



**Physicians & Surgeons 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.
- If Corporate Coverage is desired, complete the **Corporate Healthcare Application**.
- 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 below) | Gender: | Male | Female |
| Specify Other: |    |    |                       |         |      |        |

**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: |
|---------|-------------|---------------|

**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):

Are you a member of the Kansas Medical Society (KMS)?      Yes      No  
If no, and you are a Kansas physician, complete the attached KMS membership application.

**NOTE:** If you are a Kansas physician, membership in good standing in KMS is required for coverage with KAMMCO.

**B. Current & Previous Coverage**

1. Name of current or previous professional liability carrier: \_\_\_\_\_

2. Date of current or previous professional liability insurance policy expired, or will expire: \_\_\_\_\_

3. Will you continue to carry insurance with another carrier?      Yes      No  
If yes, please explain: \_\_\_\_\_

4. What type of policy do/did you have?      Claims-Made      Occurrence  
Requested Retroactive Date (MM/DD/YYYY): \_\_\_\_\_  
Policy Limits: \_\_\_\_\_

5. Did you purchase/receive a reporting endorsement (tail coverage)?      Yes      No

**C. Requested Coverage**

**Kansas Providers**

1. Limits of Liability (Limits are expressed as per claim and annual aggregate.)  
\$500,000 / \$1,500,000

2. Indicate Health Care Stabilization Fund (HCSF) Limits  
\$500,000 / \$1,500,000

**C. Requested Coverage (continued)**

**Missouri Providers**

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

\$1,000,000 / \$3,000,000

2. Are you requesting **Prior Acts Coverage**? (See note below.)

Yes No

If no, skip to **Section D**.

If yes, what is the Retroactive Date (MM/DD/YYYY): \_\_\_\_\_

3. During the period for which you are requesting **Prior Acts Coverage**, was your practice different in any way from your current practice (e.g., different states, procedures, coverages, etc.)?

Yes No

If yes, describe the changes in your practice, including all applicable dates in the space provided in the **Comments Section** at the end of this application.?

**NOTE: Prior Acts Coverage** is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by KAMMCO that your request for Prior Acts Coverage has been approved.

**D. Practice Information**

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

\_\_\_\_\_

2. List each professional corporation, limited liability company, or partnership in which you have ownership and for which you are requesting coverage.

**NOTE:** You must complete one **Corporate Healthcare Application** for each organization listed.

| Name | Description of Interest | % of Practice |
|------|-------------------------|---------------|
|      |                         |               |
|      |                         |               |
|      |                         |               |

3. If you, as an individual, employ or contract physician(s) or surgeon(s), complete the following:

| Type of Medical Professional             | How Many? | Designation         | Current Insurer |
|--|-----------|---------------------|-----------------|
| Physician / Surgeon Assistants           |           | Employee Contractor |                 |
| Nurse Anesthetists                       |           | Employee Contractor |                 |
| Nurse Midwives                           |           | Employee Contractor |                 |
| Nurse Practitioners                      |           | Employee Contractor |                 |
| Technicians (laboratory, medical, x-ray) |           | Employee Contractor |                 |
| Podiatrists                              |           | Employee Contractor |                 |
| Chiropractors                            |           | Employee Contractor |                 |
| RNs / LPNs / LVNs                        |           | Employee Contractor |                 |
| Other (specify):                         |           | Employee Contractor |                 |

4. If you, as an individual, employ or contract physician(s) or surgeon(s), complete the following:

| Employee or Contractor Name | Specialty | Insurer |
|-----------------------------|-----------|---------|
|                             |           |         |
|                             |           |         |
|                             |           |         |

## E. Education, Training, & Work Experience

### 1. Medical School Information

School of Graduation: \_\_\_\_\_

School's Location (City & State): \_\_\_\_\_

Year of Graduation (YYYY): \_\_\_\_\_

If you are a foreign medical school graduate, have you obtained an ECFMG certificate? NA    Yes    No

Indicate which certification you obtained and the year certified:

ECFMG    Fifth Pathway    Year Certified (YYYY): \_\_\_\_\_

### 2. Internship Information

Facility name where your internship was served: \_\_\_\_\_

Location where your internship was served: \_\_\_\_\_

Specialty: \_\_\_\_\_ Dates (MM/YYYY–MM/YYYY): \_\_\_\_\_

### 3. Residency Information

Facility name where your residency was served: \_\_\_\_\_

Location where your residency was served: \_\_\_\_\_

Specialty: \_\_\_\_\_ Dates (MM/YYYY–MM/YYYY): \_\_\_\_\_

4. Have you undergone additional medical training? Yes    No

If yes, indicate type: \_\_\_\_\_ Dates (MM/YYYY–MM/YYYY): \_\_\_\_\_

### 5. Specialty Information

Your medical specialty: \_\_\_\_\_

Your sub-specialty: \_\_\_\_\_

6. Are you certified by an approved specialty board? Yes    No

If yes, list the certifying board name(s): \_\_\_\_\_

Date(s) of recertification (MM/YYYY): \_\_\_\_\_

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

| State | License Number | % of Practice | Insurance Carrier |
|-------|----------------|---------------|-------------------|
|       |                |               |                   |
|       |                |               |                   |
|       |                |               |                   |

8. Indicate the name and locations of all facilities, including non-hospital facilities, where you hold staff or courtesy privileges.

| Name | Location |
|------|----------|
|      |          |
|      |          |
|      |          |

9. List all the places where you have practiced your profession during the last five (5) years, including your current employer.

| Facility or Practice Name | City & State | Dates (MM/YYYY to MM/YYYY) |
|---------------------------|--------------|----------------------------|
|                           |              | to                         |

10. Has any changes occurred in your practice or specialty during the last five (5) years? Yes      No

If yes, describe the changes: \_\_\_\_\_

### F. Classification

1. Indicate each of the following that you perform. Check each box that applies.

|                        |  |
|------------------------|--|
| No Surgery             | No surgical procedures performed other than incision of boils and superficial abscesses, suturing of skin and superficial fascia or circumcision.  |
| Minor Surgery          | Includes procedures performed under local anesthesia or assisting in major surgery on your own patients. Open reduction of fractures shall be considered minor surgery.  |
| Obstetrical Procedures | Obstetrical procedures and/or prenatal care beyond first trimester. Cesarean sections shall be considered major surgery.   |
| Major Surgery          | All other types of surgery and operations performed under general or regional anesthesia. Includes — but is not limited to — removal of tumors, amputations, abortions, removal of any gland or organ, plastic surgery, or assisting in major surgery in other than your own patients. |

2. Indicate the percentage of time you devote to the following medical and/or surgical activities. (Total should = 100%)

| Non-Surgical |                               | Surgical |  |
|--------------|-------------------------------|----------|--|
| %            | Activity                      | %        | Activity                                 |
| _____        | Administrative Medicine       | _____    | Neurology                                |
| _____        | Allergy                       | _____    | Nutrition                                |
| _____        | Anesthesiology                | _____    | Occupational Medicine                    |
| _____        | Broncho-Esophagology          | _____    | Oncology                                 |
| _____        | Cardiovascular Disease        | _____    | Ophthalmology                            |
| _____        | Dermatology                   | _____    | Orthopedics                              |
| _____        | Emergency Medicine            | _____    | Otology                                  |
| _____        | Endocrinology                 | _____    | Otorhinolaryngology                      |
| _____        | Fam. Practice / Gen. Practice | _____    | Pain Management*                         |
| _____        | Fetal & Maternal Medicine     | _____    | Pathology                                |
| _____        | Forensic Medicine             | _____    | Pediatrics                               |
| _____        | Gastroenterology              | _____    | Pharmacology - Clinical                  |
| _____        | General Preventive Medicine   | _____    | Physiatry                                |
| _____        | Genetic Counseling            | _____    | Physical Med./ Rehab.                    |
| _____        | Geriatrics                    | _____    | Psychiatry                               |
| _____        | Gynecology                    | _____    | Psychoanalysis                           |
| _____        | Hematology                    | _____    | Psychosomatic Medicine                   |
| _____        | Hospitalist                   | _____    | Public Health                            |
| _____        | Infectious Disease            | _____    | Pulmonary Diseases                       |
| _____        | Intensive Care Medicine       | _____    | Radiology                                |
| _____        | Internal Medicine             | _____    | Rheumatology                             |
| _____        | Laryngology                   | _____    | Rhinology                                |
| _____        | Neuroplastic Diseases         | _____    | Sports Medicine                          |
| _____        | Nephrology                    | _____    | Other*                                   |
| _____        |                               | _____    | Abdominal                                |
| _____        |                               | _____    | Bariatric                                |
| _____        |                               | _____    | Cardiac                                  |
| _____        |                               | _____    | Cardiovascular                           |
| _____        |                               | _____    | Colon & Rectal                           |
| _____        |                               | _____    | Dermatology                              |
| _____        |                               | _____    | Endocrinology                            |
| _____        |                               | _____    | Foot & Ankle                             |
| _____        |                               | _____    | Gastroenterology                         |
| _____        |                               | _____    | General                                  |
| _____        |                               | _____    | Geriatrics                               |
| _____        |                               | _____    | Gynecology                               |
| _____        |                               | _____    | Hand                                     |
| _____        |                               | _____    | Head & Neck                              |
| _____        |                               | _____    | Laryngology                              |
| _____        |                               | _____    | Neonatal                                 |
| _____        |                               | _____    | Nephrology                               |
| _____        |                               | _____    | Neurosurgery                             |
| _____        |                               | _____    | Obstetrics                               |
| _____        |                               | _____    | Obstetrics-Gynecology                    |
| _____        |                               | _____    | Ophthalmology                            |
| _____        |                               | _____    | Orthopedic                               |
| _____        |                               | _____    | Orthopedic<br>(Excluding Spinal Surgery) |
| _____        |                               | _____    | Orthopedic<br>(Including Spinal Surgery) |
| _____        |                               | _____    | Otorhinolaryngology                      |
| _____        |                               | _____    | Plastic                                  |
| _____        |                               | _____    | Plastic-<br>Otorhinolaryngology          |
| _____        |                               | _____    | Thoracic                                 |
| _____        |                               | _____    | Traumatic                                |
| _____        |                               | _____    | Urological                               |
| _____        |                               | _____    | Vascular                                 |
| _____        |                               | _____    | Other*                                   |

**\*Describe in the Comments Section.**

3. Please check the medical procedures you perform from the list below.

|  |   |
|--|---|
| <p>Autologous Fat Injection</p> <p>Angiography</p> <p>Arteriography</p> <p>Botox Injections</p> <p>Bronchoscopy</p> <p>Catheterization - arterial, cardiac, or diagnostic other than:</p> <ul style="list-style-type: none"> <li>• Occasional emergency insertion of pulmonary wedge, pressure recording catheters, or temporary pacemakers.</li> <li>• Urethral catheterization</li> <li>• Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen</li> </ul> <p>Chelation therapy</p> <p>Closed fracture reduction of displaced fractures</p> <p>Colonoscopy</p> <p>Cryosurgery - other than use on benign or premalignant dermatological lesions.</p> <p>Discograms</p> <p>Conscious Sedation</p> <p>Discograms</p> | <p>ECT (describe):</p> <p>Epidurals</p> <p>ERCP (Endoscopic Retrograde Cholangiopancreatography)</p> <p>Lasers (describe):</p> <p>Laparoscopy</p> <p>Liposuction</p> <p>Mohs Surgery (Chemosurgery)</p> <p>Nonendoscopic Pneumatic Esophageal Balloon Dilation</p> <p>Needle Biopsy (describe):</p> <p>Percutaneous Tracheostomy</p> <p>Phlebography</p> <p>Radiation Therapy</p> <p>Radiopaque dye injections into blood vessels, lymphatics, sinus tracts, and fistulae</p> <p>PEG (Percutaneous Endoscopic Gastrostomy)</p> <p>Other procedure by which the body or body cavity is penetrated or entered by use of a tube, needle, device, or ionizing radiation (describe):</p> |
|--|---|

**NONE OF THE ABOVE**

## G. Underwriting Questions (Please read carefully.)

|  |     |    |
|--|-----|----|
| 1. Has your medical or narcotics license ever been denied, suspended, voluntarily surrendered, revoked, or been subject to investigation or probationary terms in any jurisdiction?  | Yes | No |
| 2. 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 |
| 3. Has any hospital, medical association, medical society or 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 |
| 4. Do you provide professional service for a county jail, prison, or other correctional facility?  | Yes | No |
| 5. Have you ever been denied a medical license or been denied certification by a specialty board?  | Yes | No |
| 6. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?   | Yes | No |
| 7. Has your professional liability insurance ever been declined, canceled, non-renewed, refused, or renewed or issued with special terms?<br>If yes, explain why and give name(s) of carriers(s) in Comments Section.  | Yes | No |
| 8. Has any administrative agency, licensing entity, medical society, hospital, or professional organization ever requested you to be examined or evaluated by another physician because of an alleged mental condition, alcohol abuse, or drug dependency?   | Yes | No |
| 9. Have you ever had an illness or physical disability that impairs or could tend to impair your ability to practice medicine or could put your patients at risk? (e.g., alcoholism, convulsive disorders, Hepatitis B, HIV positive, mental illness, multiple sclerosis, narcotics addiction rheumatoid arthritis, etc.)<br>If yes, a) state illness or disability in the Comments Section, b) you must provide a statement from your physician with complete details of your illness or disability and attesting to your fitness to practice medicine. | Yes | No |
| 10. Have you ever been treated for alcohol or drug impairment or mental illness?   | Yes | No |
| 11. Do you staff an emergency room for purposes other than to maintain hospital privileges?<br>If yes, in the <b>Comments Section</b> provide an explanation that includes the hospital name, location, number of hours per month, and whether coverage is provided through another insurance carrier.   | Yes | No |
| 12. Do you provide any diagnostic, consulting or other professional services to patients in other states?<br>If yes, please provide an explanation in the <b>Comments Section</b> . Include the states, type of service, and the annual number of encounters.  | Yes | No |
| 13. Are you engaged in any “moonlighting” activities?<br>If yes, please provide the following in the <b>Comments Section</b> : number of hours per month, location, and scope of practice.   | Yes | No |
| 14. Are you interested in applying for coverage in excess of your primary and Health Care Stabilization Fund coverage?<br>If yes, complete the <b>Application for Claims-Made Excess Insurance</b> , available on the <a href="#">Applications and Forms page</a> on the KAMMCO website.   | Yes | No |

|   |     |    |
|---|-----|----|
| 15. Are you employed or contracted as a medical director or similar role?<br>If yes, please provide an explanation in the <b>Comments Section</b> , including the name of the facility.   | Yes | No |
| 16. Do you supervise non-employed allied health professionals (i.e. physician's assistants, advanced registered nurse practitioners, registered nurses, aestheticians, etc.)?<br>If yes, please include the full details in the <b>Comments Section</b> .   | Yes | No |
| 17. Do you render patients unconscious for treatment in your office or other non-hospital facility?   | Yes | No |
| 18. Do you perform surgery or obstetrical procedures at a location other than a licensed hospital?<br>If "yes," please provide an explanation in the Comments Section, including the location distance (travel time) to the nearest hospital in your explanation.   | Yes | No |
| 19. Do you work part-time?<br>If yes, please provide an explanation in the <b>Comments Section</b> , including the number of hours worked per week providing patient care, hospital rounds, administrative duties, phone calls and teaching.  | Yes | No |
| 20. Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility?<br>If yes, please complete a <b>Corporate Healthcare Application</b> for each, available on the <a href="#">Applications and Forms page</a> on the KAMMCO website. | Yes | No |
| 21. Do you practice in a staff, a surgi-center, or similar minor emergency clinic?  | Yes | No |
| 22. Are you employed by the Federal Government, or are you in the military service?   | Yes | No |
| 23. Have your Medicare or Medicaid privileges ever been suspended, revoked, voluntarily surrendered, sanction, or subject to investigation?   | Yes | No |
| 24. Do you practice in a direct primary care model?<br>If yes, what is your patient panel size? _____   | Yes | No |
| 25. Do you practice telemedicine or teleradiology in Kansas or in other states?<br>If yes, complete the <b>Telemedicine Supplemental Questionnaire</b> , available on the <a href="#">Applications and Forms page</a> on the KAMMCO website.  | Yes | No |

## H. Claim Information

|   |     |    |
|---|-----|----|
| Have any claims or suits ever been made against you, your employees, or any professional corporation, association or partnership to which you belong or have belonged arising out of the performance of professional services rendered or which should have been rendered by you or by any person for whose acts or omissions you are legally responsible?* | Yes | No |
|---|-----|----|

If yes, explain in the **Comments Section**.

\*Please complete the **Claim Information Worksheet** for each claim, suit, demand or screening panel identified above. Make additional copies as needed. The **Claim Information Worksheet** is available on the [Applications and Forms page](#) on the KAMMCO website.

## I. Comments

**Section &  
Question Number**

**Explanation**

| Section &<br>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 healthcare 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.

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**Signature of Applicant**

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**Date**

Please return this application, along with any necessary attachments, by email to [underwriting@kammco.com](mailto: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.



### 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](mailto:underwriting@kammco.com).  
If you work with a KAMMCO guest agent, please submit directly to your agent.

# Request for Taxpayer Identification Number and Certification

Go to [www.irs.gov/FormW9](http://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.

|  |           |   |          |   |
|--|-----------|---|----------|---|
| <b>Print or type.<br/>See Specific Instructions on page 3.</b> | <b>1</b>  | 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.)   |          |   |
|  | <b>2</b>  | Business name/disregarded entity name, if different from above.   |          |   |
|  | <b>3a</b> | Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.<br><br><input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate<br><br><input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____<br><b>Note:</b> 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.<br><br><input type="checkbox"/> Other (see instructions) _____ |          |   |
|  | <b>3b</b> | 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 . . . . . <input type="checkbox"/>   |          |   |
|  | <b>4</b>  | Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):<br><br>Exempt payee code (if any) _____<br><br>Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____<br><br><i>(Applies to accounts maintained outside the United States.)</i>  |          |   |
|  | <b>5</b>  | Address (number, street, and apt. or suite no.). See instructions.  | <b>6</b> | Requester's name and address (optional) |
|  | <b>6</b>  | City, state, and ZIP code   |          | <b>7</b>                                |

## 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.

|                                       |  |  |  |   |  |  |  |  |  |
|---------------------------------------|--|--|--|---|--|--|--|--|--|
| <b>Social security number</b>         |  |  |  |   |  |  |  |  |  |
|                                       |  |  |  | - |  |  |  |  |  |
| <b>or</b>                             |  |  |  |   |  |  |  |  |  |
| <b>Employer identification number</b> |  |  |  |   |  |  |  |  |  |
|                                       |  |  |  |   |  |  |  |  |  |

**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.

## 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.

|                  |                          |      |
|------------------|--------------------------|------|
| <b>Sign Here</b> | 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](http://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



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?<br>- If yes, explain why below.   | Yes | No |
| 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 |

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**Signature of Applicant**

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**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.



## Physician Application

Full Name: \_\_\_\_\_

Designation:  MD  DO

Practice name: \_\_\_\_\_

Office address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip Code

Home address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip Code

Mailing Preference:  Office address  Home address

Billing Preference:  Office address  Home address

Office phone (\_\_\_\_) \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Office fax (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Kansas License: \_\_\_\_\_

Specialty: \_\_\_\_\_ Residency Date: \_\_\_\_\_

Medical School: \_\_\_\_\_ Degree Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Gender:  Male  Female  Other

Spouse's name: \_\_\_\_\_

**Contact KMS with questions about this form: (785) 235-2383.**



## What are the eligibility requirements for KMS membership?

To be eligible for membership in KMS, an individual must be:

- A graduate of an accredited medical school holding the degree of Doctor of Medicine and/or Doctor of Osteopathy and be licensed to practice medicine in the state of Kansas, or
- A full-time student attending a recognized medical school in Kansas.

## How much are KMS dues?

Please refer to the chart below for information regarding our membership categories and current dues.

## Do I have to join my county medical society to be a KMS member?

Yes. Our bylaws require physicians to belong to their county medical society in order to be a member of KMS. County medical society dues vary from county to county. Members who have questions about their county society should contact the President or Secretary of their county medical society.

### 2026 KMS Dues

|       |                       |       |                         |
|-------|-----------------------|-------|-------------------------|
| \$500 | Active                | \$250 | Out-of-State Associate  |
| \$250 | Active, first year    | \$250 | Semi-Retired            |
| \$375 | Active, second year   | \$ 0  | Student/Resident/Fellow |
| \$115 | Osteopathic Associate | \$ 0  | Emeritus/Retired        |

### County Medical Society Dues

|       |                   |      |                   |       |              |
|-------|-------------------|------|-------------------|-------|--------------|
| \$0   | Anderson          | \$0  | Flint Hills       | \$0   | Northeast    |
| \$0   | Atchison          | \$0  | Ford              | \$0   | Northwest    |
| \$0   | Barton            | \$0  | Franklin          | \$0   | Pottawatomie |
| \$0   | Bourbon           | \$0  | Geary             | \$0   | Pratt        |
| \$100 | Butler-Greenwood  | \$50 | Harvey            | \$0   | Reno         |
| \$60  | Central Kansas    | \$0  | Iroquois          | \$0   | Republic     |
| \$0   | Cimarron          | \$0  | Johnson-Wyandotte | \$0   | Rice         |
| \$0   | Clay              | \$50 | Labette           | \$150 | Riley        |
| \$0   | Cloud             | \$25 | Leavenworth       | \$0   | Saline       |
| \$0   | Cowley            | \$0  | McPherson         | \$375 | Sedgwick     |
| \$75  | Crawford-Cherokee | \$0  | Miami             | \$50  | Shawnee      |
| \$0   | Dickinson         | \$0  | Mitchell          | \$0   | Southeast    |
| \$0   | Douglas           | \$50 | Neosho            | \$0   | Southwest    |