Kansas Medical Mutual Insurance Company

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

**Physicians And Surgeons 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.
- Please complete Corporate Health Care application if corporate coverage is desired. (Please visit www.KaMMCO.com)

## A. Applicant Information

Agency Name (if applicable)

| Name of Applicant (First, Middle, Last) | ☐ MD ☐ DO ☐ Other<br>Specify Other: | Gender<br>☐ Male ☐ Female |
|---|---|---|
| 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)<br>Other: | | Business Manager/Contact Person: |
| Telephone: | Fax: | Business E-mail: |

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other

Are you a member of the Kansas Medical Society? ☐ Yes ☐ No

If no, please complete the attached Kansas Medical Society membership application.

*Note: Membership in good standing in the Kansas Medical Society is required for coverage with KaMMCO.*

## B. Current Coverage

1. Name of current or previous professional liability carrier:
2. Date current or previous professional liability insurance policy expired, or will expire:
3. Retroactive date of current policy:

## C. Requested Coverage

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

☐ $200,000/$600,000 (KS Physicians Only)
☐ $1,000,000/$3,000,000 (MO Physicians Only)

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

2. Requested Retroactive Date:

## D. 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 health care services: ____________________

3. List each professional corporation, association, partnership or other health care related entity in which you have an ownership:

| Name | Description of Interest | % or Practice |
|---|---|---|
| | | |
| | | |
| | | |

***Complete one Corporate Health Care Application for each organization listed above, if coverage is desired.***

4. If you, as an individual, employ or contract physician(s) or surgeon(s), complete the following:

| Employee or Contractor Name | Specialty | Insurer |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

5. If you, as an individual, employ or contract other medical professionals, complete the following:

| Type | Number | Employment | Current Insurer |
|---|---|---|---|
| Physician/Surgeon Assistants | | ☐ Employee ☐ Contractor | |
| Nurse Anesthetists | | ☐ Employee ☐ Contractor | |
| Nurse Midwives | | ☐ Employee ☐ Contractor | |
| Nurse Practitioners | | ☐ Employee ☐ Contractor | |
| Technicians * | | ☐ Employee ☐ Contractor | |
| Podiatrists | | ☐ Employee ☐ Contractor | |
| Chiropractors | | ☐ Employee ☐ Contractor | |
| RNs/LPNs/LVNs | | ☐ Employee ☐ Contractor | |
| Other (describe): | | ☐ Employee ☐ Contractor | |

* Laboratory, Medical, X-Ray

## E. Education / Training / Work Experience

| 1. School of Graduation: | City & State: | Year of Graduation: |
|---|---|---|

2. If you are a foreign medical school graduate, have you obtained an ECFMG certificate? ☐ Yes ☐ No ☐ N/A
Indicate which certification you obtained and the year certified: ☐ ECFMG ☐ Fifth Pathway Year Certified:

3. Facility name and location where internship was served: ____________________
Specialty: Dates:

4. Facility name and location where residency was served: ____________________
Specialty: Dates:

5. Have you undergone additional medical training? ☐ Yes ☐ No
If yes, indicate type: Dates:

6. What is your medical specialty? What is your medical sub-specialty?

7. Are you certified by an approved specialty board? ☐ Yes ☐ No If yes, certifying board name(s): ____________
Date(s) of initial certification: Date(s) of recertification:

8. If you are not certifed, are you board eligible? ☐ Yes ☐ No If yes, date eligibility expires: ____________

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

| Name | License Number | % of Practice |
|---|---|---|
| | | |
| | | |
| | | |

*Note: If you practice in any states listed above, please include complete details in Comments section including whether coverage is provided through another insurance carrier.*

10. Indicate the name and location of all facilities, including non-hospital facilities, where you hold staff or courtesy privileges:

| Name/Location | Name/Location |
|---|---|
| | |
| | |
| | |

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

| Facility/Practice/City/State | **Dates** (month/year to month/year) |
|---|---|
| | to |
| | to |
| | to |
| | to |

12. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No
 If yes, describe changes: ______________________________

## F. Classification

1. Indicate the percentage of time devoted to the following medical and/or surgical activities: (Total should equal 100%)

**Percentage (Non-Surgical)**

___ Administrative Medicine
___ Aerospace Medicine
___ Allergy
___ Anesthesiology
___ Broncho-Esophagology
___ Cardiovascular Disease
___ Dermatology
___ Diabetes
___ Emergency Medicine
___ Endocrinology
___ Family Practice/General Practice
___ Fetal and Maternal Medicine
___ Forensic Medicine
___ Gastroenterology
___ General Preventive Medicine
___ Genetic Counseling
___ Geriatrics
___ Gynecology
___ Hematology
___ Hospitalist
___ Hypnosis
___ Infectious Diseases
___ Intensive Care Medicine
___ Internal Medicine
___ Laryngology
___ Legal Medicine
___ Neoplastic Diseases

**Percentage (Non-Surgical)**

___ Nephrology
___ Neurology
___ Nuclear Medicine
___ Nutrition
___ Occupational Medicine
___ Oncology
___ Ophthalmology
___ Orthopedics
___ Otology
___ Otorhinolaryngology
___ Pain Management*
___ Pathology
___ Pediatrics
___ Pharmacology-Clinical
___ Physiatry
___ Physical Medicine/Rehabilitation
___ Psychiatry
___ Psychoanalysis
___ Psychosomatic Medicine
___ Public Health
___ Pulmonary Diseases
___ Radiology
___ Rheumatology
___ Rhinology
___ Sports Medicine
___ Weight Reduction/Control
___ Other*

**Percentage (Surgical)**

___ Abdominal
___ Bariatric
___ Cardiac
___ Cardiovascular
___ Colon & Rectal
___ Dermatology
___ Endocrinology
___ Foot & Ankle
___ Gastroenterology
___ General
___ Geriatrics
___ Gynecology
___ Hand
___ Head & Neck
___ Laryngology
___ Neonatal
___ Nephrology
___ Neurosurgery
___ Obstetrics
___ Obstetrics-Gynecology
___ Ophthalmology
___ Orthopedic excluding Spinal Surgery
___ Orthopedic including Spinal Surgery
___ Otorhinolaryngology
___ Plastic
___ Plastic-Otorhinolaryngology
___ Thoracic
___ Traumatic
___ Urological
___ Vascular
___ Other*

*Describe in Comments section.

2. Indicate each of the following that you perform. Check **each** box that applies.

| | |
|---|---|
| ☐ **NO SURGERY** | No surgical procedures performed other than incision of boils and superficial abscess, suturing of skin and superficial fascia or circumcision. |
| ☐ **MINOR SURGERY** | Includes minor surgery and assisting in major surgery on your own patients. Open reduction of fractures shall be considered minor surgery. |
| ☐ **OBSTETRICAL PROCEDURES** | Obstetrical procedures and/or prenatal care beyond first trimester. **Cesarean sections shall be considered major surgery.** |
| ☐ **MAJOR SURGERY** | All other types of surgery and operations performed under general or regional anesthesia. Includes but not limited to: removal of tumors, amputations, abortions, removal of any gland or organ, plastic surgery. |

3. Please check the following medical procedures you perform:

- ☐ Autologous Fat Injection
- ☐ Angiography
- ☐ Arteriography
- ☐ Botox Injections
- ☐ Bronchoscopy
- ☐ Catheterization – arterial, cardiac, or diagnostic, other than:
  - a. Occasional emergency insertion of pulmonary wedge, pressure recording catheters, or temporary pacemakers.
  - b. Urethral catheterization
  - c. Umbilical cord catheterization for diagnostic purposes or for monitoring blood gasses in newborns receiving oxygen.
- ☐ Chelation therapy
- ☐ Closed fracture reduction of displaced fractures
- ☐ Colonoscopy
- ☐ Cryosurgery – other than use on benign or premalignant dermatological lesions
- ☐ Conscious sedation
- ☐ Discograms
- ☐ ECT (describe): ____________________
- ☐ Epidurals
- ☐ ERCP (Endoscopic Retrograde Cholangiopancreatography
- ☐ Lasers (describe)
- ☐ Laparoscopy
- ☐ Liposuction
- ☐ Mohs Surgery (Chemosurgery)
- ☐ Percutaneous Tracheostomy
- ☐ Nonendosopic Pneumatic Esophageal Balloon Dilation
- ☐ Needle biopsy (describe)
- ☐ Phlebography
- ☐ Radiation therapy
- ☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae
- ☐ PEG (Percutaneous Endoscopic Gastrostomy)
- ☐ Other procedure by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation (describe)

☐ **NONE OF THE ABOVE**

## G. Underwriting Questions

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

| Question | Yes | No |
|---|---|---|
| 1. Has your medical or narcotics license ever been denied, suspended, voluntarily surrendered, revoked, or subject to investigation or probationary terms in any jurisdiction? | ☐ Yes | ☐ No |
| 2. Have you ever been or are you currently aware of any complaint, investigation, disciplinary proceeding, or reprimand by any administrative agency, licensing agency, medical society or professional organization, hospital, or other medical facility? | ☐ Yes | ☐ No |
| 3. 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 |
| 4. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges or has probation been invoked? | ☐ Yes | ☐ No |
| 5. Do you provide professional services for a county jail, prison, or other correctional facility? | ☐ Yes | ☐ No |
| 6. Have you ever been denied a medical license or been denied certification by a specialty board? | ☐ Yes | ☐ No |
| 7. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? | ☐ Yes | ☐ No |
| 8. Has your professional liability insurance ever been declined, canceled, non-renewed, refused, or renewed or issued with special terms? If yes, explain why and give name of carrier(s). | ☐ Yes | ☐ No |
| 9. Has any administrative agency, licensing entity, medical society, hospital, or professional organization ever requested you to be examined or evaluated by another physician because of an alleged mental condition, alcohol abuse, or drug dependency? | ☐ Yes | ☐ No |
| 10. Have you ever had an illness or physical disability that impairs or could tend to impair your ability to practice medicine or could put your patients at risk? (e.g. alcoholism, convulsive disorders, Hepatitis B, HIV positive, mental illness, multiple sclerosis, narcotics addiction, rheumatoid arthritis, etc.)<br><br>If yes: a) state illness or disability; and b) must provide a statement from your physician with complete details of your illness or disability and attesting to your fitness to practice medicine. | ☐ Yes | ☐ No |
| 11. Have you ever been treated for alcohol or drug impairment or mental illness? | ☐ Yes | ☐ No |
| 12. Do you staff an emergency room for purposes other than to maintain hospital privileges?<br><br>If yes, in your explanation include hospital name, location, number of hours per month, and whether coverage is provided through another insurance carrier. | ☐ Yes | ☐ No |
| 13. Do you provide any diagnostic, consulting or other professional services to patients (including telemedicine or teleradiology) in other states?<br><br>If yes, include states, type of service and annual number of encounters in your explanation. | ☐ Yes | ☐ No |

| Question | Answer |
|---|---|
| 14. Are you engaged in any "moonlighting" activities?<br>If yes, indicate the number of hours per month, location, and scope of practice. | ☐ Yes ☐ No |
| 15. Are you interested in applying for coverage in excess of your primary and Health Care Stabilization Fund coverage?<br>If yes, complete the Application for Claims-Made Excess Insurance. (Please visit www.KaMMCO.com) | ☐ Yes ☐ No |
| 16. Are you employed or contracted as a medical director or similar role?<br>If yes, include name of facility in your explanation. | ☐ Yes ☐ No |
| 17. Do you supervise non-employed allied health professionals (i.e., physician's assistants, advanced registered nurse practitioners, registered nurses, aestheticians, etc.)?<br>If yes, include full details. | ☐ Yes ☐ No |
| 18. Do you render patients unconscious for treatment in your office or other nonhospital facility? | ☐ Yes ☐ No |
| 19. Do you perform surgery or obstetrical procedures at a location other than a licensed hospital?<br>If yes, include location and distance (travel time) to the nearest hospital in your explanation. | ☐ Yes ☐ No |
| 20. Do you work part-time?<br>If yes, indicate number of hours worked per week providing patient care, hospitals rounds, administrative duties, phone calls and teaching: | ☐ Yes ☐ No |
| 21. Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility?<br>If so, please complete a Corporate Health Care Application for each, if coverage is desired. | ☐ Yes ☐ No |
| 22. Do you practice in or staff a surgi-center or similar minor emergency clinic? | ☐ Yes ☐ No |
| 23. Are you employed by the Federal Government or are you in the military service? | ☐ Yes ☐ No |
| 24. Have your Medicare or Medicaid privileges ever been suspended, revoked, voluntarily surrendered, sanctioned, or subject to investigation? | ☐ Yes ☐ No |

## H. Claim Information

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

| Question | Answer |
|---|---|
| 1. Have any claims or suits ever been made against you, your employees, or any professional corporation, association or partnership to which you belong or have belonged arising out of the performance of professional services rendered or which should have been rendered by you or by any person for whose acts or omissions you are legally responsible.<br>If yes, indicate the number of previous and/or pending claims or suits: | ☐ Yes ☐ No |

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

## I. Comments

| Section & Question | Explanation |
|---|---|
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| 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 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

KaMMCO

Kansas Medical Mutual Insurance Company

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

**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.**

FOR HCSF USE ONLY

**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:

FOR HCSF USE ONLY

# Physician Application

Full Name:______________________________________________________

Designation: ❑ MD ❑ DO

Practice name: ______________________________________________________

Office address: ______________________________________________________
Street

______________________________________________________
City State Zip Code

Home address: ______________________________________________________
Street

______________________________________________________
City State Zip Code

Mailing Preference: ❑ Office address ❑ Home address

Billing Preference: ❑ Office address ❑ Home address

Office phone ( ) ______________________ Home phone ( ) ______________________

Office fax ( ) ______________________

Email address: ______________________________________________________

Kansas License: ______________________________________________________

Specialty: ______________________________________________________

Medical School: ______________________________________________________

Spouse's name: ______________________________________________________

Birthdate: ____________________/____________/____________
Month Day Year

Gender: ❑ Male ❑ Female

Contact KMS at 785.235.2383 with form questions.