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

Physician Corporate Entity Claims-Made Professional Liability Insurance

RENEWAL Application

1. Legal Name of Entity: _____

2. Entity Primary Address

Street: _____

City: _____ State: _____ Zip: _____ County: _____

3. Entity Satellite Address *(Attach additional sheet if necessary.)*

Street: _____

City: _____ State: _____ Zip: _____ County: _____

4. Primary Contact Name: _____

5. Primary Contact Phone: _____

6. Primary Contact Email: _____

7. Primary Contact Title: _____

8. Federal Tax ID #: _____

9. Confirm description of operations *(check all that apply)*:

- ☐ Physician's office
- ☐ Physician's office with diagnostic equipment
- ☐ Physician-owned and operated lab – **Owner use only**
- ☐ Physician-owned and operated lab – **Used by other than doctor/owner patients**
- ☐ Medical spa
- ☐ Outpatient surgery
- ☐ Pain clinic
- ☐ Urgent Care facility
- ☐ Other (describe): _____

10. List the names of all current partners, stockholders, or owners of the medical partnership, association, corporation, or LLC listed in Question 1 above. *(Attach separate sheet if necessary.)*

Name	Specialty	Insurance Carrier, if not KAMMCO

11. List the names of employed or contracted physicians or surgeons of the medical partnership, association, corporation, or LLC listed in Question 1 above. Exclude owners or partners. *(Attach separate sheet if necessary.)*

Name	Specialty	Insurance Carrier, if not KAMMCO

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

If yes, describe who uses the entity and facility and how they use it in the box below:

13. Are there any services or business operations conducted outside of Kansas or Missouri? ☐ Yes ☐ No

If yes, indicate the state(s) and percentage of practice in each state.

State	Percentage % of Practice

(!) Please submit a **Health Care Provider RENEWAL Liability Application** for each health care provider who has individual coverage with this Entity or Facility. The application can be found under the insurance tab on the KAMMCO website: www.kammco.com.

Authorization to Release Information

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

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

The applicant represents that the statements and answers made herein are true, and makes the same for the purpose of inducing the Company 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 the 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 or other information bearing upon the foregoing. The undersigned further agrees that the Company and all persons or organizations may rely upon a photo copy of this authorization, which shall be of equal validity with the original.

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

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

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, submit this application directly to your agent.

Name of Authorized Representative

Signature of Authorized Representative

Date