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Corporate Healthcare Entity Application for Claims-Made Professional Liability Insurance – New Business

Application Instructions & Required Information

- Answer all questions fully and accurately.
- Complete this form electronically, or print clearly if filling out by hand.
- If you need more space for any response, use the Comments Section at the end of this application or attach additional pages.
- Be sure to sign and date the application where indicated.
- Include claim information for the past five (5) years, along with current company loss runs.
- All required forms and applications are available online on the KAMMCO website.
- This application is subject to review and acceptance by the company and does not bind coverage. Additional information may be requested.
- Incomplete applications or missing information may delay the underwriting process.

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

Section A: Applicant Information

Legal Name of Entity (as filed with the Secretary of State's Office):

Tax ID Number: _____

Entity Primary Address (Cannot be a P.O. Box):

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

County: _____ Phone: _____ Fax: _____

Entity Satellite Office Address:

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

County: _____ Phone: _____ Fax: _____

Business Manager or Contact Person Information:

Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Type of Legal Entity:

Solo Incorporated

Multi-Shareholder Corporation, Partnership, or Limited Liability Company

Joint Venture (List the parties in this venture, along with their percentage ownership in the **Comments Section**.)

Other (specify): _____

Section B: Current & Previous Coverage

- 1. Name of current or previous professional liability carrier: _____
- 2. Date the current or previous professional liability insurance policy expired, or will expire: _____

Section C: Requested Coverage

Kansas Corporations

- 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

Missouri Corporations

- 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 - Practice Information.**
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.

Section D: Practice Information

- 1. Specify description of operations. (Check all that apply.)
Physician(s) office
Physician(s) office with diagnostic equipment
Physician(s) office with owner-operated laboratory (*Owner use only.*)
Physician(s) office with owner-operated laboratory (*Used by other than the physician's or owner's patients.*)
Medical Spa
Other (describe): _____
- 2. How many owners are there in the corporation? _____
- 3. Are any of the owners non-physicians? Yes No
- 4. Are all the owners insured with KAMMCO or applying to be insured by KAMMCO? Yes No

5. List the names of all the current partners or owners of the medical partnership, association, corporation, or LLC.

Name	Specialty	Insurance Carrier, if not KAMMCO

6. Is the corporation's facility used by anyone other than the owner(s), members(s), or employees? Yes No
 If yes, describe in the **Comments Section**.

7. Does the corporation conduct any business outside of Kansas, including telehealth or teleradiology? Yes No
 If yes, provide the state and the percentage of the corporation's business conducted in that state.

State	Percentage %	State	Percentage %

8. Has the corporation ever been incorporated under a name other than the **Legal Entity Name** listed in **Section A** of this application? Yes No

If yes, list all the corporation's previous legal entity names, along with the date of the name's first use.

Previous Legal Entity Name	First Use Date (MM/YYYY)

9. Has the corporation ever been incorporated in a state other than the state listed in the **Entity Primary Address** in Section A of this application? Yes No

If yes, list all previous states in which the corporation was incorporated, the legal entity name, and the date of the name's first use.

State	Legal Entity Name	First Use Date (MM/YYYY)

10. Does the corporation practice under a DBA (Doing Business As) name? Yes No

If yes, list the DBA names below.

1. _____
2. _____
3. _____

11. Does the corporation or any of its owners or employed or contracted physicians supervise any healthcare providers other than those employed or contracted by the corporation? Yes No

If yes, list the number of supervised providers, the facility they're associated with, and the providers' specialties in the **Comments Section**.

12. Provide the **total number** of each of the following:

Employees: _____

Physician employees: _____

Non-medical employees: _____

Non-physician employees: _____

13. Does the corporation employ or contract with any of the following healthcare provider types? Yes No

If yes, specify the number of employed or contracted providers for each occupation.

Provider Type	Number	Provider Type	Number	Provider Type	Number
Aesthetician		Chiropractor		Medical/Lab Technician	
Nurse		Nurse Practitioner		Occupational Therapist	
Optometrist		Physician/Surgeon Assistant		Physical Therapist	
Psychologist		Respiratory Therapist		Surgical Assistant	

Section E: Underwriting Questions

1. Does the corporation own or operate a hospital, sanatorium, or clinic with regular bed and board facilities? Yes No

2. Has the corporation's license ever been suspended, restricted, revoked, or surrendered? Or has probation ever been invoked? Yes No

If yes, provide an explanation in the **Comments Section**.

3. Has an insurance company ever canceled, declined to issue, refused to renew, surcharged the corporation's premium, or issued coverage with any restrictions or exclusions? Yes No

Section F: Claim Information

1. Have any claims or suits ever been made against the corporation or the corporation's owners, employees, or contractors that arose out of the performance of professional services rendered—or that should have been rendered—by any person for whose acts or omissions the corporation is legally responsible? Yes No

If yes, indicated the number of previous and/or pending claims or suits: _____

Complete a **Claim Information Worksheet**, available on the KAMMCO website, for each claim, suit, demand, or screening panel identified above. Make additional copies as needed.

Section G: Comments

Section and Question Number	Explanation

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 and/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.

Signature

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.

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 <i>Specific Instructions</i> 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. <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 <input type="checkbox"/> 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. <input type="checkbox"/> Other (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) _____ <i>(Applies to accounts maintained outside the United States.)</i>	
	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 _____ <input type="checkbox"/>		
	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.

Social security number									
or									
Employer identification number									

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.

Sign Here	Signature of U.S. person	Date
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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