TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION (JUA)
1812 Centre Creek Drive Suite 305 Austin, Texas 78754

QUESTIONAIRE FOR EXCESS LIABILITY INSURANCE

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

(File with JUA Manager together with copy of JUA application for Physicians, etc, Form JUA-1,or Hospitals, Form JUA-1H, whichever is appropriate, to be used for premium calculation)

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 Insurance Companies (1)______________________________(2)____________________________
Date of rejection:___________________(1)______________________________(2)____________________________

If a future effective date is desired, please specify the date desired________________, otherwise, the ASSOCIAITON will specify the effective date. Coverage will be written to expire concurrently with the expiration date of the primary policy listed on question 3 of this form, but not to exceed one (1) year.

2. **APPLICANT'S FULL NAME:** ___________________________________Telephone Number: _____________
Mailing Address: Street____

City________________________County__________________________State______ZipCode______________

Practice Address: Street____

City________________________County__________________________State______ZipCode______________
If partnership, professional association, corporation, facility or institution is to be insured, give complete name of such organization.____
Street address, City and State where records will be maintained for audit:____

3. Is the primary insurance written on a: ☐ Claims Made or ☐ Occurrence basis?

PLEASE ATTACH A COPY OF YOUR PRIMARY POLICY

Primary Insurance Co. Name	Policy Number(s)	Expiration Date	Named Insured Is	Primary Limits Of Liability
			( ) Individual ( ) Hospital	$ Each Occurrence or $ Each Claim $ Aggregate
			( ) P.A. ( ) P.C. ( ) Partnership	$ Each Occurrence or $ Each Claim $ Aggregate

4. Excess Limits desired:

$ Each Occurrence (Minimum available $100,000.; Maximum available $1,000,000.)

$ Aggregate (Minimum available $300,000.; Maximum available $3,000,000.)

5. MINIMUM DEPOSIT REQUIRED: payment of the Minimum Deposit as quoted must be made by **CASHIERS CHECK, BANK DRAFT or POSTAL MONEY ORDER** payable to the **TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION**, and must accompany this application. It is agreed that the remainder of the annual premium and the policy holder's stabilization reserve fund charge will be paid within twenty (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 receipt of the minimum deposit.

6. A POLICYHOLDERS STABILIZATION RESERVE FUND CHARGE may be collected 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.

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 it is in good faith entitled to insurance as a rejected risk and securing approval of this application, and such statements are true and correct.

The applicant authorizes and consents to investigations in respect of material information bearing upon reputation and fitness to engage in the activities embraced by the applicant's license, 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:_________________Applicant____

BY_____________________________________Title__________________________________

STATEMENT OF TEXAS INSURANCE 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 Insurance Agent.

____	____
Name of Producer of record (Type or Print)	Producer's Federal Income Tax Identification Number
____	____(________)________________________________
Mailing Address---Street and Number	Telephone Number
____	____
City State Zip Code	Signature of Producer of Record
____	
E-Mail Address	