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

# Health Care Provider Claims-Made Professional Liability Insurance
## RENEWAL Application

| **Agency Name** (if applicable): | **Policy Number:** |
|---|---|
| **Applicant's Name** (First, Middle, Last): | |

**Applicant's Business Information**

| Street: | City: | State: | Zip: |
|---|---|---|---|

| Phone: | Fax: | Work Email: |
|---|---|---|

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

| Street: | City: | State: | Zip: |
|---|---|---|---|

| County: | Mobile Phone: | Home Email: |
|---|---|---|

**Practice Information**

1. Do you practice under a direct primary care model? ☐ Yes ☐ No

   **If yes, what is your panel size?** _____

**In the Last Year:**

2. Have there been any changes in your practice or specialty during the past year (i.e., change from full-time to part-time, changes in procedures offered, changes in locations where you practice, etc.)? ☐ Yes ☐ No

   **If yes, identify changes:**

3. Are you licensed to practice medicine in any states other than your primary state of residence? ☐ Yes ☐ No

   **If yes, list state(s), license number(s), and percentage of practice in each state:**

4. Do you moonlight in the emergency room outside of your primary practice? ☐ Yes ☐ No

   **If yes, indicate hospital name(s), location(s), and number of hours per month:**

5. Are you currently involved in a collaboration agreement with any non-physician providers who are **NOT EMPLOYED BY YOU OR YOUR PRACTICE**? ☐ Yes ☐ No

**If yes, provide details:**

6. Do you utilize telecommunications technology for rendering medical services or do you read, interpret, or diagnose films, slides, or specimens taken on patients who reside outside of the state of your primary residence? ☐ Yes ☐ No

**If yes, list all state(s) in which the patients being treated reside and the percentage of your overall practice for each:**

7. Do you currently, or plan to, practice in a medical spa setting? ☐ Yes ☐ No

**If yes, provide details on the services or procedures you currently, or plan, to provide:**

8. Has any revocation, suspension, limitation, or other change in license status occurred that you have not previously reported to KAMMCO underwriting? To your knowledge, have you been the subject of any investigation with respect to **1)** your license to practice; **2)** your license to prescribe or dispense controlled substances: **3)** your privileges or participation at or with any hospital, health maintenance organization, or other medical facility; or **4)** your certification by or membership in any medical society or medical specialty board? ☐ Yes ☐ No

**If yes, provide complete details on a separate page.**

9. In the last five years, have you undergone treatment for alcohol abuse, drug addiction, or mental illness? ☐ Yes ☐ No

**If yes, please provide the complete details on a separate sheet, and attach it to this application.**

10. Have you become aware of any illness, infection, contagious disease, or physical disability that you have not previously reported to KAMMCO underwriting that impairs or could tend to impair your ability to practice medicine or put your patients at risk? ☐ Yes ☐ No

**If yes, please provide the complete details on a separate sheet, and attach it to this application.**

11. List each ***new*** medical professional association, medical partnership, limited liability company, corporation, or other health care-related entity in which you have ownership. ☐ Yes ☐ No

**or**

Have you become a partner, owner, or stockholder in a professional association, medical partnership, limited liability company, or corporation?

**If yes, list the names of each entity:**

## Higher Limits for License Defense Coverage*

**Important. Please Read.**

KAMMCO embeds License Defense Coverage with limits of $2,500 for Defense Costs per Licensure Matter with an annual aggregate of $5,000. This embedded coverage is an added benefit that comes at no cost to you.

If higher limits for License Defense Coverage are desired, this may be purchased at the annual rate of $250 per provider per policy year. The coverage limits are $25,000 for Defense Costs per Licensure Matter with an annual aggregate of $25,000. An Extended Reporting Endorsement is not offered for License Defense Coverage Higher Limits.

***Your current coverage will be renewed unless you provide a signed cancellation.**

12. Do you want to purchase License Defense Coverage Higher Limits? ☐ Yes ☐ No

13. Have you ever been – or are you currently aware of – any complaint, investigation, disciplinary proceeding, or reprimand by any administrative agency, licensing agency, medical society or professional organization, hospital, or other medical facility? ☐ Yes ☐ No

    **If yes, please provide an explanation on a separate sheet, and attach it to this application.**

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

    **If yes, please provide an explanation on a separate sheet, and attach it to this application.**

**Note:** **If you are interested in applying for coverage in excess of your KAMMCO and HCSF coverage, complete the application for Claims-Made Excess Insurance located at** www.kammco.com**, and return it to** underwriting@kammco.com.

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. 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.

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 photocopy or this authorization, which shall be of equal validity with the original.

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, please submit this application directly to your agent.

**Applicant's Name**

**Applicant's Signature** **Date**