KaMMCO

Kansas Medical Mutual Insurance Company

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

Non-Physician Health Care Professionals 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.
- Physician Assistants must complete the attached "Statement of Supervising/Responsible Physician."

Note: *Pursuant to Kansas law, the following professional occupations are required to participate with the Kansas Health Care Stabilization Fund: Certified Registered Nurse Anesthetist, Physician Assistant, and Certified Nurse Midwife. If this is your professional occupation, it is mandated that you complete the attached Health Care Stabilization Fund Notice of Basic Coverage Form and answer Section D-Requested Coverage, question 1, on page 2 of this application.*

A. Applicant Information

Agency Name (if applicable)

Name of Applicant (First, Middle, Last)	Gender ☐ Male ☐ Female
Applicant's Employer	
Applicant's Business Address (Street, City, State, Zip Code)	County

Business Phone:	Fax:	E-mail:

Date of Birth:	Social Security Number:

Applicant's Home Address (P.O. Box not accepted) (Street, City, State, Zip Code)

Home Phone:	Cell Phone:	Personal E-mail:
Mailing/Billing Address: ☐ Home ☐ Business ☐ Other (specify) Other:		Business Manager/Contact Person:
Telephone:	Fax:	Business E-mail:

Type of Practice: ☐ Individual ☐ Employee ☐ Independent Contractor ☐ Owner ☐ Partner ☐ Other *(specify)*:_____________

B. Professional Occupation

Specify your professional occupation:

☐ Aesthetician	☐ Nurse Practitioner	☐ Physical Therapist
☐ Certified Registered Nurse Anesthetist*	☐ Operating Room/Surgical Assistant	☐ Physical Therapist Assistant
☐ Certified Nurse Midwife*	☐ Optician	☐ Physician Assistant*
☐ EEG/EKG/Ultrasound Technician	☐ Optometrist	☐ Psychologist
☐ Laboratory Director	☐ Optometry Assistant	☐ Respiratory Therapist
☐ Laboratory Technician	☐ Orthotist/Prosthetist	☐ Social Worker
☐ Medical Office Assistant	☐ Paramedic/EMT	☐ X-Ray Technician
☐ Nurse	☐ Pharmacist	☐ Other: ________________________
☐ Nurses Aid	☐ Pharmacy Assistant	

**Kansas Health Care Stabilization Fund participation required.*

C. Current Coverage

Existing Form of Insurance: ☐ Occurrence ☐ Claims-made

Specify below insurance coverage for the past 5 years:

Carrier Name	Policy #	Coverage Dates	Limits	Retroactive Date

D. Requested Coverage

1. Limits of Liability (Limits are expressed as per claim and annual aggregate)

☐ $200,000/$600,000*

☐ $1,000,000/$3,000,000

Requested Retroactive Date: ___________________

**Basic Limits required by Kansas HCSF*

For Kansas HCSF participants please indicate HCSF limits: ☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

Note: HCSF participants must complete attached HCSF Notice of Basic Coverage Form

E. Education/Training/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

☐ Diploma ☐ Associate's Degree ☐ Doctorate's Degree ☐ Other (specify): ______________

2. School of Graduation:	City & State:	Degree:	Year of Graduation:

3. Do you hold the certification or licensure required to practice your profession? ☐ Yes ☐ No ☐ N/A

If "yes", please specify: ____

List each state where you are licensed to practice, license number, and percentage in each state:

State	License/Certification Number	Percentage

4. Do you prescribe drugs? ☐ Yes ☐ No

5. Do you perform surgical procedures? ☐ Yes ☐ No

6. List all medical societies or professional organizations in which you are currently a member:

7. List all places where you have practiced your profession during the past 5 years:

Facility/Practice/City/State	Dates (month/year to month/year)

8. Has there been any change in your practice or specialty during the last five years? ☐ Yes ☐ No

If "yes", please describe:

F. Practice Information

1. If you are employed, indicate the name of your employer:

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

3. How many hours per week are you working (include patient care, administrative duties, phone calls and teaching): ____________

4. List each professional corporation, association, partnership or other healthcare related entity in which you have an ownership:

Name	Description of Interest	% of Practice

Complete one Healthcare Corporate Application for each organization listed in question 4 above, if coverage is desired.

G. Underwriting Questions

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

1. Is your employer insured with KaMMCO? ☐ Yes ☐ No

2. Has your license or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked? ☐ Yes ☐ No

3. 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

4. Has any hospital, medical association, medical society or 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

5. Have you ever been treated for alcoholism, narcotics addiction or mental illness? ☐ Yes ☐ No

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

6. Do you provide any professional services to patients (including telemedicine) in other states? ☐ Yes ☐ No

7. Do you moonlight (work outside of control of KaMMCO employer)? ☐ Yes ☐ No

   If "yes", provide location, scope of practice, number of hours per month in your explanation.

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

9. 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 name of carrier(s).

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

    If "yes", please give details.

H. Claim Information

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

1. Have any claims or suits 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", please complete attached "Claim Information" worksheet. Make additional copies as needed.

I. Comments

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.

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 authorize the Company to release a certificate of insurance to professional credentials verification services and/or health care facility medical or credentialing staff.

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

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Statement of Supervising/Responsible Physician

(This statement must be completed, signed and returned with completed application)

Applicant's Name: ______________________________

License Number (if applicable): ______________________________

Supervising/Responsible Physician: ______________________________

1. Description of the physician's practice and way in which the applicant is to be utilized (please include applicant's routine duties, the type of practice, and the practice setting):

____
____
____
____

2. Practice location(s) (including hospitals if applicable) at which applicant will routinely render professional services:

____
____
____
____

3. I understand the supervising/responsible physician will always be available for communication within thirty (30) minutes during the performance of patient service.

I have carefully read the above questions and have answered them completely, and my answers and all statements contained herein are true and correct.

______________________________	______________________________
Supervising/Responsible Physician	Applicant
______________________________	______________________________
Date	Date

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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: $ ______________________ *(Reserve Amount Required)*

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)

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form (July 2014)

Kansas law requires the insurance company to forward this completed form to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the effective date of the basic policy. A copy of this completed form must also be given to the health care provider.

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SECTION I – Health Care Provider Identification and Residency

Health Care Provider's Name:

Last name, first name, middle initial, and professional acronym, or full name of medical care facility or other type of health care provider

Health Care Provider's Legal Residence:

Street Address, City, State, Zip Code (For a hospital or other facility, or a business entity, this should be the legal location.)

Daytime Phone Number:

Health Care Provider's Email Address:

Business Address (optional):

Street Address, City, State, Zip Code (if not the same as legal residence)

SECTION II - Coverage Limit Selection (Health care provider's signature is required if this is the first NBC. HCSF coverage limits cannot be increased using this form. A request for HCSF coverage limits increase may be submitted to the Board of Governors for consideration.)

☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

Date Signed

Health Care Provider's Signature

Notice to Health Care Provider: If you discontinue your professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact your licensing agency and request that your license be made inactive.

SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information

					For Fund Classes 1 to 14	For Fund Classes 15 to 24	
HCSF Rate Classification Number	Provider's License Number	Basic Coverage Premium Amount	Fund Compliance Year	HCSF Class Group Number	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment
		$			$	%	$

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reasons:

☐ The policy is issued for only part of a year and the surcharge was prorated based on the number of days divided by 365. The proration percent was ____ %.

☐ The policy is a part-time policy approved for use by the primary professional liability insurer. The part-time factor used was ____ %.

☐ This Kansas resident health care provider has an active Missouri license. The applicable Missouri modification factor was included in the surcharge calculation and the factor used was ____ %.

Type of Primary Coverage Professional Liability Insurance Policy: ☐ Occurrence ☐ Claims Made

Insurance Company Name:

Name of Agent or Other Company Representative:	Policy Number:
Agent or Company Rep. Email Address:	Coverage Effective Date:
Agent or Company Rep. Phone Number:	Coverage Expiration Date:

For insurer explanation of extraordinary circumstances:

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