

MINNESOTA JOINT UNDERWRITING ASSOCIATION  
PIONEER P.O. BOX 1760  
ST. PAUL, MN 55101  
(651) 222-0484 OR 1-800-555-0013

**CAREER FIDUCIARY LIABILITY INSURANCE APPLICATION  
FOR CLAIMS MADE COVERAGE**

1. Named and mailing address: \_\_\_\_\_  
\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Agent: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

2. The Proposed Named Insured is:  
\_\_\_\_\_ Individual \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation  
\_\_\_\_\_ Joint Venture \_\_\_\_\_ Other: \_\_\_\_\_

3. List of officers, partners or the name of individual:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

If the Proposed Named 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 career fiduciary cases in which you expect to serve as career fiduciary during the next twelve months: \_\_\_\_\_

	NO	YES
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 children 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
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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 \_\_\_\_\_

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Date of loss: \_\_\_\_\_ Type of loss: \_\_\_\_\_  
Amount paid: \_\_\_\_\_ Reserve: \_\_\_\_\_  
Description \_\_\_\_\_

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Date of loss: \_\_\_\_\_ Type of loss: \_\_\_\_\_  
Amount paid: \_\_\_\_\_ Reserve: \_\_\_\_\_  
Description \_\_\_\_\_

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Date of loss: \_\_\_\_\_ Type of loss: \_\_\_\_\_  
Amount paid: \_\_\_\_\_ Reserve: \_\_\_\_\_  
Description \_\_\_\_\_

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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.**