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

Corporate Health Care 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 (5) years, and include current company loss runs.
- All forms and applications are available online under the Insurance tab of the KAMMCO website.
- 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.

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

A. Applicant Information

Agency Name (if applicable):

Legal Entity Name:

Tax ID Number:

Principle Business Address

Street:	City:	State:	Zip:

County:

Phone Number:	Fax Number:

Secondary Business Address

Street:	City:	State:	Zip:

County:

Phone Number:	Fax Number:

Business Manager / Contact Person Information

Name:	Title:

Phone:	Fax:	Email:

Type of Legal Entity:

☐ Solo Incorporated

☐ Multi-Shareholder Corporation, Partnership, Limited Liability Company

☐ Joint Venture (List the parties in this venture, along with their percentage ownership in the **Comments Section**.)

☐ Other (specify): _____

B. Current & Previous Coverage

1. Name of current or previous professional liability carrier: _____

2. Date the current or previous professional liability insurance policy expired, or will expire: _____

3. If coverage is claims-made, what is the retroactive date of the policy (MM/DD/YYYY): _____

C. Requested Coverage

Kansas Corporations

1. Limits of Liability (Limits are expressed as per claim and annual aggregate.)
   ☐ $500,000 / $1,500,000

2. Indicate Health Care Stabilization Fund (HCSF) Limits
   ☐ $500,000 / $1,500,000

Missouri Corporations

1. Limits of Liability (Limits are expressed as per claim and annual aggregate.)
   ☐ $1,000,000 / $3,000,000

2. Are you requesting **Prior Acts Coverage**? *(See note below.)* ☐ Yes ☐ No
   If no, skip to **Section D**.
   If yes, what is the Retroactive Date (MM/DD/YYYY): _____

3. During the period for which you are requesting **Prior Acts Coverage**, was your practice different in any way from your current practice (e.g., different states, procedures, coverages, etc.)? ☐ Yes ☐ No
   If yes, describe the changes in your practice, including all applicable dates in the space provided in the **Comments Section** at the end of this application.

NOTE: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by KAMMCO that your request for **Prior Acts Coverage** has been approved.

D. Practice Information

1. Specify description of operations. ***(Check all that apply.)***

   ☐ Physician(s) office

   ☐ Physician(s) office with diagnostic equipment

   ☐ Physician(s) office with owner-operated lab ***(Owner Use Only)***

   ☐ Physician(s) office with owner-operated lab ***(Used by Other than the Physician/Owner's Patients)***

   ☐ Medical spa

   ☐ Outpatient surgery

   ☐ Pain clinic

   ☐ Urgent care facility

   ☐ Other (describe): _____

2. Indicate how many owners there are in the corporation: _____

3. Are all the owners of the corporation insured with KAMMCO or applying to be insured by KAMMCO? ☐ Yes ☐ No

4. List the names of all the current partners, stockholders, or owners of the medical partnership, association, corporation, and/or LLC:

Name	Specialty	Insurance Carrier, if not KAMMCO

5. Is the entity/facility used by anyone other than the owner(s), member(s), or employees? ☐ Yes ☐ No

   If yes, describe in the **Comments Section**.

6. Indicate the percentage of services provided or business operations conducted outside the state in which the corporation is based.

State	Percentage (%)	State	Percentage (%)

7. Has the corporation ever been incorporated under a name other than the **Legal Entity Name** listed in **Section A** of this application? ☐ Yes ☐ No

If yes, list all previous legal entity names and the first use day of each.

Previous Legal Entity Name	First Use Date (MM/YYYY)

8. Has the corporation ever been incorporated in a state other than the state listed in the **Principle Business Address** in **Section A** of this application? ☐ Yes ☐ No

If yes, list all previous states in which the corporation was incorporated, the legal entity name, and the first use day of each.

State	Legal Entity Name	First Use Date (MM/YYYY)

9. Does the corporation practice under a DBA (Doing Business As) name? ☐ Yes ☐ No

If yes, list all the DBA names.

Doing Business As (DBA) Names
1.
2.
3.
4.

10. Are there any other separate entities for which coverage is requested that are not listed above? ☐ Yes ☐ No

If yes, list below all other entities for which coverage is requested.

1.

2.

3.

4.

11. Does the corporation or any of its owners or employed or contracted physicians supervise any health care providers other than those employed or contracted by the corporation? ☐ Yes ☐ No

If yes, list then number of supervised providers, the facility they're associated with, and the providers' specialties in the **Comments Section**.

12. Specify the total number for each of the following:

Total Number of Employees: _____

Total Number of Physician Employees: _____

Total Number of Non-Medical Employees: _____

Total Number of Non-Physician Employees: _____

13. Does the corporation employ or contract with any of the following health care providers? ☐ Yes ☐ No

If yes, specify the number of employed/contracted providers for each occupation.

Number	Provider Type	Number	Provider	Number	Provider
	Aesthetician		Chiropractor		Medical / Lab Technician
	Nurse		Nurse Practitioner		Occupational Therapist
	Optometrist		Physician/Surgeon Assistant		Physical Therapist
	Psychologist		Respiratory Therapist		Surgical Assistant

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

1. Does the corporation provide diagnostic, consulting, or other professional services to patients (including telemedicine or teleradiology in states other than Kansas and Missouri? ☐ Yes ☐ No

If yes, provide an explanation in the **Comments Section** — include the states, type of service, and the annual number of patient encounters.

2. Does the corporation own or operate a hospital, sanitarium, or clinic with regular bed and board facilities? ☐ Yes ☐ No

3. Has the corporation's license ever been suspended, restricted, revoked, or surrendered? Or has probation ever been invoked? ☐ Yes ☐ No

If yes, provide an explanation in the **Comments Section**.

4. Has an insurance company ever canceled, declined to issue, refused to renew, surcharged corporation's premium, or issued coverage with any restrictions or exclusions? ☐ Yes ☐ No

F. Claim Information

1. Have any claims or suits ever been made against the corporation or the corporation's owners, employees, or contractors that arose out of the performance of professional services rendered – or that should have been rendered – by any person for whose acts or omissions the corporation is legally responsible? ☐ Yes ☐ No

If yes, indicate the number of previous and/or pending claims or suits:

Please complete the **Claim Information Worksheet** for each claim, suit, demand, or screening panel identified above. Make additional copies as needed. The **Claim Information Worksheet** is available under the Insurance tab of the KAMMCO website.

G. Comments

Section & Question Number	Explanation

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.