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

Healthcare Facility Application for Claims-Made Professional Liability and General Liability Insurance – New Business

Application Instructions and Information:

- Answer all questions fully and accurately.
- Be sure to sign and date the application where indicated.
- Incomplete applications or missing information may delay the underwriting process.
- Include financial information for one year prior, including the **most recent annual report** and **audited income statements** and **balance sheets**.

Section A: *Applicant Information*

Facility Name: _____ Tax ID #: _____

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

Administrator/CEO Information:

Name: _____ Phone: _____

Email: _____

Risk Manager:

Name: _____ Phone: _____

Email: _____

Director of Nursing:

Name: _____ Phone: _____

Email: _____

Section B: *Requested Coverage*

1. Requested effective date of coverage: _____

2. Requested retroactive date: _____ **(Date first insured under a claims-made policy.)**
   Please attach verification of prior retroactive coverage (i.e., current declarations page).

3. Indicate your desired **Limits of Liability:**

☐ Healthcare Facility Professional Liability: $ _____ Per Claim / $ _____ Annual Aggregate

☐ General Liability: $ 1,000,000 Per Claim / $ 3,000,000 Annual Aggregate

☐ Umbrella Liability (*Requests for umbrella liability coverage must include completed loss run information.):

- ○ $1,000,000
- ○ $2,000,000
- ○ $3,000,000
- ○ $4,000,000
- ○ $5,000,000

☐ Employee Benefit Liability: $ 250,000 Per Claim / $ 250,000 Annual Aggregate

Section C: *General Information*

1. Type of Facility: ○ For Profit ○ Not-for-profit
   - ☐ General Hospital
   - ☐ Pediatric Hospital
   - ☐ Specialized Hospital:
     - ☐ Psychiatric
     - ☐ Rehabilitation
     - ☐ Teaching and/or Research
     - ☐ Other (specify): _____

2. Options and Ownership: ○ Corporate-owned ○ Governmental ○ Other (specify): _____

3. Is this facility managed by another company or facility? ○ Yes ○ No

   If yes, provide the name and address of the management company:

4. Is this facility accredited by The Joint Commission (TJC) or another accrediting organization? ○ Yes ○ No

   If yes, provide the date of the most recent TJC (or other) accreditation: _____

5. Is this facility Medicare-approved? ○ Yes ○ No

   If yes, provide the date of the most recent Medicare inspection: _____

Section D: *Census Information*

1. This section assumes a 12-month period ending on: _____

2. Provide the licensed number of beds and the average number of occupied beds, which is defined as the total annual inpatient days divided by 365 days per year.

	Licensed Number of Beds	Average Number of Occupied Beds
a. Acute Care / Surgical Beds	_____	_____
b. Convalescent / Nursing Beds	_____	_____
c. Psychiatric Beds	_____	_____
d. Bassinets / Cribs	_____	_____
e. Extended Care Beds	_____	_____
f. Swing Beds	_____	_____
g. Other, specify: _____	_____	_____

3. Within the facility, provide the total number for the following over the last 12 months:

Emergency Visits: _____ Home Health Visits: _____

Psychiatric Visits: _____ Outpatient Surgeries: _____

All Other Outpatient Visits: _____

- *(Including, but not limited to, visits for lab, x-ray, or other services)*

Section E: *Services and Facilities Provided*

1. Indicate if the following are present within the facility, and provide the number of requested rooms, beds, bassinets, or surgeries for each.

a. Operating Rooms	○ Yes ○ No	Number of Rooms:	_____
b. Intensive Care Unit	○ Yes ○ No	Number of Beds:	_____
c. Psychiatric Unit	○ Yes ○ No	Number of Beds:	_____
d. Labor and Delivery Unit	○ Yes ○ No	Number of Beds:	_____
e. Nursery	○ Yes ○ No	Number of Bassinets:	_____
f. Neonatal Intensive Care Unit	○ Yes ○ No	Number of Bassinets:	_____
g. Open Heart Surgery	○ Yes ○ No	Number of Surgeries:	_____

2. Does the hospital own, operate,or anticipate opening any of the following?

a.	Outpatient Surgical Center	○ Yes ○ No
b.	Freestanding Emergency Center or Walk-in Clinic	○ Yes ○ No
c.	Physical Fitness Unit	○ Yes ○ No
d.	Wellness Center	○ Yes ○ No
e.	Home Healthcare Services	○ Yes ○ No
f.	Daycare Center	○ Yes ○ No
g.	Collection Agency	○ Yes ○ No
h.	Nursing Home	○ Yes ○ No
i.	Freestanding Psychiatric or Substance Abuse Center	○ Yes ○ No
j.	Other, specify below: (i.e., durable medical equipment sales or service, etc.) (Specify below)	○ Yes ○ No

Section F: *Physicians and Other Professional Employees*

1. Provide the number of physicians, by specialty, that are employed and contracted by the facility. If a specialty isn't listed, use the blanks provided.

Specialty	Number (FTEs)	Employed?	Contract?
Obstetricians	_____	○ Yes ○ No	○ Yes ○ No
Anesthesiologists	_____	○ Yes ○ No	○ Yes ○ No
Emergency Medicine	_____	○ Yes ○ No	○ Yes ○ No
Radiologists	_____	○ Yes ○ No	○ Yes ○ No
_____	_____	○ Yes ○ No	○ Yes ○ No
_____	_____	○ Yes ○ No	○ Yes ○ No
_____	_____	○ Yes ○ No	○ Yes ○ No
_____	_____	○ Yes ○ No	○ Yes ○ No

2. Provide the number of Advanced Practice Professionals that are employed and contracted by the facility.

APPs	Number (FTEs)	Employed?	Contract?
a. CRNAs	_____	○ Yes ○ No	○ Yes ○ No
b. Nurse Midwives	_____	○ Yes ○ No	○ Yes ○ No
c. Physician Assistants	_____	○ Yes ○ No	○ Yes ○ No
d. Surgical Assistants	_____	○ Yes ○ No	○ Yes ○ No
e. All Other APPs	_____	○ Yes ○ No	○ Yes ○ No

3. If your facility is a teaching facility, provide answers to the following:

   a. Number of Interns: _____

   b. Number of Residents (PGY-1): _____

   c. Number of Residents (PGY-2+): _____

   d. Number of Fellows: _____

   e. What specialties are represented?

   f. Who supervises the participants?

   g. Are all foreign medical graduate students required to be certified by the Educational Council on Foreign Medical School Graduates? ○ Yes ○ No

Section G: *Medical Staff Information*

1. How many active members does your facility have? _____

2. Are credentials of new staff physicians reviewed and approved prior to privileges being granted? ○ Yes ○ No

   If yes, by whom: _____

3. Are privileges granted based on verified, objective data (i.e., current state licensure, DEA licensure, claims information, etc.)? ○ Yes ○ No

   If yes, by whom: _____

4. Are privileges provisional for the first six to twelve months? ○ Yes ○ No

5. Is an ongoing Quality Assurance review maintained on all staff members' clinical work? ○ Yes ○ No

6. How often is clinical staff reappointed? _____

7. Are privileges and reappointment based on physician profiles which include objective clinical data? ○ Yes ○ No

8. Are there currently any staff members who are not licensed, or who have restricted licenses or privileges? ○ Yes ○ No

   If yes, explain below:

9. Are the criteria or parameters by which medical staff are evaluated written? ○ Yes ○ No

   If yes, provide a copy of the criteria or parameters used.

Section H: *Emergency Department*

1. Is the Emergency Department run by the facility? ○ Yes ○ No

2. Is the Emergency Department run by a contract group? ○ Yes ○ No

   If yes:

   a. What is the name of the contract group: _____

   b. Insured by: _____

   c. Limits of Liability: _____

   d. Does the contract group furnish the facility with a hold harmless indemnification agreement? ○ Yes ○ No

   e. Does the contract group furnish the facility with a certificate of insurance? ○ Yes ○ No

3. If your facility does not operate an Emergency Department, how does the facility arrange for treatment of trauma patients? ○ Yes ○ No

   a. Name of the closest referral center? _____

   b. Distance in miles: _____

4. Does the emergency department have a trauma center designation? ○ Yes ○ No

   If yes, what is it? _____

5. Does the emergency department have a formal triage procedure? ○ Yes ○ No

   If yes, who is it performed by? ☐ **RN** ☐ **Aide** ☐ **Other (specify):** _____

6. Are all emergency department patients assessed by a physician? ○ Yes ○ No

Section I: *Anesthesia Services*

1. Are anesthesia services run by the facility? ○ Yes ○ No
2. Are anesthesia services run by a contract group? ○ Yes ○ No

   If yes:

   a. What is the name of the contract group: _____
   b. Insured by: _____
   c. Limits of Liability: _____
   d. Does the contract group furnish the facility with a hold harmless indemnification agreement? ○ Yes ○ No
   e. Does the contract group furnish the facility with a certificate of insurance? ○ Yes ○ No
3. If CRNAs are on staff, does an anesthesiologist supervise? ○ Yes ○ No
4. Is CRNA supervision managed by a physician other than an anesthesiologist? ○ Yes ○ No

   If yes, what is the supervising physician's specialty? _____
5. What is your facility's ratio of anesthesiologists to CRNAs? _____ to _____

Section J: *Obstetrics Department*

1. Is this facility a regional referral center for newborns? ○ Yes ○ No
2. Does the facility have a neonatal ICU? ○ Yes ○ No
3. Is a physician or surgeon available in-house, 24 hours/day, for emergency C-sections? ○ Yes ○ No

   If yes:

   a. Is the available physician an OB? ○ Yes ○ No
   b. Is the available physician a surgeon? ○ Yes ○ No

   If no:

   a. Is there 24-hour, on-call OB physician coverage? ○ Yes ○ No
   b. Is the physician available within 30 minutes? ○ Yes ○ No

   If no, explain in the box below.

4. How many labor beds does the facility have? _____
5. How many fetal monitors does the facility have? _____

6. Who provides anesthesia services during labor and delivery? _____

7. What percentage of deliveries are C-Sections? _____

8. What percentage of deliveries are high-risk? _____

9. Does the facility have a separate birthing center? ○ Yes ○ No

If yes:

a. Where is the birthing center located? _____

b. If the birthing center is not in the facility, how far away from the facility is it located? _____

10. Does a board-certified obstetrician head the OB Department? ○ Yes ○ No

11. What is the total number of OBs on staff? _____

12. Do family practice or general practice physicians have OB privileges? ○ Yes ○ No

If yes:

a. How many family practice physicians have privileges? _____

b. Are these privileges specifically delineated? ○ Yes ○ No

c. Do these physicians perform C-Sections? ○ Yes ○ No

13. Do nurse midwives practice in labor and delivery? ○ Yes ○ No

If yes:

a. Are there written protocols for nurse midwife privileges or supervision? ○ Yes ○ No

b. Are these nurse midwives employees of the facility? ○ Yes ○ No

If yes:

- How many nurse midwives does the facility employ? _____

If no:

- Do these nurse midwives have their own medical liability insurance? ○ Yes ○ No

If yes:

- Does each nurse midwife furnish the facility with hold harmless indemnification agreement? ○ Yes ○ No
- Does each nurse midwife furnish the facility with a certificate of insurance? ○ Yes ○ No

Section K: *Radiology Services*

1. Are radiology services run by the facility? ○ Yes ○ No

2. Are radiology services run by a contract group? ○ Yes ○ No

If yes:

a. What is the name of the contract group: _____

b. Insured by: _____

c. Limits of Liability: _____

d. Does the contract group furnish the facility with a hold harmless indemnification agreement? ○ Yes ○ No

e. Does the contract group furnish the facility with a certificate of insurance? ○ Yes ○ No

3. Does the facility have magnetic resonance imaging (MRI) equipment? ○ Yes ○ No

If yes:

a. Is the MRI equipment: ○ Owned ○ Provided by an outside contractor

b. If separately insured, by whom is the MRI equipment insured: _____

c. What are the limits of liability? _____

d. Who maintains the equipment? _____

- Is this maintenance agreement specified in the contractual agreement? ○ Yes ○ No

4. Does the facility provide therapeutic x-rays? ○ Yes ○ No

5. Does the facility provide nuclear medicine, including cobalt, radium, etc.? ○ Yes ○ No

Section L: *Real Property Owned, Leased, or Occupied by Applicant*

1. Detail the buildings owned, leased, or occupied by the applicant that are used for **patient care only**. (Use additional sheets if necessary.)

Building or Addition	Location Address (if different from hospital address)	Occupancy	Age	Number of Stories	Total Sq. Feet

2. Detail the buildings owned, leased, or occupied by the applicant that are used for purposes **other than patient care**. (Use additional sheets if necessary.)

Building or Addition	Location Address (if different from hospital address)	Occupancy	Age	Number of Stories	Total Sq. Feet

3. For each parking lot or parking garage, identify the location, area in square feet, and if parking there is free or paid.

Parking Lot or Garage Location	Area (sq ft)	Paid or Free?
		○ Paid ○ Free
		○ Paid ○ Free
		○ Paid ○ Free
		○ Paid ○ Free

4. For vacant land, identify the location and the frontage in linear feet.

Vacant Land Location	Frontage (linear ft)

5. Does the hospital own and operate a heliport or helipad? ○ Yes ○ No

If yes:

a. Is the heliport licensed by the State Department of Aviation, Department of Transportation? ○ Yes ○ No

If yes, what is the date the license was issued? _____

b. What is the distance between the heliport or helipad and the nearest building? _____

c. How many landings are there annually? _____

d. The helipad is used by:

☐ State Police ☐ Life Flight ☐ Other, specify: _____ ☐ NA

e. Do all users of the heliport or helipad provide certificates of insurance? ○ Yes ○ No

6. Are any fundraising events sponsored by the hospital, its foundation, or its auxiliary? ○ Yes ○ No

If yes, describe the types of sponsored events (i.e., carnivals, tournaments, etc.) and **the number of events that typically take place every year?**

7. Does the hospital rent or lease any equipment from others (i.e., computers, medical equipment, etc.)? ○ Yes ○ No

If yes:

a. Describe the kinds of equipment and provide an estimated value:

b. Who maintains the equipment:

8. Is any new construction, or renovation to existing structures, planned within the next 12 months? ○ Yes ○ No

If yes:

a. What is the estimated cost of the planned construction or renovation? _____

b. Briefly describe the nature of the planned construction or renovation:

Section M: *Risk Management*

1. Does the hospital have a designated risk manager on staff? ○ Yes ○ No

   If yes:

   a. Are they: ○ Full-time ○ Part-time

   b. To whom does the risk manager report? _____

2. Is there a quality assurance coordinator on staff? ○ Yes ○ No

   If yes, to whom do they report? _____

3. Is there a written quality assurance plan for the facility? ○ Yes ○ No

4. Is there a written incident reporting procedure for the facility? ○ Yes ○ No

5. Are there formal quality assurance and risk management committees? ○ Yes ○ No

   If yes:

   a. How often are quality assurance and risk management indicators reviewed by the committee(s): _____

   b. Is there a safety committee? ○ Yes ○ No

Section N: *Prior Coverage and Loss History*

1. What is the expiration date of your expiring insurance coverage? _____

2. Is your expiring coverage: ○ Occurrence ○ Claims-made

   If Claims-made, what is your retroactive date: _____

3. Has an extended reporting endorsement (i.e., tail coverage) been purchased? ○ Yes ○ No

   If yes, provide the name of the insurance carrier(s) and the date purchased:

4. Are there any known occurrences, incidents, or circumstances which might give rise to future claims or lawsuits? ○ Yes ○ No

   If yes, describe any such incidents on the *Claim Information Worksheet*, attached to this application.

   Note: *Any such known occurrences, incidents, or circumstances should be reported to the current and prior carrier or program administrator.*

5. Most insurance companies provide **loss runs** listing claims with the amounts paid and reserved. Please attach a 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.

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 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 authorize KAMMCO 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.

Name of CEO or Authorized Representative

Title

Signature

Date Signed

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.

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

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): _____

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