



**Healthcare Facility Professional Liability and General Liability Application**

**Renewal**

Facility Name: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Renewal Date: \_\_\_\_\_ Expiring Policy Number: \_\_\_\_\_

1. Limits of Insurance:  
 Are any changes to the expiring limits desired?  Yes  No  
 If yes, describe below:  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Statistics:  
 Census Data: From: \_\_\_\_\_ To: \_\_\_\_\_

<u>Inpatient</u>	<u>Licensed Number</u>	<u>Patient Days</u>
Facility Days – Acute	_____	_____
Facility Days – Swing Bed	_____	_____
Extended Care	_____	_____
Psychiatric	_____	_____
Bassinets	_____	_____
 <u>Outpatient</u>		
Emergency Room Visits	_____	
Home Health Visits	_____	
Psychiatric Visits	_____	
Outpatient Surgeries	_____	
Outpatient Visits (lab, x-ray, other services)	_____	
 <u>Other</u>		
Live Births	_____	
Still Births	_____	
Units of Blood	_____	
Total Patient Admissions	_____	

3. Special Events:  
Describe any special events sponsored by the facility, e.g., carnivals, athletic events, tournaments, etc.

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4. Premises Information:  
Describe any changes made to the facility's premises, e.g., additions, new purchases, disposal of property, new parking, property donated to the facility, etc.

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5. Additional Insureds:  
List any new additional insureds to be considered.

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6. New Services:  
Does the facility have plans for any new services or operations?  Yes  No  
Does the facility plan to discontinue any services currently being offered?  Yes  No  
If yes to either, describe below:

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7. Organization:  
Has the facility made any changes to the organizational structure, e.g., mergers, acquisitions, subsidiaries, etc.?  Yes  No  
If yes, describe below:

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8. Contracts:  
Has the facility been involved in any new contracts that include a transfer of liability or hold harmless agreement?  Yes  No  
If yes, describe below:

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9. Email Addresses:  
a. Administrator Name - \_\_\_\_\_ Phone - \_\_\_\_\_  
Email - \_\_\_\_\_  
b. Risk Manager Name - \_\_\_\_\_ Phone - \_\_\_\_\_  
Email - \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



623 SW 10<sup>th</sup> Avenue  
Topeka, Kansas 66612  
800-232-2259  
www.KAMMCO.com

## 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 KAMMCO, 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 KAMMCO, may have a bearing upon applicant's acceptability to the KAMMCO 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 or licensing agency in any state which applicant has practiced; or any other similar agency in any state in which applicant has practiced or resided; and any and all physicians having information regarding the undersigned, to release to the KAMMCO, upon its request, any information any such person or entity may have which, in the judgment of any such person or entity or the KAMMCO, may have a bearing upon applicant's acceptability to the KAMMCO 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 KAMMCO, 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 KAMMCO and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Please return application by email to [underwriting@kammco.com](mailto:underwriting@kammco.com) or by fax to 785.232.4704.  
If you work with a KAMMCO agent, please submit directly to your agent.