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

Healthcare Facility Application for Umbrella Coverage

To be eligible for umbrella coverage the applicant must be insured with KAMMCO or be in the process of making application to KAMMCO for primary medical professional liability insurance coverage.

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.

Requested Effective Date: _____

Section A: *Applicant Information*

Facility Name: _____ Tax ID Number: _____

Facility Address

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

Administrator or CEO

Name: _____ Phone: _____ Email: _____

Risk Manager

Name: _____ Phone: _____ Email: _____

Director of Nursing

Name: _____ Phone: _____ Email: _____

1. Is the applicant facility owned by or managed by another entity? ○ Yes ○ No

   If yes, please explain:

2. Within the past 36 months, or within the next 12 months, has—or does—the applicant expect to:
   a. Merge, acquire, or consolidate with another entity? ○ Yes ○ No
   b. Enter into any new business activities or services (i.e., new procedures or products offered?) ○ Yes ○ No

   If yes to either, explain below:

Section B: *License and Coverage Information*

1. Select your desired excess limit of liability, below (limits expressed as per claim / annual aggregate):

   ○ $1,000,000 / $1,000,000*
   ○ $1,000,000 / $2,000,000*
   ○ $1,000,000 / $3,000,000
   ○ $1,000,000 / $4,000,000
   ○ $1,000,000 / $5,000,000

   **Long-Term Care Facilities are only eligible for the starred coverage.*

Section C: *Loss History*

1. Are there any known occurrences, incidents, or circumstances which might give rise to future claims or suits? Or do you have any current open claims or suits? ○ Yes ○ No

   If yes, describe those incidents in the *Claim Information Worksheet*, attached to this application.

   NOTE: **Any such known occurrence, incident, or circumstance should be reported to the current and prior carrier or program administrator.**

2. **Loss Runs** – Attach 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, and other information bearing upon the foregoing. The undersigned further agrees that KAMMCO and all persons or organizations may reply 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 KAMMCO to release a certificate of insurance to professional credentials verification services and/or healthcare facility, medical, or credentialing staff.

Name of Authorized Representative

Signature of Authorized Representative **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.

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.