623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
www.kammco.com

Non-Physician Health Care Professionals Application for Claims-Made Professional Liability Insurance New Business

Effective January 1, 2022

Application Instructions & Required Information

- Answer all questions completely and accurately.
- Complete this form electronically or print your responses legibly.
- If space is insufficient to answer any question fully, use the **Comments Section** at the end of this application, or attach separate documentation.
- Sign and date the application where indicated.
- Provide claim information for the last five years, and include current company loss runs.
- All forms and applications are available online under the Insurance tab of the KAMMCO website.
- Complete the attached **Statement of Supervising / Responsible Physician Form**.
- This application is subject to review and acceptance by the company and does not bind coverage. Additional information may be requested.
- Incomplete submissions or lack of required information may delay the underwriting process.

Note for Kansas residents and Kansas licensed health care providers:

Pursuant to Kansas law, the following professional occupations are required to participate with the Kansas Health Care Stabilization Fund (HCSF): Certified Registered Nurse Anesthetist, Physician Assistant, and Certified Nurse Midwife. If this is your professional occupation, it is mandated that you:

1. Complete the attached **Health Care Stabilization Fund Notice of Basic Coverage Form**, and
2. Answer **Section D: Requested Coverage, question 1, on page 2** of this application.

Requested Effective Date (MM/DD/YYYY): _____

A. Applicant Information

Name (First, MI, Last):	**Gender:** ☐ Male ☐ Female	**SS#:**
Name of Employer:	**Date of Birth** (MM/DD/YYYY):	

Applicant's Business Information

Street:	City:	State:	Zip:
County:	Business Name:		
Phone:	Fax:	Email:	

Applicant's Home Information (P.O. Box not accepted)

Street:	City:	State:	Zip:
County:	Home Phone:	Cell Phone:	

Applicant's Billing/Mailing Information

☐ Home ☐ Business ☐ Other (specify):

Street:	City:	State:	Zip:

Business Manager / Contact Person Information

Name:	Title:

Phone:	Fax:	Email:

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other (specify):

B. Professional Coverage

Specify your professional occupation:

☐ Aesthetician
☐ Certified Registered Nurse Anesthetist*
☐ Certified Nurse Midwife*
☐ EEG / EKG / Ultrasound Technician
☐ Laboratory Director
☐ Laboratory Technician
☐ Medical Office Assistant
☐ Nurse
☐ Nurses Aid
☐ Nurse Practitioner
☐ Operating Room / Surgical Assistant
☐ Optician
☐ Optometrist
☐ Optometry Assistant
☐ Orthotist / Prosthetist
☐ Paramedic / EMT
☐ Pharmacist
☐ Pharmacy Assistant
☐ Physical Therapist
☐ Physical Therapist Assistant
☐ Physician Assistant*
☐ Psychologist
☐ Respiratory Therapist
☐ Social Worker
☐ X-Ray Technician
☐ Other (specify): _____

C. Current & Previous Coverage

Existing form of insurance: ☐ Occurrence ☐ Claims-made

Specify below your insurance coverage for the past five (5) years:

Carrier Name	Policy #	Coverage Dates	Limits	Retroactive Date

D. Requested Coverage

1. Limits of Liability (Limits are expressed as per claim and annual aggregate.)

☐ $500,000 / $1,500,000 ☐ $1,000,000 / $3,000,000

2. Health Care Stabilization Fund (HCSF) Limits (if applicable)

☐ $500,000 / $1,500,000

NOTE: HCSF participants must complete the HCSF **Notice of Basic Coverage** form.

E. Education, Training, & Work Experience

1. Specify the highest level of education you have completed related to your field of practice:

☐ None Required ☐ Bachelor's Degree ☐ Master's Degree ☐ Post-Doctorate Degree

☐ Diploma ☐ Associate's Degree ☐ Doctorate's Degree ☐ Other: _____

2. **School Information**

School of Graduation: _____

School's Location (City & State): _____

Degree: _____

Year of Graduation (YYYY): _____

3. Do you hold the certification or licensure required to practice your profession? ☐ Yes ☐ No

If yes, specify: _____

List each state where you are licensed to practice, your license number, and the percentage in each state:

State	License / Certification Number	Percentage %

4. List all places where you have practiced your profession during the past five (5) years:

Facility / Practice	City and State	Dates (MM/YYYY) to (MM/YYYY)
		to
		to
		to
		to

5. Do you prescribe drugs? ☐ Yes ☐ No

6. Do you perform surgical procedures? ☐ Yes ☐ No

7. List all medical societies or professional organizations in which you are currently a member:

_____

8. Has there been any change in your practice or specialty during the last five (5) years? ☐ Yes ☐ No

If yes, specify: _____

F. Practice Information

1. If you are an independent contractor, name each entity with which you have contracted health care services:

_____

2. How many hours per week are you working (including patient care, administrative duties, phone calls, and teaching)?

_____

3. List each professional corporation, association, partnership, or other health care related entity in which you have ownership?*

Name	Description of Interest	Percentage of Practice

*Complete one **Corporate Health Care Application** for each organization listed.

G. Underwriting Questions *(Please read carefully.)*

1. Is your employer insured with KAMMCO? ☐ Yes ☐ No

2. Is your collaborative physician insured with KAMMCO? ☐ Yes ☐ No

3. Is your supervising physician insured with KAMMCO? ☐ Yes ☐ No

4. Has your license or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked? ☐ Yes ☐ No

5. Are you aware of any complaint or investigation with respect to your license to practice, your BNDD/DEA license, your privileges or participation at or with any hospital or other medical facility? ☐ Yes ☐ No

6. Has any hospital, medical association, medical society/medical board, licensing authority, or peer review organization notified you of its intention to consider imposing a change of status, penalties, privileges, participation, certification, or membership? ☐ Yes ☐ No

7. Have you ever been treated for alcoholism, narcotics addiction, or mental illness? ☐ Yes ☐ No

   If yes, attach a letter outlining dates of treatment, results of treatment, and current status. **This letter should be from your physician or institution.**

8. Do you provide any professional services to patients in other states? ☐ Yes ☐ No

9.	Do you practice telemedicine in Kansas or in other states? If yes, please complete a **Telemedicine Supplemental Questionnaire** form.	☐ Yes	☐ No
10.	Do you moonlight (i.e., work outside of control of KAMMCO employer)? If yes, provide location, scope of practice, number of hours per month in your explanation in the **Comments Section**. If yes, will you carry malpractice insurance coverage with another carrier?	☐ Yes ☐ Yes	☐ No ☐ No
11.	Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic offense?	☐ Yes	☐ No
12.	Has any insurer canceled, declined coverage, declined to issue, refused renewal, or offered professional liability insurance only on special terms? If yes, explain why and give name of carrier(s) in the **Comments Section**.	☐ Yes	☐ No
13.	Will you be scheduled to work at a separate location from your supervising physician? If yes, please give details in the **Comments Section**.	☐ Yes	☐ No

H. Claim Information

1.	Have any claims or suits ever been made against you arising out of the performance of professional services rendered, or which should have been rendered by you? If yes, complete the **Claim Information Worksheet** for each claim or suit. The **Claim Information Worksheet** is available under the Insurance tab of the KAMMCO website. Make additional copies as needed.	☐ Yes	☐ No

Continue to Next Page

I. Comments

Section & Question Number	Explanation

Please attach additional pages, as needed.

Execution of this application by the applicant does not bind KAMMCO to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

I understand membership in good standing in the Kansas Medical Society is required for coverage with KAMMCO.

If a policy is issued, the policy will be issued on a claims-made basis and will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy.

The applicant represents the statements and answers made herein are true, and makes the same for the purpose of inducing KAMMCO to issue the policy for which application is hereby made. It is understood that this entire policy shall be void if, whether before or after a loss or claim, the applicant has intentionally concealed or misrepresented any material fact or circumstance concerning the insurance or subject thereof.

I authorize and consent to investigations of information bearing upon moral character, training, professional reputation, previous claims and suits, and fitness to engage in the activities authorized by my license to practice medicine, including authorization to every person or entity, public or private, to release to KAMMCO, any documents, records and other information bearing upon the foregoing. The undersigned further agrees that KAMMCO and all persons or organizations may rely upon a photocopy of this authorization, which shall be of equal validity with the original.

I authorize the Company to release a certificate of insurance to professional credentials verification services an/or health care facility medical or credentialing staff.

I understand and agree these investigations shall not be confined to information submitted in the application, but shall include any other sources of information deemed relevant by KAMMCO as may be authorized by law.

_____ _____

Signature of Applicant **Date**

Please return this application, along with any necessary attachments,
by email to underwriting@kammco.com or by fax to **785.232.4704**.

If you work with a KAMMCO agent, please submit this application directly to your agent.

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Claim Information Worksheet

(Make additional copies, if necessary.)

No Claims: ☐ *(A signature is required, regardless of claim history.)*

Applicant's Name (First, MI, Last): _____

Patient's Name (First, MI, Last): _____ Patient's Gender: ☐ Male ☐ Female

Allegation:

Date of Incident (MM/DD/YYYY): _____ Date Reported (MM/DD/YYYY): _____

Insurance Carrier: _____ Location of Incident: _____

Was a lawsuit filed? ☐ Yes ☐ No Are/were you the primary defendant? ☐ Yes ☐ No

If you are/were not the primary defendant, please describe your involvement in the patient care:

Additional Defendants: _____

Claim Status: ☐ Open ☐ Closed Date Closed (MM/DD/YYYY): _____

If open, indicate the reserve amount. *(Required)* _____

If closed, indicate:

a. Method of closing: ☐ Dismissed ☐ Settled ☐ Judgment

b. Amount of settlement or judgment: $ _____

I understand information submitted herein becomes part of my **Professional Liability Insurance Application** as submitted.

_____ _____

Signature **Date**

Please return this form, along with your application, or email it directly to underwriting@kammco.com.
If you work with a KAMMCO guest agent, please submit directly to your agent.

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form

(for policy periods effective on and after Jan. 1, 2022)

Kansas law requires the insurance company to forward this completed form to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the effective date of the basic policy. A copy of this completed form must also be given to the health care provider.

FOR HCSF USE ONLY

SECTION I – Health Care Provider Identification and Residency

Health Care Provider's Name:
Last name, first name, middle initial, and professional acronym, or full name of medical care facility or other type of health care provider

Health Care Provider's Legal Kansas Residence: | Kansas |
Street Address and City (For a hospital or other facility, or a business entity, this should be the legal location.) Zip Code

Daytime Phone Number:

Health Care Provider's Email Address:

Mailing Address:
(Optional, if not the same as legal residence) Street Address or P.O. Box, City, State, Zip Code

SECTION II - HCSF Coverage Limit

☐ $500,000/$1,500,000

Date Signed

Health Care Provider's Signature

Notice to Health Care Provider: *If you discontinue your professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact your licensing agency and request that your license be made inactive.*

SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information

					For Fund Classes 1 to 14	For Fund Classes 15 to 24	
HCSF Rate Classification Number	Provider's License Number	Fund Compliance Year	Basic Coverage Premium Amount	HCSF Class Group Number	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment
			$		$	%	$

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or reasons:

☐ The policy is issued for only part of a year and the surcharge was prorated based on the number of days divided by 365. The proration (rounded to the nearest whole percent) was ____ %.

☐ The policy is a unique part-time policy issued by the primary professional liability insurer (requires explanation below under "extraordinary circumstances"). The part-time factor used was ____ %.

☐ This Kansas resident health care provider has an active Missouri license. The applicable Missouri modification factor was included in the surcharge calculation and the factor used was ____ %.

Type of Primary Coverage Professional Liability Insurance Policy: ☐ Occurrence ☐ Claims Made

Insurance Company Name:

Name of Agent or Other Company Representative:

Policy Number:

Agent or Company Rep. Email Address:

Coverage Effective Date:

Agent or Company Rep. Phone Number:

Coverage Expiration Date:

For insurer explanation of extraordinary circumstances:

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Statement of Supervising/Responsible Physician

(This statement must be completed, signed, and returned with your completed application.)

Applicant's Name: _____ **License Number** (if applicable): _____

Supervising/Responsible Physician Name: _____

1. Provide a description of the physician's practice and the way in which the applicant is to be utilized—include applicant's routine duties, the type of practice, and the practice setting.

2. Identify the practice location(s) at which the applicant will routinely render professional services. Include hospitals, if applicable.

I understand the supervising/responsible physician will always be available for communication within thirty (30) minutes during the performance of patient service.

I have carefully read the above questions and have answered them completely, and my answers and all statements contained herein are true and correct.

_____ _____

Supervising/Responsible Physician's Signature **Applicant's Signature**

_____ _____

Date **Date**

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Telemedicine Supplemental Questionnaire

Name (First, MI, Last): _____ **KAMMCO Policy #** (if applicable): _____

Name of Employer (if applicable): _____

Definition of Telemedicine
The delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. Telemedicine is to be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology, to provide or support health care and delivery that facilitates the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. ***K.S.A.40-2,211**

1. Do you practice telemedicine? ☐ Yes ☐ No
   - If yes, fill out this form in its entirety.
   - If no, it is not necessary to complete this form.

2. What specialty to do you practice? _____

3. What percentage of your medical practice is—or will be—dedicated to telemedicine: _____

4. List the state and the percentage of telemedicine you practice in each state.

5. Do you hold a medical license for each state in which you practice telemedicine? ☐ Yes ☐ No
   - If no, explain why below.

6. Identify the types and scope of telemedicine services you provide.

7. Have you been named in a claim tied to the telemedicine services you provide? ☐ Yes ☐ No
   – If yes, explain why below.

8. Do you have a written agreement or contract to provide telemedicine services? ☐ Yes ☐ No

9. Do you have additional or specialized procedures for ensuring privacy and security of patient information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) with regard to telemedicine? ☐ Yes ☐ No

10. Have policies and protocols been established which provide a means of maintaining and documenting e-visit records for continuity of care? ☐ Yes ☐ No

11. Do you use an informed consent specifically for the telemedicine encounter? ☐ Yes ☐ No

12. Have policies and protocols been established to identify when face-to-face visits may be necessary? ☐ Yes ☐ No

Signature of Applicant **Date**

Return this form together with your completed application to KAMMCO.

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