KaMMCO
Kansas Medical Mutual Insurance Company

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

Health Care Facility Professional Liability and General Liability Application
New Business

APPLICATION INSTRUCTIONS AND REQUIRED INFORMATION

- Please type or print clearly all responses and answer all questions as instructed.
- If any questions do not apply, print N/A in the space.
- If more space is needed, please use the Supplemental Information form or attach separate documentation.
- Long-term Care Facilities must complete the Long-term Care Supplemental Application.

1. Applicant Information

Facility Name

Address
(Street, City, State, Zip Code)

Tax ID Number

Administrator/CEO	Telephone	Fax	E-Mail
Risk Manager	Telephone	Fax	E-Mail
Director of Nursing	Telephone	Fax	E-Mail

2. Requested Coverage

A. Desired effective date of coverage: _____

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

C. Limits of Liability (Indicate Limit Desired)

Health Care Facility Professional Liability:	$ _____	Each Claim	$ _____	Aggregate
General Liability:	$ _____	Each Claim	$ _____	Aggregate
Excess Liability:	$ _____	Each Claim	$ _____	Aggregate
Umbrella Liability:	$ _____	Each Claim	$ _____	Aggregate
Employee Benefit Liability	$ _____	Each Claim	$ _____	Aggregate

3. General Information

A. Type of Facility ☐ For Profit ☐ Not for Profit

- ☐ General Hospital
- ☐ Pediatric Hospital
- ☐ Specialized:
  - ☐ Long-term Care Facility
  - ☐ Psychiatric
  - ☐ Rehabilitation
  - ☐ Teaching (and/or Research)
  - ☐ Other – Specify: _____

B. Operations and Ownership

- ☐ Corporate Owned
- ☐ Governmental
- ☐ Other – Specify: _____

C. Management

Is this hospital managed by another company or facility? ☐ Yes ☐ No

If "yes", provide name and address of management company: _____

_____

Does this hospital contract to provide management services to other facilities? ☐ Yes ☐ No

D. Affiliations/Accreditations

Accredited by TJC or other accrediting organization? ☐ Yes ☐ No

Date of most recent TJC (or other) accreditation: _____

Medicare approved? ☐ Yes ☐ No

Date of most recent Medicare Inspection: _____

Member of American Hospital Association? ☐ Yes ☐ No

Date of last KDHE review: _____ (Attach copy of report.)

4. Census Information

Twelve Month Period Ending: _____ Licensed Beds: _____ Staffed Beds: _____

A. Facility Beds	Registered Beds	Patient Days
Acute Care/Surgical		
Convalescent/Nursing		
Psychiatric Beds		
Bassinets/Cribs		
Extended Care		
Swing Beds		
Other (Specify) _____		

B. Admissions — Indicate Total Number

Admissions during the last 12 months:	
Patient Days:	
a) Live Births / b) Stillbirths	a) _____ b) _____
Emergency Visits:	
Psychiatric Visits:	
Home Health Visits:	
Outpatient Surgeries:	
All other outpatient visits (including but not limited to visits for laboratory, x-ray, or other services):	

5. Services and Facilities Provided

A. Within the facility

			Number of:	
Operating Rooms	☐ Yes	☐ No	Rooms:	
Intensive Care Unit	☐ Yes	☐ No	Beds:	
Psychiatric Unit	☐ Yes	☐ No	Beds:	
Labor and Delivery Unit	☐ Yes	☐ No	Beds:	
Nursery	☐ Yes	☐ No	Bassinets:	
Neonatal Intensive Care Unit	☐ Yes	☐ No	Bassinets:	
Open Heart Surgery	☐ Yes	☐ No	Surgeries:	
Blood Bank	☐ Yes	☐ No	Units:	

B. Ancillary Activities: Does the hospital own, operate, or anticipate opening any of the following?

1. Outpatient Surgical Center	☐ Yes	☐ No
2. Freestanding Emergency Center or Walk-in Clinic	☐ Yes	☐ No
3. Physical Fitness Center	☐ Yes	☐ No
4. Wellness Center	☐ Yes	☐ No
5. Home Health Care Services	☐ Yes	☐ No
6. Day Care Center	☐ Yes	☐ No
7. Collection Agency	☐ Yes	☐ No
8. Nursing Home	☐ Yes	☐ No
9. Freestanding Psychiatric or Substance Abuse Center	☐ Yes	☐ No
10. Other (i.e., Durable Medical Equipment Sales or Service, etc.) Specify: _____		

6. Physicians and Other Professional Employees

A. Physicians Specialty	Number (FTE's)	Employed		Contract*	
Obstetricians		☐ Yes	☐ No	☐ Yes	☐ No
Anesthesiologists		☐ Yes	☐ No	☐ Yes	☐ No
Emergency Medicine		☐ Yes	☐ No	☐ Yes	☐ No
Radiologists		☐ Yes	☐ No	☐ Yes	☐ No
All Other Physicians Surgeons (List Specialties that apply)					
		☐ Yes	☐ No	☐ Yes	☐ No
		☐ Yes	☐ No	☐ Yes	☐ No
		☐ Yes	☐ No	☐ Yes	☐ No

B. Other Professional Employees					
CRNAs		☐ Yes	☐ No	☐ Yes	☐ No
Nurse Midwives		☐ Yes	☐ No	☐ Yes	☐ No
Physician Assistants		☐ Yes	☐ No	☐ Yes	☐ No
Surgical Assistants		☐ Yes	☐ No	☐ Yes	☐ No
All Other Professional Employees		☐ Yes	☐ No	☐ Yes	☐ No

* Provide copy of sample contract.

C. If this is a teaching hospital:

1. Number of interns
   Residents (PGY-1): _____
   Residents (PGY-2 and above) _____
   Fellows: _____
2. What specialties are involved? _____
3. Who supervises participants? _____
4. Are all foreign medical graduates required to be certified by the Educational Council on Foreign Medical School Graduates? _____

7. Medical Staff

Number of active members? _____

Are credentials of new staff physicians reviewed and approved prior to privileges being granted? If "yes", by whom? _____ ☐ Yes ☐ No

Are privileges granted based on verified, objective data (i.e., current state licensure, D.E.A. licensure, claims information, etc.)? If "yes", by whom? _____ ☐ Yes ☐ No

Are privileges provisional for the first six to twelve months? ☐ Yes ☐ No

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

How often is clinical staff reappointed? _____

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

Are there currently any staff members who are not licensed or who have restricted licenses or privileges? ☐ Yes ☐ No

Are the criteria or parameters by which medical staff are evaluated written? If "yes", please provide a copy. ☐ Yes ☐ No

8. Emergency Department

A. Is the Emergency Department run by the Hospital? ☐ Yes ☐ No

Contract Group? ☐ Yes ☐ No

If contract group, name of group: _____

Insured by: _____

Limits of Liability: _____

Does Contract Group furnish hospital with:

1) Hold harmless indemnification agreement? ☐ Yes ☐ No
2) Certificate of Insurance? ☐ Yes ☐ No

B. If your hospital does <u>not</u> operate an Emergency department, how does the hospital arrange for treatment of trauma patients? _____

Name of closest referral center: _____

Distance (in miles): _____

C. TJC Level? _____

Does the department have trauma center designation (if so, indicate level)? _____

Is there a formal triage procedure? ☐ Yes ☐ No

If yes, is it performed by: ☐ RN ☐ Aide ☐ Other-Specify: _____

Are all Emergency Department patients assessed by a physician? ☐ Yes ☐ No

9. Anesthesia Services

A. Are the Anesthesia services run by the hospital? ☐ Yes ☐ No

Contract Group? ☐ Yes ☐ No

If contract group, name of group: _____

Insured by: _____

Limits of Liability: _____

Does Contract Group furnish hospital with:

1) Hold harmless indemnification agreement? ☐ Yes ☐ No
2) Certificate of Insurance? ☐ Yes ☐ No

B. If CRNA's are on staff, does anesthesiologist supervise? ☐ Yes ☐ No

C. 1. Is supervision managed by another physician? ☐ Yes ☐ No

2. If so, what specialty ? _____

3. Ratio of Anesthesiologists: _____ to CRNA's _____

10. Obstetrics Department

A. Is this facility a regional referral center for newborns? ☐ Yes ☐ No

Do you have a neonatal ICU? ☐ Yes ☐ No

Is a physician/surgeon available in-house 24 hours for emergency C-Sections? ☐ Yes ☐ No

If yes, is the available physician an: OB? ☐ Yes ☐ No Surgeon ☐ Yes ☐ No

If not, is there 24-hour on-call OB Physician coverage? ☐ Yes ☐ No

Is the physician available within 30 minutes? ☐ Yes ☐ No

If not, please explain: _____

_____

_____

B. Number of: Labor Beds: _____ Fetal Monitors: _____

Who provides anesthesia services during labor and delivery? _____

What percent of deliveries are: C-Sections? _____

High-Risk? _____

Is there a separate birthing center? ☐ Yes ☐ No

If so, where is the birthing center located? _____

Distance from the hospital, if not hospital-based? _____

C. Does a Board Certified Obstetrician head the OB Department? ☐ Yes ☐ No

D. Total number of OB's on staff: _____

Do Family Practice or General Practice physicians have OB privileges? ☐ Yes ☐ No

If yes, how many Family Practice M.D.'s have privileges? _____

Are these privileges specifically delineated? ☐ Yes ☐ No

Do these physicians perform C-Sections? ☐ Yes ☐ No

E. Do nurse midwives practice in labor and delivery? ☐ Yes ☐ No

If yes, are there written protocols for privileges/supervision? ☐ Yes ☐ No

Are these nurse midwives hospital employees? ☐ Yes ☐ No

If so, how many? _____

If not, do they have their own malpractice insurance? ☐ Yes ☐ No

What limits of liability are they required to carry? _____

Do the nurse midwives furnish hospital with:

1) Hold harmless indemnification agreement? ☐ Yes ☐ No

2) Certificate of Insurance? ☐ Yes ☐ No

11. Radiology Services

A. Are the radiology services run by the hospital? ☐ Yes ☐ No

Contract Group? ☐ Yes ☐ No

If contract group, name of group: _____

Insured by: _____

Limits of Liability: _____

Does Radiology Group furnish hospital with:

1) Hold harmless indemnification agreement? ☐ Yes ☐ No

2) Certificate of Insurance? ☐ Yes ☐ No

B. Does the hospital have Magnetic Resonance Imaging equipment? ☐ Yes ☐ No

1) Owned, or provided by outside contractor? _____

2) If separately insured, insured by: _____

3) Limits of Liability: _____

4) Who maintains the equipment? _____

Is this specified in the contractual arrangement? ☐ Yes ☐ No

Does the hospital provide: Therapeutic x-rays? ☐ Yes ☐ No

Nuclear medicine (including cobalt, radium, etc.)? ☐ Yes ☐ No

12. Real Property Owned, Leased, or Occupied by Applicant

A. Buildings:

Patient care only:

Building (or addition)	Location Address (If different from Facility Address)	Occupancy (Indicate if leased to others)	Age	Number of Stories	Total Square Feet

(Use additional sheet if necessary)

Other than patient care:

Building (or addition)	Location Address (If different from Facility Address)	Occupancy (Indicate if leased to others)	Age	Number of Stories	Total Square Feet

B. Parking Lots/Garages – Location | Area | Paid/Free

C. Vacant Land – Location | Frontage (Linear Feet)

D. Does the facility own/operate a heliport, etc.? ☐ Yes ☐ No

If yes, complete 1 through 5 below:

1) Is the heliport licensed by the State Department of Aviation, Department of Transportation? ☐ Yes (Date license was issued _____); ☐ No
2) Distance between heliport or helipad and nearest building: _____
3) Annual number of landings: _____
4) Is the heliport or helipad used by: ☐ State Police; ☐ Life Flight; ☐ Other (Specify): _____
5) Do all users of the heliport/helipad provide Certificates of Insurance? ☐ Yes ☐ No

E. Are any fund-raising events sponsored by the facility or its auxiliary? ☐ Yes ☐ No

If yes, please describe types of events sponsored (carnivals, tournaments, etc.) and number per year: _____

F. Does the facility rent or lease any equipment from others? (i.e., computers, medical equipment, etc?) ☐ Yes ☐ No

If yes, please describe and estimate value:

Who maintains the equipment? _____

G. Is any new construction, or renovation to existing structures, planned during the next 12 months? ☐ Yes ☐ No

Estimated cost of construction/renovation planned? _____

Briefly describe the nature of the new construction or renovation: _____

13. Risk Management

A. Is there a designated risk manager on staff? ☐ Yes ☐ No

Full- or part-time _____

To whom does the risk manager report? _____

Is there a quality assurance coordinator on staff? ☐ Yes ☐ No

To whom does the assurance coordinator report? _____

B. Is there a written quality assurance plan? ☐ Yes ☐ No

Is there a written incident reporting procedure? ☐ Yes ☐ No

C. Are there formal quality assurance and risk management committees? ☐ Yes ☐ No

If so, how often are quality assurance/risk management indicators reviewed by the formal committee(s)?

_____

Is there a safety committee? ☐ Yes ☐ No

14. Prior Coverage and Loss History

A. Expiration date of expiring insurance coverage: _____

☐ Occurrence? ☐ Claims Made? If so, indicate Retroactive Date: _____

IMPORTANT: If Extended Reporting Endorsement (tail) coverage has been purchased, please provide name of carrier(s) and date purchased.

B. Are there any known occurrences, incidents, or circumstances which might give rise to future claims or suits?

If so, please describe any such incidents on attached Claim Information Form. (Please make additional copies as needed.)

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

C. Loss Runs – Most Insurance Companies provide loss runs listing claims with amounts paid and reserved. Please attach claims history as currently evaluated for the last five years. Complete details must be provided for all losses (reserved or paid).

Although this form shall be the basis of the contract if a policy is issued, it is agreed that the undersigned is not bound by the signing of this proposal to complete the insurance. The undersigned authorized officer declares that the statements set forth herein are true, to the best of their knowledge.

_____ _____

Date Completed Signature (CEO or Authorized Representative)

_____

Name (Please Type or Print)

_____

Title

Attachments

1. List of all affiliates and subsidiaries to which this insurance is to apply. Include: Description of operations and relationship to the Named Insured, and corporate organization chart, if available.

2. A copy of the most recent TJC, AHA report, or inspection of a long-term care facility.

3. Financial Information for prior 1 year, including audited Income Statements and Balance Sheets.

4. Loss runs (as specified in 14. C).

5. Most recent Annual Report.

Claim Information Form (Please make additional copies if necessary)

1. Name of Applicant: _____
2. Patient's Name: _____
3. Date of Incident or occurrence from which claim resulted or is likely to result in a claim: _____
4. Date claim was made: _____
5. Allegations made against you: _____

   _____
6. Explain, in detail, the specifics of the occurrence which led or may lead to the claim:

   _____

   _____

   _____
7. Present status or disposition of claim including amount of settlement or judgment:

   _____

   _____

   _____
8. Date of settlement or judgment: Month _____ Day _____ Year _____
9. What insurance company was involved?
   Company: _____ Policy No.: _____
10. Name of other doctors, and hospitals, if any, involved in the claim or suit:

    _____

    _____

_____ _____

Date Completed Signature of Applicant

Supplemental Information

Applicant's Instructions:

1. This form may be used by those Applicants who need additional space to answer any question:

I understand that information submitted herein becomes a part of my Professional Liability Application and is subject to the same representations and conditions.

Signature of Applicant

Date

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Authorization to Release Information

The undersigned applicant for insurance hereby authorizes applicant's present and prior professional liability insurance carriers, and any and all attorneys who have represented the undersigned in connection with any claim of professional liability, to release to the Company, upon its request, information regarding closed, pending, or anticipated claims and any underwriting or other information which, in the judgment of any such carrier, attorney, or the Company, may have a bearing upon applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which applicant is, or has been, a member; all hospitals in which applicant now holds, or has held, staff privileges; any state licensing board in any state which applicant has practiced; the Department of Health and Environment, or any other similar agency in which applicant has practiced or resided; and any and all physicians having information regarding the undersigned, to release to the Company, upon its request, any information any such person or entity may have which, in the judgment of any such person or entity or the Company, may have a bearing upon applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release, or use, of any information released, or furnished, pursuant to the authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Signed: _____ Address: _____

Date: _____ _____

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Long-term Care Facility Supplemental Application
New Business

APPLICATION INSTRUCTIONS AND REQUIRED INFORMATION

- This application must be completed in addition to the Health Care Facility Professional Liability Application.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue on the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

Name of Applicant: _____
(Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)

This supplemental application should be completed if the Applicant provides any of the following long-term care services:

- Sub-Acute Care
- Intermediate Care
- Home Health Care
- Skilled Care
- Assisted Living
- Independent Living

A. Resident Information

1. Indicate the percentage of residents by age range:

_____ < 30 _____ = 30-64 _____ = 65-74 _____ = 75-84 _____ = 85-94 _____ > 94

2. If any residents are under 64, please explain: _____

3. Please indicate the following number of residents on an annual basis for each category of service/type of resident:

Service / Type of Resident	Provided		Number of Residents
Residents Requiring IV Infusion Therapy	☐ Yes	☐ No	
Residents Requiring Ventilation Therapy	☐ Yes	☐ No	
Residents Requiring Dialysis Services	☐ Yes	☐ No	
Patients Recovering from Bariatric Surgery	☐ Yes	☐ No	
Developmentally Disabled Residents	☐ Yes	☐ No	
Alzheimers/Dementia Residents	☐ Yes	☐ No	
Residents Requiring Psychiatric Care	☐ Yes	☐ No	
Residents Requiring Chemical Dependency Treatment	☐ Yes	☐ No	
Short-Stay Rehabilitation Residents	☐ Yes	☐ No	

4. Does the Applicant have a dedicated/special unit for any of the categories listed above? ☐ Yes ☐ No

If yes, please explain: _____

_____

5. Are nursing assessment protocols in place to identify residents at risk for the following:

a. Elopement ☐ Yes ☐ No
b. Falls ☐ Yes ☐ No
c. Cognitive impairment ☐ Yes ☐ No
d. Nutritional deficiency ☐ Yes ☐ No

B. Staffing

1. Is there a licensed administrator on staff? ☐ Yes ☐ No

If no, who assumes the administration duties? _____

2. Please indicate staffing by shift:

Category	1st shift	2nd shift	3rd shift	Annual Turnover %
RN				
LPN				
CNA/Personal Caregiver				
Agency				
Pool				

3. Is there a licensed nurse for each shift? ☐ Yes ☐ No

4. Is there a physician on site or on call on a 24-hour basis? ☐ Yes ☐ No

5. Are nursing agencies/registries utilized? ☐ Yes ☐ No

If yes, how many agencies/registries are used: _____

Is a complete shift staffed exclusively by temporary staff? ☐ Yes ☐ No

C. Premises and Operations

1. Complete this section if the Applicant uses a pool. Please indicate if not applicable: ☐ N/A

a. Is the pool owned by the applicant? ☐ Yes ☐ No

b. Is it open to the public? ☐ Yes ☐ No

c. Is a certified lifeguard present? ☐ Yes ☐ No

d. Is the area secured when the pool is not in use? ☐ Yes ☐ No

e. What is the depth of the pool? _____ feet

f. Is there an emergency call system in close proximity? ☐ Yes ☐ No

g. Where is the pool located? ☐ Inside ☐ Outside ☐ Other _____

h. Are employees allowed to access the pool? ☐ Yes ☐ No

i. How is access controlled? _____

2. Are there other bodies of water present? ☐ Yes ☐ No

If yes, describe: _____

3. Are there saunas and/or hot tubs? ☐ Yes ☐ No If yes, how many: _____

Is there an attendant on duty? ☐ Yes ☐ No If yes, how many hours per day? _____

4. Is the facility used for activities other than by residents? ☐ Yes ☐ No

If yes, use the Comments section to explain.

5. Complete this section if there are Independent Living Facilities. Please indicate if not applicable: ☐ N/A

a. Do individual units have cooking appliances (ex. stove and/or oven)? ☐ Yes ☐ No

b. Is there a daily mechanism to keep track of residents? ☐ Yes ☐ No

If yes, explain procedure: _____

c. Are there licensed nursing personnel on staff? ☐ Yes ☐ No

What hours are they available? _____ What services do they provide? _____

d. Are there written guidelines in place that stipulate the types of residents able to live within the facility. ☐ Yes ☐ No

If yes, how often are residents re-assessed for adherence to the guidelines?_____

D. Additional Space for Answering Questions

Section and Question	Comments

Applicant Signature | Title | Date

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form (May 2013)

Kansas law requires the insurance company to forward this completed form and the HCSF surcharge payment to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the date the insurer receives the premium for primary coverage. A copy of this completed form must also be given to the health care provider.

FOR HCSF USE ONLY

SECTION I - Individual health care provider's name, professional acronym (CRNA, DC, DO, DPM, or MD), or the name of the health care provider institution or entity (ambulatory surgery center, hospital, limited liability company, or other health care provider organization).

Health Care Provider's Name:

Last name (or full name of medical care facility or other entity), first name, middle initial and professional acronym

Residence Address: Daytime Phone Number:

City: State: Zip Code: Country:

Email or Business Address of Health Care Provider:

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 the Health Care Stabilization Fund Board of Governors and request information regarding the availability of the Health Care Stabilization Fund's prior acts "tail" coverage for inactive health care providers.

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

					For Fund Classes 1 to 14	For Fund Classes 15 to 20	
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 subject to a part-time practice rating rule 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 HCSF USE ONLY