623 SW 10th Avenue
Topeka, KS 66612
1-800-232-2259
www.kammco.com

Physician Claims-Made Excess Insurance

Application Instructions & Required Information

- Answer all questions completely and accurately.
- Complete this form electronically or print your responses legibly.
- Sign and date the application where indicated.
- All forms and applications are available online under the **Insurance tab of the KAMMCO website**.
- To be eligible for excess 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.
- 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 (MM/DD/YYYY): _____

A. Applicant Information

Agency Name (if applicable): _____

Applicant's Name (First, Middle, Last): _____

Date of Birth (MM/DD/YYYY): _____ Social Security Number: _____

Designation: ☐ MD ☐ DO ☐ Other (specify): _____ Gender: ☐ Male ☐ Female

Applicant's Business Address:

Street: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

Email: _____

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

Street: _____ City: _____ State: _____ Zip: _____

County: _____ Home Phone: _____ Mobile Phone: _____

Email: _____

Applicant's Billing / Mailing Information:

☐ Home ☐ Business ☐ Other (specify): _____

Street: _____ City: _____ State: _____ Zip: _____

Business Manager / Contact Person Information:

Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

B. License / Coverage Information

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

State	License Number	Percentage (%) of Practice

Excess Limits:

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 those incidents in the **Claim Information Worksheet**.

   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).

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 **1-785-232-4704**.

If you work with a KAMMCO agent, please submit this application directly to your agent.

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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.