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

Healthcare Professional Claims-Made Professional Liability Insurance
Renewal Application

Applicant Name (First, MI, Last): _____ **Policy Number:** _____

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

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

Phone: _____ Mobile: _____ Email: _____

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

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

County: _____ Phone: _____ Email: _____

Practice Information

1. Do you practice under a direct primary care model, where patients pay a flat monthly or annual membership fee instead of billing insurance for primary care services? ○ Yes ○ No

   If yes, what is your panel size? _____

In the last year:

2. Have there been any changes in your practice or specialty during the past year (i.e., change from full-time to part-time, changes in procedures offered, changes in locations where you practice, etc.)? ○ Yes ○ No

   If yes, describe those changes:

3. Are you licensed to practice medicine in any states other than your primary state of residence? ○ Yes ○ No

   If yes, list state(s), license numbers(s), and the percentage of practice in each state:

4. Do you moonlight in an emergency room outside of your primary practice? ○ Yes ○ No

   If yes, indicate hospital name(s), location(s), and number of hours worked per month:

5. Are you currently involved in a collaboration agreement with any non-physician providers who are **NOT EMPLOYED BY YOU OR YOUR PRACTICE?** ○ Yes ○ No

   If yes, provide details:

6. Do you use telecommunications technology (e.g., telemedicine) to provide medical services, or do you read, interpret, or diagnose films, slides, or specimens from patients who reside outside of your primary residence? ○ Yes ○ No

   If yes, list each state in which your patients reside and the approximate percentage of your practice attributable to patients in each state:

7. Do you currently practice, or do you plan to practice, in a medical spa setting? ○ Yes ○ No

   If yes, describe the service and procedures you currently provide or plan to provide:

8. Has any revocation, suspension, limitation, or other change in your license status occurred that you have not previously reported to KAMMCO Underwriting? This includes being the subject of an investigation into any of the following: ○ Yes ○ No
   - Your license to practice;
   - Your license to prescribe or dispense controlled substances;
   - Your privileges or participation at any hospital, health maintenance organization, or other medical facility
   - Your certification by, or membership in, any medical society or medical specialty board.

   If yes, provide complete details on a separate page and attach it to this application.

9. In the last five (5) years, have you undergone treatement for alcohol abuse, drug addition, or mental illness? ○ Yes ○ No

   If yes, provide complete details on a separate page and attach it to this application.

10. Have you become aware of any health condition, including an illness, infection, contagious disease, or physical disability, that you have not previously reported to KAMMCO Underwriting and that affects, or may affect, your ability to safely practice medicine or provide patient care? ○ Yes ○ No

    If yes, provide complete details on a separate page and attach it to this application.

11. Have you become a partner, owner, or stockholder in a professional association, medical partnership, limited liability company, or corporation? ○ Yes ○ No

    If yes, list each new medical professional association, medical partnership, limited liability company, corporation, or other healthcare-related entity in which you have ownership:

Advance Practice Providers - Scope of Practice

Fill out this section only if you're an Advanced Practice Provider.

1. Do you assist in surgeries ? ○ Yes ○ No

   If yes, on average, how many hours do you assist per week? _____

2. Do you work at a surgery center? ○ Yes ○ No

   If yes, on average, how many hours do you work per week? _____

3. Do you practice in an emergency department? ○ Yes ○ No

   If yes, on average, how many hours do you work per week? _____

4. List your specialty and sub-specialty below:

   Specialty: _____ **Sub-Specialty:** _____

Higher Limits for License Defense Coverage

License Defense coverage is included in individual KAMMCO policies. However, for only $250 per healthcare professional, an endorsement that covers defense costs up to five times higher than the embedded license defense coverage can be purchased.

To select this coverage, complete the **License Defense Coverage Higher Limits application** available at **https://www.kammco.com/apps-and-forms/higher-limits/** and submit it to **underwriting@kammco.com**.

Excess Coverage

If you're a physician or surgeon, and you're interested in applying for excess coverage above your KAMMCO and Health Care Stabilization Fund coverage, complete the **Claims-Made Excess Insurance application** available at **https://www.kammco.com/apps-and-forms/higher-limits/** and submit it to **underwriting@kammco.com**.

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 that membership in good standing in the Kansas Medical Society is required for physicians to get coverage with KAMMCO.

I authorize KAMMCO to release a renewal certificate of insurance to professional credentials verification services and/or healthcare facility medical or credentialling staff.

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 or other information bearing upon the foregoing. The undersigned further agrees that the Company and all persons or organizations may rely upon a photocopy or this authorization, which shall be of equal validity with the original.

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.

_____

Applicant's Name

_____ _____

Applicant's 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.