ Surgery-plastic	80156
☐ No surgery	80253	☐ Surgery-plastic-otorhinolaryngology	80155
☐ Minor surgery	80280	☐ Surgery-rhinology	80160
☐ Radiopaque Dye Injections	80449	☐ Surgery-thoracic	80144
☐ Rheumatology	80252	☐ Surgery-traumatic	80171
☐ Rhinology		☐ Surgery-urological	80145
☐ No surgery	80247	☐ Surgery-vascular	80146
☐ Minor surgery	80270	☐ Therapeutic abortion	80437
☐ Shock Therapy	80431	☐ Weight control-as a specialty	80437

*Dentistry procedures that require any cutting that may require suturing shall be considered oral surgery or operative dentistry.

6. Do you perform any procedures not customary to your specialty? (If yes, please list) ☐ Yes ☐ No

7.. a. Check the LIMITS OF LIABILITY desired:

☐ $100,000./$ 300,000. ☐ $ 300,000./$ 900,000.
☐ $200,000./$ 600,000. ☐ $ 500,000./$1,500,000.
☐ $250,000./$ 750,000. ☐ $1,000,000./$3,000,000.

8.. Do you perform any one or more of the following procedures?

a. Minor** surgery other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia ..... ☐ Yes ☐ No
b. Assisting in major** surgical procedures on your own patients ..... ☐ Yes ☐ No
c. Assisting in major surgical procedures on other than your own patients ..... ☐ Yes ☐ No
d. Major surgery (includes procedures done under general, spinal or caudal anesthesia)..... ☐ Yes ☐ No
e. Normal deliveries of newborns ..... ☐ Yes ☐ No
f. Percutaneous biopsy for diagnostic study of organs or structures other than skin or superficial fascia ..... ☐ Yes ☐ No
g. Weight control surgery or procedures. Describe procedures..... ☐ Yes ☐ No
h. Prenatal care ..... ☐ Yes ☐ No

**Tonsillectomies, Adenoidectomies and Cesarean Sections are considered to be major surgical procedures.

i. Administer Anesthesia
1. General
–To your own patients? ..... ☐ Yes ☐ No
–Is general anesthesia administered in your office? ..... ☐ Yes ☐ No
If yes, list who administers and explain relationship:

_____

_____

–Is general anesthesia administered in a hospital or surgicenters? ..... ☐ Yes ☐ No
If yes, list who administers and explain relationship:

_____

_____

2. Spinal ..... ☐ Yes ☐ No
3. Caudal ..... ☐ Yes ☐ No
4. Acupuncture ..... ☐ Yes ☐ No

j. Treat by intravenous or intramuscular sedation ..... ☐ Yes ☐ No
–Is treatment administered in your office? ..... ☐ Yes ☐ No
If yes, list who administers and explain relationship:

_____

_____

–Is treatment administered in a hospital or surgicenters? ..... ☐ Yes ☐ No
If yes, list who administers and explain relationship:

_____

_____

k. Catheterization-arterial, cardiac or diagnostic-other than (1) the occasional emergency insertion of pulmonary wedge pressure recording catheters or temporary pacemakers, (2) urethral catheterization or (3) umbilical cord catheterization for diagnostic purposes or for monitory blood gases in newborns receiving oxygen ..... ☐ Yes ☐ No
l. Needle biopsy (Please explain, i.e. lung, liver, kidney, breast, etc.) _____ ☐ Yes ☐ No
m. Pneumatic or mechanical esophageal dilatation (not with bougie or olive) ..... ☐ Yes ☐ No
n. Radiopaque Dye-injections into blood vessels, lymphatics, sinus tracts or fistulae ..... ☐ Yes ☐ No
o. Lumbar epidural steroid injections ..... ☐ Yes ☐ No
p. Cervical epidural steroid injections ..... ☐ Yes ☐ No
q. Selective nerve root blocks ..... ☐ Yes ☐ No
r. Sacroiliac joint injections ..... ☐ Yes ☐ No
s. Lumbar facet injections ..... ☐ Yes ☐ No
t. Cervical facet injections ..... ☐ Yes ☐ No
u. Selective occipital nerve blocks ..... ☐ Yes ☐ No
v. Trigger point injections ..... ☐ Yes ☐ No
w. Joint Injections ..... ☐ Yes ☐ No
x. Sympathetic nerve blocks ..... ☐ Yes ☐ No

y. Spinal taps/Lumbar punctures..... ☐ Yes ☐ No

z. Closed reductions ..... ☐ Yes ☐ No

aa. Paracentesis ..... ☐ Yes ☐ No

bb. Thoracentesis ..... ☐ Yes ☐ No

cc. Circumcisions ..... ☐ Yes ☐ No

dd. Chemotherapy..... ☐ Yes ☐ No

If yes, explain how it is administered:

_____

_____

ee. BOTOX Injections for:

1. Muscle relaxant..... ☐ Yes ☐ No
2. Anti-wrinkle or other cosmetic purposes..... ☐ Yes ☐ No
3. Migraines..... ☐ Yes ☐ No
4. Abnormal sweating..... ☐ Yes ☐ No
5. Other (describe in detail)..... ☐ Yes ☐ No

_____

_____

_____

6. Describe training and qualifications of all persons administering BOTOX in connection with your practice:

_____

_____

_____

7. If administered in any setting other than in your medical office at which other professional services are rendered, explain in detail:

_____

_____

_____

8. Attach a copy of the informed consent agreement patients are required to review and sign prior to treatment with BOTOX.

ff. Wound Care (Please furnish list of procedures)..... ☐ Yes ☐ No

gg. Neonatology..... ☐ Yes ☐ No

hh. Telemedicine (Please explain)..... ☐ Yes ☐ No

ii. Do you perform cosmetic/aesthetic procedures?..... ☐ Yes ☐ No
If yes, please attach list of procedures performed.

jj. Pain Management procedures? If yes, please attach list ..... ☐ Yes ☐ No

kk. Cardioversion (chemical or electrical) ..... ☐ Yes ☐ No

ll. Arterial Lines/Arterial Punctures? ..... ☐ Yes ☐ No

9. Are you engaged in emergency practice? If so, where? _____ ☐ Yes ☐ No

10. Are you a member of an emergency room team? ..... ☐ Yes ☐ No

11. Do you render emergency room care other than as a requirement for staff privileges? ..... ☐ Yes ☐ No

If yes, number of hours per week _____

12. Do you perform procedures in an ICU/CCU/NICU unit? (other than to maintain staff privileges) ..... ☐ Yes ☐ No

13. Are you in active U.S. Military Service? ..... ☐ Yes ☐ No

14. a. Medical, Dental or Nursing School: _____ Country: _____ Degree: _____ Year: _____

b. Served internship at: _____ Country: _____ Year: _____

c. Served residency at: _____ Country: _____ Year: _____

d. Are you Board Certified ( ) Yes ( ) No Specialty _____ Year: _____

e. Are you Board Eligible ( ) Yes ( ) No Specialty _____ Year: _____

f. Are you a foreign medical or dental school graduate? ..... ☐ Yes ☐ No

If "yes," please provide: Year _____ Name of certifying school or organization _____

15. Are you licensed, registered or certified to practice your profession in the State of Texas? ..... ☐ Yes ☐ No

16. Has your license, authority or privileges ever been revoked, cancelled or suspended? ..... ☐ Yes ☐ No
If yes, please submit a copy of the details issued by the state licensing board.

17. Has any claim or suit for any alleged malpractice been brought against you within the past eight years resulting in an indemnity payment? ..... ☐ Yes ☐ No

WE REQUIRE A COMPLETE COPY OF A CURRENT SELF-QUERY FROM THE NATIONAL PRACTITIONER DATA BANK OR A CURRENT VALUED LOSS RUN FROM THE PRIOR CARRIER(S) COVERING AT LEAST THE LAST EIGHT YEARS. THIS IS A MANDATORY REQUIREMENT. COVERAGE WILL NOT BE BOUND WITHOUT THIS INFORMATION.

18. Are you a partner/stockholder/owner in any of the following?

a. Medical Partnership ..... ☐ Yes ☐ No

b. Professional Association ..... ☐ Yes ☐ No

c. Corporation ..... ☐ Yes ☐ No

d. Facility or Institution ..... ☐ Yes ☐ No

If "yes," please give complete name of organization and list of all members:

Name of organization: _____

Name of member doctors	Specialty	Insurer	Limits

e. Do you desire Coverage for your Partnership, Professional Association, Corporation, Facility or Institution? ..... ☐ Yes ☐ No
If yes, attach a copy of the Partnership Agreement, Articles of Association or Incorporation or Certificate of Formation for medical/dental purposes only.

f. If a single member Professional Association, do you desire a separate policy with separate limits of liability at an additional charge of 20%? ..... ☐ Yes ☐ No

19. Do you (or does your Partnership/Professional Association/Corporation, Facility or Institution) employ, contract or share space with any of the following for professional service:

a. Licensed physicians, surgeons, podiatrists, dentists, pharmacists, optometrists, chiropractors or perfusionists? ..... ☐ Yes ☐ No

If "yes," give full details below and submit evidence that each carries individual medical (professional) liability insurance with limits of at least $100,000. each occurrence, $300,000. aggregate per annum. **SELF INSURED PROGRAMS ARE NOT ACCEPTABLE. THIS IS A MANDATORY REQUIREMENT. NONCOMPLIANCE RENDERS YOU INELIGIBLE FOR COVERAGE.**

Name	Specialty	Performs IV/IM Sedation?	Performs General Anesthesia?	Performs Invasive Procedures?	Performs Shock Therapy?	Performs Minor Surgery?	Performs Major Surgery?
		☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no
		☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no
		☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no

b. Physician's or surgeon's assistants? ..... ☐ Yes ☐ No If Yes, how many? _____

c. Licensed or certified technicians?

1. Radium, diagnostic, x-ray, laboratory, pathological or other? ..... ☐ Yes ☐ No If Yes, how many? _____
2. Radiation therapy? ..... ☐ Yes ☐ No If Yes, how many? _____
3. Certified Registered Nurse Anesthetists? ..... ☐ Yes ☐ No If Yes, how many? _____
4. Certified Nurse Midwife – Births? ..... ☐ Yes ☐ No If Yes, how many? _____
5. Certified Nurse Midwife – No Births ..... ☐ Yes ☐ No If Yes, how many? _____
6. Nurse (Registered) Practitioner? ..... ☐ Yes ☐ No If Yes, how many? _____

20. Are you employed, contracted or share space with another physician, surgeon, dentist, podiatrists, pharmacists, optometrists, chiropractor or perfusionist?

If yes, please provide name: _____ ☐ Yes ☐ No

21. Record of Previous Insurance carrier for past three years:

	Name of Company	Policy No.	Period of Coverage	Premium
a.	_____	_____	_____ to _____	$_____
b.	_____	_____	_____ to _____	$_____
c.	_____	_____	_____ to _____	$_____

d. Expiration date of current coverage _____

22. **MINIMUM DEPOSIT REQUIRED:** Payment of the Minimum Deposit must be made by CASHIER'S CHECK, BANK DRAFT or POSTAL MONEY ORDER payable to the Texas Medical Liability Insurance Underwriting Association and must accompany this application. When two or more classifications apply, the deposit premium for the highest rated shall be submitted. It is agreed that the remainder of the annual premium and policyholder's stabilization reserve fund charge will be paid within (20) days after receipt of the ASSOCIATION'S billing. Failure to make this payment within such period of time will result in cancellation of any policy (or policies) bound or issued pursuant to this application. Coverage will not be bound by the ASSOCIATION prior to the receipt of the minimum deposit.
For renewal of a JUA expiring policy the full estimated renewal premium plus the Policyholders Stabilization Reserve Fund Charge quoted must be submitted with the application.

23. A POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE will be collected, when required, on all policies with an effective date on or after JANUARY 1, 1978. This charge was authorized by H.B. 1048 of the 65th legislature.

24. It is understood that the ASSOCIATION'S Manager may designate an Insurance Company to issue and service the policy on behalf of the ASSOCIATION. The undersigned agrees:
   a. To comply with all reasonable rules of the Servicing Company for the prevention of injuries
   b. To furnish the Servicing Company promptly with any Report of Injury
   c. To furnish all other forms and information required by the terms of the policy
   d. To maintain adequate records in order that an accurate audit may be made by the Servicing Company.
   e. To pay as due all monies for premium under such policy, including the policyholder's stabilization reserve fund charge, to the Servicing Company provided, however, that in the event of default on payment of any premiums or other charges due under any policy issued as a result of this application all premiums and other charges due and unpaid shall become payable at the office of the Texas Medical Liability Insurance Underwriting Association, Austin, Travis County, Texas, and the undersigned hereby promises and agrees to pay all such premiums at the office of the ASSOCIATION. I further agree that there are no unpaid premiums or other charges due this Association from prior insurance of the type applied for.
   f. That no insurance coverage will be considered bound until applicant has received a Binder duly executed by the Manager of the ASSOCIATION and such insurance shall become effective from the date and time specified by the ASSOCIATION Manager.

25. Is this policy being financed by a premium finance company? ..... ☐ Yes ☐ No

If yes, the finance agreement must be issued in the name of the insured as it appears on the policy, and we must receive a complete copy of the signed finance agreement. The use of outside financing does not change any payment requirements stated above or in any renewal notification.

IMPORTANT: THIS APPLICATION AND RELEASE MUST BE SIGNED BY THE APPLICANT

The foregoing statements are made by applicant as material representations of fact for the purpose of showing that he/she is in good faith entitled to insurance as a rejected risk and securing approval of this application, and such statements are true and correct. It is understood that the underwriting data on this application may be made available to all Member Companies of the ASSOCIATION.

I authorize and consent to investigations in respect of material information bearing upon moral character, professional reputation and fitness to engage in the activities embraced by my license or authority to practice my profession, including authorization to every person or entity, public or private, to release to the ASSOCIATION any documents, records or other information bearing upon the foregoing.

Date	# LICENSE NUMBER (Medical, Dental, Other)	Signature of Applicant
Telephone Number	Fax Number	Print Name

STATE OF TEXAS LOCAL RECORDING AGENT KNOWN AS PRODUCER OF RECORD

As Producer of Record, I certify that the information relating to rating and classifications as shown and all other answers and data given above, are true and correct to the best of my knowledge and belief and that I am a licensed Texas Local Recording Agent.

Name of Producer of Record (Type or Print)		Producer's Federal Income Tax Identification Number
Street Address	Telephone Number	Fax Number
City State Zip		Signature of Producer of Record
Email address of Customer Service Representative		Email address of Agency or Producer