

## 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.

Paguacted Effective Date (MM/DD/VVVV)

- Provide claim information for the last five (5) years, and include current company loss runs.
- All forms and applications are available online under the <u>Insurance tab of the KAMMCO website</u>.
- 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.

nequested Effective Date (MM/DD/1111).							
A. Applicant Information							
Agency Name (if applicable):	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: C		City:	<i>r</i> :		State:	Zip:	
County:							
Phone Number:			Fax Number:				
Business Manager / Contact Person Information							
Name:			Title:				
Phone:	Fax:			Email:			

	Solo Incorporated		
	Multi-Shareholder Corporation, Partnership, Limited Liability Company		
	Joint Venture (List the parties in this venture, along with their percentage ownership in the Commer	its Section	.)
	Other (specify):		
В.	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		
Ka	nsas 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		,
Mis	ssouri Corporations		
1.	Limits of Liability (Limits are expressed as per claim and annual aggregate.) \$1,000,000 / \$3,000,000		
2.	Are you requesting <b>Prior Acts Coverage</b> ? (See note below.)  If no, skip to <b>Section D</b> .	Yes	No
	If yes, what is the Retroactive Date (MM/DD/YYYY):		
3.	During the period for which you are requesting <b>Prior Acts Coverage</b> , was your practice different in any way from your current practice (e.g., different states, procedures, coverages, etc.)?  If yes, describe the changes in your practice, including all applicable dates in the space provided in the <b>Comments Section</b> at the end of this application.	Yes	No
you	<b>DTE: Prior Acts Coverage</b> is optional and subject to separate underwriting approval. For your protectur right to purchase extended reporting endorsement coverage from your current carrier unless you tified in writing by KAMMCO that your request for <b>Prior Acts Coverage</b> has been approved.		

Type of Legal Entity:

D.	Practice Information						
1.	Specify description of operations. (0	Check a	ll 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-op	perated	lab <b>(Used by Oth</b>	er than the Physician/Own	er's Patients)		
	Medical spa						
	Outpatient surgery						
	Pain clinic						
	Urgent care facility						
	Other (describe):						
2.	Indicate how many owners there ar	e in the	corporation:				
3.	Are all the owners of the corporation KAMMCO?	n insur	ed with KAMMC	O or applying to be insure	d by	Yes	No
4.	List the names of all the current par and/or LLC:	tners, s	stockholders, or c	owners of the medical part	nership, associa	ation, corpora	tion,
Na	me		Specialty		Insurance Ca	rrier, if not KAI	имсо
			<u> </u>				
5.	Is the entity/facility used by anyone If yes, describe in the <b>Comments Se</b>		than the owner(s	), member(s), or employees	5?	Yes	No
6.	Indicate the percentage of services is based.	provide	ed or business op	erations conducted outsid	e the state in w	hich the corp	oration
Sta	te	Perce	entage (%)	State		Percentage	(%)
		ĺ					
		<u> </u>					
		1		I		I	

/.		oration ever been incorporated under a name other than the <b>Legal Entity</b> in <b>Section A</b> of this application?	Yes	No
		• •		
		revious legal entity names and the first use day of each.	1	
Pre	vious Legal Entity	Name	First Use Date (MM/YYYY)	
8.		pration ever been incorporated in a state other than the state listed in the iness Address in Section A of this application?	Yes	No
		revious states in which the corporation was incorporated, the legal entity e first use day of each.		
Sta	te	Legal Entity Name	First Use Date (MM/YYYY)	
	If yes, list all t	poration practice under a DBA (Doing Business As) name? the DBA names.	Yes	No
роі	ng Business As (D	BA) Names		
1.				
2.				
2				
3.				
4.				
10	Are there and above?	y other separate entities for which coverage is requested that are not listed	Yes	No
	If yes, list bel	ow all other entities for which coverage is requested.		
1.				
<u> </u>				
2.				
3.				
4.				
<del></del> -				

11.	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?						
	If yes, list then number of supervised the providers' specialties in the <b>Con</b>	d providers, the facility they're associate ments Section.	d with, and				
12.	12. Specify the total number for each of the following:						
	Total Number	of Employees:					
	Total Number of Physici	an Employees:					
	Total Number of Non-Medi	cal Employees:					
	Total Number of Non-Physici	an Employees:					
13.	, , ,	stract with any of the following health ca red/contracted providers for each occup	•	Yes	No		
Num	nber Provider Type	Number : Provider	Number Provider				
	Aesthetician	Chiropractor	Medical	l / Lab Technicia	n		
	Nurse	Nurse Practitioner	Occupa	tional Therapist			
	Optometrist	Physician/Surgeon Assistant	Physica	l Therapist			
	Psychologist	Respiratory Therapist	Surgical	Assistant			
	·	<u>.                                      </u>	· · · · · · · · · · · · · · · · · · ·				
E.	Underwriting Questions (F	Please read carefully.)					
1.	Does the corporation provide diagn	ostic, consulting, or other professional se ogy in states other than Kansas and Mis	-	Yes	No		
	If yes, provide an explanation in the the annual number of patient encou	<b>Comments Section</b> — include the states nters.	, type of service, and				
2.	2. Does the corporation own or operate a hospital, sanitarium, or clinic with regular bed and board facilities?				No		
3.	Has the corporation's license ever b probation ever been invoked?	een suspended, restricted, revoked, or si	urrendered? Or has	Yes	No		
	If yes, provide an explanation in the	Comments Section.					
4.		celed, declined to issue, refused to renewerage with any restrictions or exclusion		Yes	No		
F. (	Claim Information						
1.	employees, or contractors that arose or that should have been rendered - is legally responsible?	nade against the corporation or the corpe out of the performance of professional by any person for whose acts or omissi	services rendered -	Yes	No		
	If yes, indicate the number of previo						
	Please complete the <b>Claim Information Worksheet</b> for each claim, suit, demand, or screening panel identified above. Make additional copies as needed. The <b>Claim Information Worksheet</b> is available under the <u>Insurance tab of the KAMMCO website</u> .						

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.

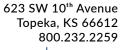
I authorize the Company to release a certificate of insurance to professional credentials verification services an/or health care facility medical or credentialing staff.

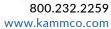
I understand and agree these investigations shall not be confined to information submitted in the application, but shall include any other sources of information deemed relevant by KAMMCO as may be authorized by law.

	_		
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.







## **Claim Information Worksheet**

(Make additional copies, if necessary.)

<b>No Claims:</b> (A s	ignature is required, regardless of claim history.)		
Applicant's Name (First, MI, Last):			
Patient's Name (First, MI, Last):		Male	Female
Allegation:			
Date of Incident (MM/DD/YYYY):			
Insurance Carrier:	Location of Incident:		
Was a lawsuit filed? Yes No	Are/were you the primary defendant?	Yes	No
Additional Defendants:			
Claim Status: Open Closed Date Close	ed (MM/DD/YYYY):		
If open, indicate the reserve amount. (Requi			
If closed, indicate:			
a. Method of closing: Dismissed	Settled Judgment		
b. Amount of settlement or judgment: \$			
I understand information submitted herein become	es part of my <b>Professional Liability Insurance Applicat</b>	<b>ion</b> as sub	mitted.
	 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.