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

Non-Physician Healthcare Professionals Application for Claims-Made Professional Liability Insurance
New Business

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 years, and include current company loss runs.
- All forms and applications are available online under the Applications and Forms page of the KAMMCO website.
- Complete the attached **Collaborative Practice Agreement / Statement of Responsible Physician Form**.
- 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.

Note for *Kansas residents* and *Kansas-licensed healthcare providers*:

Pursuant to Kansas law, the following professional occupations are required to participate with the Kansas Health Care Stabilization Fund (HCSF): Certified Registered Nurse Anesthetist, Physician Assistant, and Certified Nurse Midwife. If this is your professional occupation, it is mandated that you:

1. Complete the attached **Health Care Stabilization Fund Notice of Basic Coverage Form**, and
2. Answer **Section D: Requested Coverage, question 1, on page 3** of this application.

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

A. Applicant Information

Name (First, MI, Last):	Gender: ☐ Male ☐ Female	SS#:
Name of Employer:	Date of Birth (MM/DD/YYYY):	

Applicant's Business Information

Street:	City:	State:	Zip:
County:			
Phone:	Fax:	Email:	

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

Street:	City:	State:	Zip:
County:	Home Phone:	Cell Phone:	

Applicant's Billing/Mailing Information

☐ Home ☐ Business ☐ Other (specify):

Street:	City:	State:	Zip:

Business Manager / Contact Person Information

Name:	Title:	
Phone:	Fax:	Email:

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other (specify):

B. Professional Coverage

Specify your professional occupation:

- ☐ Aesthetician
- ☐ Certified Registered Nurse Anesthetist*
- ☐ Certified Nurse Midwife*
- ☐ EEG / EKG / Ultrasound Technician
- ☐ Laboratory Director
- ☐ Laboratory Technician
- ☐ Medical Office Assistant
- ☐ Nurse
- ☐ Nurses Aid
- ☐ Nurse Practitioner
- ☐ Operating Room / Surgical Assistant
- ☐ Optician
- ☐ Optometrist
- ☐ Optometry Assistant
- ☐ Orthotist / Prosthetist
- ☐ Paramedic / EMT
- ☐ Pharmacist
- ☐ Pharmacy Assistant
- ☐ Physical Therapist
- ☐ Physical Therapist Assistant
- ☐ Physician Assistant*
- ☐ Psychologist
- ☐ Respiratory Therapist
- ☐ Social Worker
- ☐ X-Ray Technician
- ☐ Other (specify): _____

*Kansas HCSF participation required for ***Kansas residents*** and ***Kansas-licensed healthcare providers***.

C. Current & Previous Coverage

Existing form of insurance: ☐ Occurrence ☐ Claims-made

Specify below your insurance coverage for the past five (5) years:

Carrier Name	Policy #	Coverage Dates	Limits	Retroactive Date

D. Requested Coverage

1. Limits of Liability (Limits are expressed as per claim and annual aggregate.)

   ☐ $500,000 / $1,500,000

2. Health Care Stabilization Fund (HCSF) Limits (if applicable)

   ☐ $500,000 / $1,500,000

   NOTE: HCSF participants must complete the **HCSF Notice of Basic Coverage form**.

E. Education, Training, & Work Experience

1. Specify the highest level of education you have completed related to your field of practice:

☐ None Required ☐ Bachelor's Degree ☐ Master's Degree ☐ Post-Doctorate Degree

☐ Diploma ☐ Associates Degree ☐ Doctorate's Degree ☐ Other: _____

2. **School Information**

School of Graduation: _____

School's Location (City & State): _____

Degree: _____

Year of Graduation (YYYY): _____

3. Do you hold the certification or licensure required to practice your profession? ☐ Yes ☐ No

If yes, specify: _____

List each state where you are licensed to practice, your license number, and the percentage in each state:

State	License / Certification Number	Percentage %

4. List all places where you have practiced your profession during the past five (5) years:

Facility / Practice	City and State	Dates (MM/YYYY) to (MM/YYYY)
		to
		to
		to
		to

5. Do you prescribe drugs? ☐ Yes ☐ No

6. Do you perform surgical procedures? ☐ Yes ☐ No

7. List all medical societies or professional organizations in which you are currently a member:

_____

8. Has there been any change in your practice or specialty during the last five (5) years? ☐ Yes ☐ No

If yes, specify: _____

F. Practice Information

1. If you are an independent contractor, name each entity with which you have contracted healthcare services:

_____

2. How many hours per week are you working (including patient care, administrative duties, phone calls, and teaching)?

_____

3. List each professional corporation, association, partnership, or other healthcare related entity in which you have ownership?*

Name	Description of Interest	Percentage of Practice

*Complete one **Physician Corporate Entity Application** for each organization listed. It's available online under the **Applications and Forms page** of the KAMMCO website.

G. Underwriting Questions (Please read carefully.)

1. Is your employer insured with KAMMCO? ☐ Yes ☐ No

2. Is your collaborative physician insured with KAMMCO? ☐ Yes ☐ No

3. Is your supervising physician insured with KAMMCO? ☐ Yes ☐ No

4. Has your license or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked? ☐ Yes ☐ No

5. Are you aware of any complaint or investigation with respect to your license to practice, your BNDD/DEA license, your privileges or participation at or with any hospital or other medical facility? ☐ Yes ☐ No

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

7.	Have you ever been treated for alcoholism, narcotics addiction, or mental illness? If yes, attach a letter outlining dates of treatment, results of treatment, and current status. **This letter should be from your physician or institution.**	☐ Yes	☐ No
8.	Do you provide any professional services to patients in other states?	☐ Yes	☐ No
9.	Do you practice telemedicine in Kansas or in other states? If yes, please complete a Telemedicine Supplemental Questionnaire form.	☐ Yes	☐ No
10.	Do you moonlight (i.e., work outside of control of KAMMCO employer)? If yes, provide location, scope of practice, number of hours per month in your explanation in the **Comments Section**.	☐ Yes	☐ No
	If yes, will you carry malpractice insurance coverage with another carrier?	☐ Yes	☐ No
11.	Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic offense?	☐ Yes	☐ No
12.	Has any insurer canceled, declined coverage, declined to issue, refused renewal, or offered professional liability insurance only on special terms? If yes, explain why and give name of carrier(s) in the **Comments Section**.	☐ Yes	☐ No
13.	Will you be scheduled to work at a separate location from your supervising physician? If yes, please give details in the **Comments Section**.	☐ Yes	☐ No

H. Claim Information

Have any claims or suits ever been made against you arising out of the performance of professional services rendered, or which should have been rendered by you? If yes, complete the **Claim Information Worksheet** for each claim or suit. The **Claim Information Worksheet** is available under the **Applications and Forms page** of the KAMMCO website. Make additional copies as needed.	☐ Yes	☐ No

Continue to Next Page

I. Comments

Section & Question Number	Explanation

Please 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.

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

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.

Kansas Resident
Annual Health Care Stabilization Fund Application

(All requested information required. Incomplete applications will be returned.)

Section 1 - Health Care Provider Identification and Residency

Health Care Provider's Name: _____ _____ _____ _____
Last Name First Name MI Prof. Acronym

Or Business Entity/Hospital/Other Facility Name: _____

Date of Birth: _____/_____/_____ Daytime Phone Number: _____-_____-_____ HCP Email Address: _____

Legal Residence: _____ _____ _____ _____ _____
(Or facility legal address) Street address City State Zip Country if not U.S.

Mailing Address: _____ _____ _____ _____ _____
(If different from above) Street address City State Zip Country if not U.S.

Section 2 - Health Care Provider Credentials - Fund Coverage: $500,000/$1,500,000

Statutory credentials:

Kansas Licensing Agency: ☐ Board of Healing Arts ☐ Board of Nursing ☐ Business Entity/Hospital/Other Facility

Provider's Kansas License/Registration Number: _____ (include dashes/hyphens)

Section 3 – Insurance Policy and Information

Insurance Company *(The insurance carrier writing the professional liability policy.)*: _____

Insurance Policy Number: _____ Effective date: ____/____/_____ Expiration date: ____/____/_____

Type of Coverage: ☐ Claims Made ☐ Occurrence **(Occurrence Requirement: see pg. 2 instructions)**

Company Rep.: _____ Phone Number: _____-_____-_____ Email Address: _____

Section 4 – HCSF Surcharge Calculation (Rate table/MO modification factor pg.4 of instructions.)

Class Groups 1-14 (only complete applicable lines)

HCSF Classification Group Number: _____	Insurance Premium Amount **(required)**: $_____	Active MO license: ☐ No ☐ Yes	
Surcharge amount for HCSF Class Group Number above		=	$
Missouri active license modification factor, added additional 30%		=	$
Short-term policy, number of days (< 365 days) _____ ÷ 365 rounded to nearest whole percent.	_____ % x surcharge	=	$
Unique Circumstance **(part-time policy)** can be no less than 50% (see pg. 2 of instructions).	_____ % x surcharge	=	$

HCSF Premium Surcharge Paid = $_____

Class Groups 15-24 (only complete applicable lines)

(Percent based surcharges are calculated by the **individual** annual basic professional liability coverage.)

HCSF Classification Group Number: _____	Insurance Premium Amount: **(required)** below	Active MO license: ☐ No ☐ Yes	
Individual annual insurance premium paid $_____ x HCSF Class Group Number surcharge _____ % from table		=	$
Missouri active license modification factor, added additional 30%		=	$
(If short-term policy, the insurance premium paid above should be the prorated insurance premium amount.)			

HCSF Premium Surcharge Paid = $_____

NOTE: The Minimum surcharge fee is $200.00 All surcharge payments must be rounded to the nearest whole dollar amount. (*The minimum surcharge fee applies to **all** Fund compliance periods, including short-term policies and surcharge refund adjustments due to mid-term cancellation or termination of existing compliance periods.)*

For insurer explanation of (e.g. locum, part-time etc...)	**HCSF USE ONLY**

Health Care Stabilization Fund
300 SW 8th Ave, 2nd Floor Topeka, KS 66603
Phone: (785) 291-3777: Fax: (785) 291-3550: Email: hcsf@ks.gov
Revised 11/4/2024

623 SW 10th Avenue
Topeka, KS 66612
1.800.232.2259
www.kammco.com

Collaborative Practice Agreement / Statement of Responsible Physician

(This document must be completed, signed, and returned with your completed application.)

Applicant's Name: _____ **License Number** ***(if applicable)*****:** _____

Collaborative or Responsible Physician's Name: _____

1. Provide a description of the physician's practice and the way in which the applicant is to be utilized—include applicant's routine duties, the type of practice, and the practice setting.

2. Identify the practice location(s) at which the applicant will routinely render professional services—include hospitals, if applicable.

I understand the collaborative or responsible physician will always be available for communication within thirty (30) minutes during the performance of patient service.

I have carefully read the above questions and have answered them completely, and my answers and all statement contained herein are true and correct.

_____ _____

Collaborative or Responsible Physician's Signature **Applicant's Signature**

_____ _____

Date **Date**

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Telemedicine Supplemental Questionnaire

Name (First, MI, Last): _____ **KAMMCO Policy #** (if applicable): _____

Name of Employer (if applicable): _____

Definition of Telemedicine
The delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. Telemedicine is to be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology, to provide or support health care and delivery that facilitates the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. ***K.S.A.40-2,211**

1. Do you practice telemedicine? ☐ Yes ☐ No
   - If yes, fill out this form in its entirety.
   - If no, it is not necessary to complete this form.

2. What specialty to do you practice? _____

3. What percentage of your medical practice is—or will be—dedicated to telemedicine: _____

4. List the state and the percentage of telemedicine you practice in each state.

5. Do you hold a medical license for each state in which you practice telemedicine? ☐ Yes ☐ No
   - If no, explain why below.

6. Identify the types and scope of telemedicine services you provide.

7. Have you been named in a claim tied to the telemedicine services you provide? ☐ Yes ☐ No
   – If yes, explain why below.

8. Do you have a written agreement or contract to provide telemedicine services? ☐ Yes ☐ No

9. Do you have additional or specialized procedures for ensuring privacy and security of patient information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) with regard to telemedicine? ☐ Yes ☐ No

10. Have policies and protocols been established which provide a means of maintaining and documenting e-visit records for continuity of care? ☐ Yes ☐ No

11. Do you use an informed consent specifically for the telemedicine encounter? ☐ Yes ☐ No

12. Have policies and protocols been established to identify when face-to-face visits may be necessary? ☐ Yes ☐ No

Signature of Applicant **Date**

Return this form together with your completed application to KAMMCO.

If you work with a KAMMCO agent, submit this form along with your completed application to your agent.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they