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

Application for Umbrella Coverage for a Healthcare Facility

Application Instructions & Required Information

- To be eligible for umbrella coverage the Applicant must be insured with KAMMCO or be in the process of making application to KAMMCO for primary medical professional liability insurance coverage.
- Sign and date the application where indicated.
- 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.

Requested Effective Date: _____

A. Applicant Information

Facility Name: _____

Agent Name (if applicable): _____

Tax ID Number: _____

Facility Address

Street: _____

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

Administrator or CEO

Name: _____ Phone: _____ Email: _____

Risk Manager

Name: _____ Phone: _____ Email: _____

Director of Nursing

Name: _____ Phone: _____ Email: _____

1. Is the Applicant owned by or managed by another entity? ☐ Yes ☐ No

If yes, please explain:

2. Within the past 36 months or within the next 12 months, has, or does, the Applicant expect to:

a) Merge, acquire or consolidate with another entity? ☐ Yes ☐ No

b) Enter into any new business activities or services (i.e., new procedures or products offered?) ☐ Yes ☐ No

If yes to either, please explain:

B. License / Coverage Information

1. Desired effective date of coverage: _____

2. Excess limits requested:

- ☐ $1,000,000 xs $1,000,000
- ☐ $1,000,000 xs $2,000,000
- ☐ $1,000,000 xs $3,000,000
- ☐ $1,000,000 xs $4,000,000
- ☐ $1,000,000 xs $5,000,000

C. Loss History

1. Are there any known occurrences, incidents, or circumstances which might give rise to future claims or suits? If yes, describe such incidents in the **Claim Information Form.** (Make additional copies as needed.)

   Note: Any such known occurrence, incident, or circumstance should be reported to the current and prior carrier or program administrator.

2. **Loss Runs** – Attach claims history as currently evaluated for the last five (5) years. Complete details must be provided for all losses (reserved or paid).

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 certificate of insurance to professional credentials verification services and/or healthcare 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.

_____

Name of Authorized Representative

_____

Signature of Authorized Representative

_____

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, 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.