Kansas Medical Mutual Insurance Company

623 S.W. 10th Avenue
Topeka, Kansas 66612
800-232-2259 | 785-232-2224
www.KaMMCO.com

Corporate Health Care Application for Claims-Made Professional Liability Insurance
New Business

Requested Effective Date: ____________

APPLICATION INSTRUCTIONS AND REQUIRED INFORMATION

- Please answer all questions completely and accurately.
- Please complete this form electronically or print your responses legibly.
- If space is insufficient to answer any question fully, please use the Comments Section at the bottom of the application form, or attach separate documentation.
- Please sign and date the application where indicated.
- Please provide claim information for the last five years and include current company loss runs.

A. Applicant Information

Agency Name
(if applicable)

Legal Entity Name	Tax ID Number

Principle Business Address (Street, City, State, Zip Code)	County

Business Phone	Fax	E-Mail

Office Location #2 (Street, City, State, Zip Code) Use Comments section for additional locations.	County

Business Manager/Contact Person	Telephone	Fax	E-Mail

Mailing/Billing Address (If different from principle business address listed above) (Street, City, State, Zip Code)	County

Type of Legal Entity:
☐ Solo Incorporated
☐ Multi-shareholder Corporation, Partnership, Limited Liability Company
☐ Joint Venture (indicate parties in venture and percentage ownership in Comments section)
☐ Other (specify):

B. Current Coverage

Name of current or previous professional liability carrier:
____

Date current or previous professional liability insurance policy expired, or will expire: ____________________

If coverage is claims-made, what is retroactive date of policy: ____________________

C. Requested Coverage

1. Limits of Liability (Limits are expressed as per claim and annual aggregate)
   - ☐ $200,000/$600,000 (KS Corporations Only)
   - ☐ $1,000,000/$3,000,000 (MO Corporations Only)

For KS or MO corporations indicate HCSF limits: ☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

2. Requested Retroactive Date:
   If current coverage is claims-made and Applicant is not requesting prior acts coverage from KaMMCO, was reporting endorsement purchased from the current carrier? ☐ Yes ☐ No

   If “yes”, attach a copy of the reporting endorsement. If no, explain: ____________________

D. Practice Information

Explain any “yes” answers to the following questions in the Comments section.

1. Specify description of operations (check all that apply):
   - ☐ Physician(s) Office
   - ☐ Physician(s) office with diagnostic equipment
   - ☐ Physician(s) office with owner/operated lab – owner use only
   - ☐ Physician(s) office with owner/operated lab – used by other than doctor/owner patients
   - ☐ Medical spa
   - ☐ Outpatient surgery
   - ☐ Pain clinic
   - ☐ Urgent care facility
   - ☐ Other – Describe: ____________________

2. Specify the number of owners of Applicant: ____________________
3. Are all owners insured with KaMMCO or applying for coverage (if new business applicant)? ☐ Yes ☐ No
4. List name of all current partners, stockholders, or owners of the medical partnership, association, corporation or LLC:

Name	Specialty	Carrier if not KaMMCO

5. Is the entity/facility used by anyone other than the owner(s), member(s), or employee(s)? ☐ Yes ☐ No
   If “yes”, describe: ____________________

6. Are there any services or business operations conducted outside of Kansas or Missouri? ☐ Yes ☐ No
   If “yes”, describe:

State(s)	% of Practice

7. Does the Applicant or any of its owners or employed or contracted physicians supervise any health care providers other than those employed or contracted at the Applicant's practice? ☐ Yes ☐ No

If "yes", specify facility, specialty and number supervised.

8. Specify total number of employees for each of the following:

Total number of employees:	______	Total number of non-medical employees:	______
Total number of physician employees:	______	Total number of non-physician medical professional employees:	______

9. Does Applicant employ or contract with any of the following health care providers? ☐ Yes ☐ No

If "yes", indicate the number of employed/contracted providers for each occupation:

___ Chiropractor	___ Nurse Practitioner	___ Optometrist	___ Psychologist
___ Medical/Lab Technician	___ Nurse	___ Physician/Surgeon Assistant	___ Respiratory Therapist
___ Surgical Assistant	___ Occupational Therapist	___ Physical Therapist	___ Aestheticians

E. Underwriting Questions

Explain any "yes" answers to the following questions in the Comments section.

1. Does the Applicant provide diagnostic, consulting or other professional services to patients (including telemedicine or teleradiology) in states other than Kansas or Missouri? ☐ Yes ☐ No

   If "yes", include states, type of service and annual number of encounters in your explanation.
2. Does the Applicant own or operate a hospital, sanitarium or clinic with regular bed and board facilities? ☐ Yes ☐ No
3. Has the Applicant's license ever been suspended, restricted, revoked or surrendered or has probation ever been invoked? ☐ Yes ☐ No

F. Claim Information

Explain any "yes" answers to the following questions in the Comments section.

1. Have any claims or suits ever been made against the Applicant, the Applicant's owners, employees or contractors arising out of the performance of professional services rendered or which should have been rendered by any person for whose acts or omissions the Applicant is legally responsible for? ☐ Yes ☐ No

   If "yes", indicate the number of previous and/or pending claims or suits:

Please complete the Claim Information Worksheet for each claim, suit, demand, or screening panel. Make additional copies as needed.

G. Comments

Section & Question	Explanation

Section & Question	Explanation

Execution of this application by the applicant does not bind Kansas Medical Mutual Insurance Company (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 photo static copy 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 this application, but shall include any other sources of information deemed relevant by KaMMCO as may be authorized by law.

______________________________ Signature of Applicant

______________________________ Date

______________________________ Title

KaMMCO

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Claim Information Worksheet (Please make additional copies if necessary)

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

Patient's Name: ______________________________
(Last, First, Middle)

Gender: ☐ Male ☐ Female

Allegation: ______________________________

____

____

Date of Incident: ______________________ **Date reported:** ______________________

Insurance Carrier: ______________________________

Was a lawsuit filed? ☐ Yes ☐ No Are/were you the primary defendant? ☐ Yes ☐ No

If "No", please describe your involvement in patient care: ______________________________

____

____

____

____

Additional defendants: ______________________________

Location of occurrence: ______________________________

Claim Status:

☐ Open ☐ Closed Date Closed: ______________________

If open, indicate reserve amount: $ ______________________

If closed, indicate:

a. Method of closing: ☐ Dismissed ☐ Settled ☐ Judgment
b. Amount of settlement or judgment: $ ______________________

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

______________________________ ______________

Signature Date

(Signature Required)