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

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

**Application Instructions & Required Information**

- Answer all questions fully and accurately.
- 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.
- All required forms and applications are available online on the KAMMCO website.
- Incomplete applications or missing information may delay the underwriting process.

**Requested Effective Date:** _____

## 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, if applicable:**

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?:** _____

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.** ○ Yes ○ No

**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 (describe): _____

   ☐ 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.**

a. _____

b. _____

c. _____

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: _____ Non-medical employees: _____

Physician 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. Has the entity, or any of its employees ever had hospital privileges, DEA license, medical license, or Medicaid/Medicare privileges revoked, suspended, restricted, or surrendered? ○ Yes ○ No
**If yes, provide an explanation in the Comments Section.**

2. 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

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 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.

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

**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.

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# Claim Information Worksheet

*Make additional copies, if necessary.*

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**No Claims:** ☐ *(A signature is required, regardless of claim history)*

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

Patient's Name (First, MI, Last): _____

Allegation:

| |
|---|
| |

Date of Incident (MM/DD/YYYY): _____ Date Reported (MM/DD/YYYY): _____

Insurance Carrier: _____ Location of Incident: _____

Was a Lawsuit Filed? ○ Yes ○ No Are or were you the primary defendant? ○ Yes ○ No

Additional Defendants: _____

Please describe your involvement in the patient's care:

| |
|---|
| |

**Claim Status:**

○ Open ○ Closed: _____
Date Closed (MM/DD/YYYY)

If **OPEN**, indicate the reserve amount. *(Required):* _____

If **CLOSED**, indicate the following:

a. Method of closing: ○ Dismissed ○ Settled ○ Judgment

b. Amount of settlement or judgement paid on your behalf: _____

I understand the information submittedherein becomes part of my Professional Liability Insurance Application as submitted.

_____ _____
Signature Date

Please email this form, along with your application, to **underwriting@kammco.com**.
If you work with a KAMMCO agent, please submit this document directly to your agent.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

# 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 ***Specific Instructions*** 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.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ 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.

☐ Other (see instructions)

**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 . . . . . ☐

**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)

*(Applies to accounts maintained outside the United States.)*

**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.

**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.

**Social security number**

| | | | – | | – | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

**or**

**Employer identification number**

| | | – | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

## 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** |
|---|---|---|

# 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