KAMMCO

Kanas Medical Mutual Insurance Company
KAMMCO Casualty Company, Inc.

Election of Payment Form

Kansas Medical Mutual Insurance Company and KAMMCO Casualty Company, Inc. (KAMMCO) are pleased to provide our insureds with three (3) payment options.

Choose <u>one</u> payment option:

☐ **Option 1.** ***Payment-in-Full/Credit***

If I elect to purchase insurance from KAMMCO as evidenced by payment of premium, I agree to pay the total premium due to KAMMCO by no later than the date of the inception or renewal of the annual Policy. I understand a credit in the amount of one (1) % of the annual KAMMCO Primary Coverage Premium will be applied (which will reduce the amount due) if I elect **Option 1**.

☐ **Option 2.** ***Third-Party Financing***

If I elect to purchase insurance from KAMMCO as evidenced by payment of premium, I agree to pay the total premium due to KAMMCO and may use third-party financing. See the Fidelity Bank **Finance Premium Acceptance Form** for additional information. I understand a credit in the amount of one (1) % of the annual KAMMCO Primary Coverage Premium will be applied (which will reduce the amount due) if I elect **Option 2**.

☐ **Option 3.** ***Installment***

If I elect to purchase insurance from KAMMCO as evidenced by payment of premium, I agree to pay the total premium due to KAMMCO in four equal installments. Each installment will be due beginning on the date of the inception or renewal of the annual Policy, and, every consecutive quarter thereafter through the term of the Policy. KAMMCO will provide a minimum of ten (10) days written notice prior to any cancellation of the Policy due to a non-payment of any installment. **Please note, the option for installments is only available for the amount due KAMMCO for primary coverage. The premium due for Cyber Liability Coverage and the amount due to the Kansas Health Care Stabilization Fund must be paid in full by no later than the annual inception or renewal of the Policy.**

Regardless of which option is chosen, KAMMCO will send the insured an invoice itemizing the amount and date due of payment.

Please indicate the following:

Facility / Organization Name: _____

Name (First, MI, Last): _____

Title: _____

Policy Number: _____

_____ _____

Signature **Date**