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

Advanced Practice Professionals Application for Claims-Made Professional Liability Insurance – New Business

Application Instructions and 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.
- 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*

Applicant Name (First, MI, Last): _____

Date of Birth (MM/DD/YYYY): _____ **Social Security Number:** _____

Name of Employer: _____ **Sex:** ○ Male ○ Female

Type of Practice: ○ Individual ○ Employee ○ Owner/Partner ○ Other (specify): _____

Applicant's Residential/Home Information:

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

Phone: _____ Mobile: _____ Email: _____

Applicant's Business Information (P.O. Box Not Accepted):

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

County: _____ Phone: _____ Email: _____

Business Manager or Contact Person Information:

Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Billing Information: Send billing information to: ○ Home ○ Business ○ Other (specify): _____

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

Section B: *Professional Coverage*

Specify your professional occupation:

- ☐ Certified Registered Nurse Anesthetist*
- ☐ Certified Nurse Midwife*
- ☐ Medical Office Assistant
- ☐ Nurse
- ☐ Nurses Aide
- ☐ Nurse Practitioner
- ☐ Operating Room/Surgical Assistant
- ☐ Optometrist
- ☐ Pharmacist
- ☐ Physician Assistant*
- ☐ Other (specify): _____

** Participation in the Kansas Health Care Stabilization Fund is required for these Kansas-licensed healthcare providers.*

Section C: *Coverage History*

1. Select your existing form of insurance: ○ Occurrence ○ Claims-made
2. Specify below your insurance coverage for the past five (5) years.

Carrier Name	**Policy Number**	**Coverage Dates**	**Limits of Liability**	**Retroactive Date** *(if Claims-made)*
		to		
		to		
		to		
		to		

Section D: *Requested Coverage*

1. Limits of Liability (Limits are expressed as per claim/annual aggregate)
   ○ $500,000 / $1,500,000 ○ $1,000,000 / $3,000,000
2. Health Care Stabilization Fund Limits of Liability *(if applicable to your occupation)*
   ○ $500,000 / $1,500,000

Section E: *Education, Training, and Work Experience*

1. Specify the highest level of education you have completed related to your field of practice.
   ○ None Required ○ Bachelor's Degree ○ Master's Degree ○ Post-Doctorate Degree
   ○ High School Diploma ○ Associate's Degree ○ Doctoral Degree ○ Other: _____
2. Provide the following information about your highest level of education:

School: _____ **School's Location (City & State):** _____

Degree: _____ **Graduation Year:** _____

3. Do you hold the certification or licensure required to practice your profession? ○ Yes ○ No

If yes, please specify: _____

4. List each state in which you are licensed to practice, your license number, and the percentage of your practice done in each state, both in-person practice and telemedicine practice.

State	License or Certification #	In-Person %	Telemed %	State	License or Certification #	In-Person %	Telemed %

5. List all the places where you have practiced your profession in the last five (5) years.

Facility or Practice Name	City and State	Dates MM/YYYY to MM/YYYY
		to
		to
		to
		to
		to

6. Have there been any changes in your practice or specialty during the past five (5) years (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:

7. If you are an independent contractor, name each entity with which you have contracted services.

Name of Entity	Description of Interest	Percentage of Practice

8. Do you prescribe controlled substances? ○ Yes ○ No

If yes, what is your DEA registration number: _____

Section F: *Practice Information*

1. What is your employment status? ☐ Employed ☐ Independent Contractor ☐ Self-Employed Practice Owner

2. What is your practice setting? (Check all that apply):

☐ Behavioral Health or Psych Facility	☐ Long-term Care	☐ Surgery Center
☐ Clinic	☐ Med Spa	☐ Telehealth
☐ Direct Primary Care	☐ Private Practice	☐ Urgent Care
☐ Home Health or Hospice	☐ School, University, or Teaching Facility	☐ Other (specify below):
☐ Hospital	☐ State or County Health Department	_____

3. What is the average number of hours you work per week? _____

4. Do you work in an emergency or operating department as part of your primary employment? ○ Yes ○ No

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

5. Do you work in an emergency or operating department outside your primary employment? ○ Yes ○ No

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

6. Do you work in a surgery center? ○ Yes ○ No

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

Section G: *Scope of Practice*

1. Below is a list of procedures you may perform or assist with. Carefully read each description, and check each box that applies to you.

Category	Description
☐ **No Surgical Procedures**	No surgical performed or assisted with other than incision of boils and superficial abscesses, suturing of skin, and superficial fascia or circumcision.
☐ **Minor Surgical Procedures**	Minor surgical procedures include procedures performed under local anesthesia or assisting in major surgery on your own patients.
☐ **Obstetrical Procedures**	Obstetrical procedures performed or assisted with and prenatal care beyond the first trimester. Cesarean sections shall be considered *major* surgery.
☐ **Major Surgical Procedures**	All other types of surgery and procedures performed, or assisted with, under general or regional anesthesia. This includes, but isn't limited to, removal of tumors; amputations; abortions; removal of any gland or organ; plastic surgery; or assisting in major surgery in other than your own patients.

2. List your medical specialty(ies) in the box below and provide the estimated percentage of your total practice for each.

Section H: *Underwriting Questions*

1. Is your employer insured with KAMMCO? ○ Yes ○ No

2. Is your collaborative or supervising physician insured with KAMMCO? ○ Yes ○ No

   If yes, what is their name: _____

3. Has your license, DEA registration, or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked? ○ Yes ○ No

4. Are you aware of any complaint or investigation with respect to your license to practice, your BNDD/ DEA license, your privileges, or participation at or with any hospital or other medical facility? ○ Yes ○ No

5. Has any hospital, medical association, medical society/medical board, licensing authority, or peer review organization notified you of its intention to consider imposing a change of status, penalties, privileges, participation, certification, or membership? ○ Yes ○ No

6. Have you ever been treated for alcoholism, narcotics addition, or mental illness within the last 10 years? ○ Yes ○ No

   If yes, attach a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your physician or institution.

7. Do you provide any professional services to patients in other states? ○ Yes ○ No

8. Do you practice telemedicine in Kansas or in other states? ○ Yes ○ No

   If yes, do you have specific procedures for telemedicine, including informed consent? ○ Yes ○ No

9. Do you moonlight (i.e., work outside of control of a KAMMCO-insured employer?) ○ Yes ○ No

   If yes, provide location, scope of practice, number of hours per month in your explanation in the *Comments Section* at the end of this form.

   If yes, will you carry malpractice insurance coverage with another carrier? ○ Yes ○ No

10. Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ○ Yes ○ No

11. Has any insurer canceled, declined coverage, declined to issue, refused renewal, or offered professional liability insurance only on special terms? ○ Yes ○ No

    If yes, explain why and give the name of carrier(s) in the *Comments Section* at the end of this form.

12. Will you be scheduled to work at a separate location from your supervising physician? ○ Yes ○ No

    If yes, please provide details in the *Comments Section* at the end of this form.

13. Have you ever practiced without professional liability insurance or had a lapse in coverage? ○ Yes ○ No

    If yes, please provide an explanation in the *Comments Section* at the end of this form.

Section I: *Claim Information*

1. Have any claims or lawsuits ever been made against you arising out of the performance of professional services rendered, or which should have been rendered by you? ○ Yes ○ No

   If yes, complete the Claim Information Worksheet (attached to this application) for each claim or suit. Make additional copies, as needed.

Section J: *Comments*

Use this section to provide any additional information that may help us evaluate your application. You may elaborate on responses provided elsewhere in the application, explain any unique circumstances, or include details that were not captured in the previous questions. Attach additional pages, if necessary.

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.

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.

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.

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