623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
www.kammco.com

Non-Physician Healthcare Professionals Application for Claims-Made Professional Liability Insurance New Business

Application Instructions & Required Information

- Answer all questions completely and accurately.
- Complete this form electronically or print your responses legibly.
- If space is insufficient to answer any question fully, use the **Comments Section** at the end of this application, or attach separate documentation.
- Sign and date the application where indicated.
- Provide claim information for the last five years, and include current company loss runs.
- All forms and applications are available online under the Insurance tab of the KAMMCO website.
- Complete the attached **Collaborative Practice Agreement / Statement of Responsible Physician Form**.
- This application is subject to review and acceptance by the company and does not bind coverage. Additional information may be requested.
- Incomplete submissions or lack of required information may delay the underwriting process.

Note for Kansas residents and Kansas licensed healthcare providers:

Pursuant to Kansas law, the following professional occupations are required to participate with the Kansas Health Care Stabilization Fund (HCSF): Certified Registered Nurse Anesthetist, Physician Assistant, and Certified Nurse Midwife. If this is your professional occupation, it is mandated that you:

1. Complete the attached **Health Care Stabilization Fund Notice of Basic Coverage Form**, and
2. Answer **Section D: Requested Coverage, question 1, on page 3** of this application.

Requested Effective Date (MM/DD/YYYY): _____

A. Applicant Information

Name (First, MI, Last):	**Gender:** ☐ Male ☐ Female	**SS#:**
Name of Employer:	**Date of Birth** (MM/DD/YYYY):	

Applicant's Business Information

Street:	City:	State:	Zip:
County:			
Phone:	Fax:	Email:	

Applicant's Home Information (P.O. Box not accepted)

Street:	City:	State:	Zip:
County:	Home Phone:	Cell Phone:	

Applicant's Billing/Mailing Information

☐ Home ☐ Business ☐ Other (specify):

Street:	City:	State:	Zip:

Business Manager / Contact Person Information

Name:	Title:

Phone:	Fax:	Email:

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other (specify):

B. Professional Coverage

Specify your professional occupation:

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

***Kansas HCSF participation required for Kansas residents and Kansas licensed health care providers.**

C. Current & Previous Coverage

Existing form of insurance: ☐ Occurrence ☐ Claims-made

Specify below your insurance coverage for the past five (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.)
   ☐ $500,000 / $1,500,000

2. Health Care Stabilization Fund (HCSF) Limits (if applicable)
   ☐ $500,000 / $1,500,000
   NOTE: HCSF participants must complete the 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: _____

2. **School Information**

School of Graduation: _____

School's Location (City & State): _____

Degree: _____

Year of Graduation (YYYY): _____

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

If yes, specify: _____

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

State	License / Certification Number	Percentage %

4. List all places where you have practiced your profession during the past five (5) years:

Facility / Practice	City and State	Dates (MM/YYYY) to (MM/YYYY)
		to
		to
		to
		to

5. Do you prescribe drugs? ☐ Yes ☐ No

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

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

_____

8. Has there been any change in your practice or specialty during the last five (5) years? ☐ Yes ☐ No

If yes, specify: _____

F. Practice Information

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

_____

2. How many hours per week are you working (including patient care, administrative duties, phone calls, and teaching)?

_____

3. List each professional corporation, association, partnership, or other healthcare related entity in which you have ownership?*

Name	Description of Interest	Percentage of Practice

*Complete one **Physician Corporate Entity Application** for each organization listed. It's available online under the Insurance tab of the KAMMCO website.

G. Underwriting Questions (Please read carefully.)

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

2. Is your collaborative physician insured with KAMMCO? ☐ Yes ☐ No

3. Is your supervising physician insured with KAMMCO? ☐ Yes ☐ No

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

5. 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

6. Has any hospital, medical association, medical society/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

7. Have you ever been treated for alcoholism, narcotics addiction, or mental illness? If yes, attach a letter outlining dates of treatment, results of treatment, and current status. **This letter should be from your physician or institution.**	☐ Yes	☐ No
8. Do you provide any professional services to patients in other states?	☐ Yes	☐ No
9. Do you practice telemedicine in Kansas or in other states? If yes, please complete a **Telemedicine Supplemental Questionnaire** form.	☐ Yes	☐ No
10. Do you moonlight (i.e., work outside of control of KAMMCO employer)? If yes, provide location, scope of practice, number of hours per month in your explanation in the **Comments Section**.	☐ Yes	☐ No
If yes, will you carry malpractice insurance coverage with another carrier?	☐ Yes	☐ No
11. Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic offense?	☐ Yes	☐ No
12. Has any insurer canceled, declined coverage, declined to issue, refused renewal, or offered professional liability insurance only on special terms? If yes, explain why and give name of carrier(s) in the **Comments Section**.	☐ Yes	☐ No
13. Will you be scheduled to work at a separate location from your supervising physician? If yes, please give details in the **Comments Section**.	☐ Yes	☐ No

H. Claim Information

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? If yes, complete the **Claim Information Worksheet** for each claim or suit. The **Claim Information Worksheet** is available under the Insurance tab of the KAMMCO website. Make additional copies as needed.	☐ Yes	☐ No

Continue to Next Page

I. Comments

Section & Question Number	Explanation

Please attach additional pages, as needed.

Execution of this application by the applicant does not bind 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 photocopy 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 an/or health care facility medical or credentialing staff.

I understand and agree these investigations shall not be confined to information submitted in the application, but shall include any other sources of information deemed relevant by KAMMCO as may be authorized by law.

_____ _____

Signature of Applicant **Date**

Please return this application, along with any necessary attachments,
by email to underwriting@kammco.com or by fax to **785.232.4704**.

If you work with a KAMMCO agent, please submit this application directly to your agent.

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Claim Information Worksheet

(Make additional copies, if necessary.)

No Claims: ☐ *(A signature is required, regardless of claim history.)*

Applicant's Name (First, MI, Last): _____

Patient's Name (First, MI, Last): _____ Patient's Gender: ☐ Male ☐ Female

Allegation:

Date of Incident (MM/DD/YYYY): _____ Date Reported (MM/DD/YYYY): _____

Insurance Carrier: _____ Location of Incident: _____

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

If you are/were not the primary defendant, please describe your involvement in the patient care:

Additional Defendants: _____

Claim Status: ☐ Open ☐ Closed Date Closed (MM/DD/YYYY): _____

If open, indicate the 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**

Please return this form, along with your application, or email it directly to underwriting@kammco.com.
If you work with a KAMMCO guest agent, please submit directly to your agent.

Kansas Health Care Stabilization Fund
Notice of Basic Coverage (NBC)
General Instructions

The Availability Act requires insurers to notify the Board of Governors when a professional liability policy is issued to a Kansas resident health care provider. All health care provider facilities licensed to operate in the state of Kansas are resident health care providers, as are health care provider professionals whose legal residence is in Kansas.

The Notice of Basic Coverage (NBC) form is available to download from the Health Care Stabilization Fund website. Select the "Forms" tab in the menu bar. https://hcsf.kansas.gov

The downloadable version of the NBC can be completed on a computer and then be printed for the health care provider's signature. A certified digital signature is acceptable. Whether using a traditional paper NBC or one of the web-based versions, accuracy and completeness will avoid delays. If the essential information is not provided, the NBC will be returned to the insurer for completion.

Section I

Correct spelling of a health care provider's full name is important, particularly if the notice of basic coverage is the first one for the health care provider. If the health care provider is a facility or business, it is important to indicate the name identified on the license or in the articles of incorporation; in other words, indicate the legal name of the health care provider.

If a health care provider lives in Kansas but practices in another state, the Kansas residence address must be submitted accurately.

The legal residence is extremely important because the statutory coverage for Kansas residents differs from statutory coverage for non-residents. An office mailing address or a post office box number will not suffice. If the health care provider is a facility, the address on the facility's license should be indicated on the NBC. Similarly, if a health care provider business entity is incorporated in Kansas, but has a place of business in another state, it is imperative that the Kansas address be submitted.

Section II

The Health Care Provider Insurance Availability Act requires each health care provider to have coverage limits in the amount of $500,000 per claim, subject to $1,500,000 annual aggregate limit. To assure that the health care provider has acknowledged the coverage, a signature is required on the first Notice of Basic Coverage. When renewing HCSF compliance, the health care provider's signature is not required.

Section III

The HCSF Board of Governors relies on primary insurers to determine the appropriate risk category of health care providers. The following general guidelines are provided for this section of the NBC:

- Enter the provider's complete **license number** which often includes a prefix and hyphen. If the health care provider is not licensed (for example, a professional corporation) use the provider's federal taxpayer identification number in lieu of a license number.

- Enter the provider's basic insurance coverage **premium amount**. Normally this amount will be the annual premium determined in accordance with rates and rating factors approved by the Kansas Insurance Department, absent any credits or discounts for policy deductibles. If the policy is for less than 365 days or is a part-time policy, this amount should be the actual premium rather than the annual premium.
- Enter the applicable HCSF **Class Group Number** and annual **HCSF Premium Surcharge amount** in the respective boxes. The **minimum** surcharge is **$200.00.** Classification Groups and the Surcharge Payment Table can be found at Surcharge Information | Kansas Health Care Stabilization Fund and on page 4.

    - For providers in HCSF Class Groups 1 through 14, this amount is reflected on the surcharge table. For HCSF Class Group Numbers 15 through 24, the surcharge is a percentage of the provider's basic coverage premium amount. The percentage should be indicated in the HCSF surcharge percentage box and be used to calculate the HCSF surcharge payment, to be indicated in the box immediately to the right of the percentage box.
    - Residents in training are self-insured by the state of Kansas under a unique statutory arrangement. On the other hand, some residents purchase a separate insurance policy to cover their liability exposure resulting from employment in an extracurricular position during residency training ("moonlighting"). If the moonlighting resident was insured under an occurrence policy, the physician's surcharge should be calculated based on the HCSF first year rate.

  There are very few acceptable reasons to adjust the amount of the HCSF surcharge calculation.
  a. If the health care provider is classified in one of the groups 1-14 and the basic policy is issued for only part of a year, the annual HCSF surcharge may be prorated. If, however, the health care provider is classified in one of the groups 15-24, and the premium indicated is for only part of a policy year, the HCSF surcharge should not be prorated because it is the product of the applicable percentage rate applied to the premium, which is already prorated.
  b. The policy may be for a unique part-time practice. If the health care provider is no longer practicing full time (for example, teaching at a university half time and practicing medicine or surgery half time) and the insurer has agreed to issue a part-time policy and charge a reduced premium, the HCSF surcharge may be adjusted commensurately. This does not apply to health care providers who practice in Kansas part time and practice in another state part time. Contact the HCSF Compliance Section to discuss part-time insurance policies.
  c. The Missouri Modification Factor may be applicable. It applies to all health care providers, including entities, residing in Kansas who have an active license to render professional services in Missouri. Check the box if applicable and add the additional 30% Missouri rate modification amount to the calculated Fund surcharge. If a health care provider is licensed to practice in Missouri, but is no longer actively practicing in Missouri, he or she may convert the Missouri license to inactive until he or she wishes to resume rendering services in Missouri. The modification is not required if the Missouri license is inactive.
- Complete remaining sections regarding insurance company and policy.

Online Application (Compliance e-form)

An online application is available at the HCSF website, under the "Providers" tab in the navigation menu bar. The electronic application (Compliance e-form) accommodates both resident and non-resident health care providers as well as health care provider facilities. For that reason, some of the fields may not always be applicable. For example, either 2a (the profession) or 2b (the type of facility or entity) must be entered, but never both. An accurate, complete Kansas license number must be entered in the appropriate field because the license number is the key field in the HCSF database. This usually includes a prefix and hyphen. If the health care provider is already in compliance and the NBC is simply for renewal of coverage, several of the fields in the form will automatically populate after the correctly formatted license number is entered. If any of the information in those populated fields is outdated or incorrect, the information must be deleted and replaced. The HCSF staff will be alerted that a change has been submitted.

The compliance e-form may be printed for record-keeping and then it can be submitted directly to the HCSF electronically. Payment may also be made electronically using the separate state KanPay system. The convenience fee for a credit card payment is generally more expensive than an electronic transfer directly from a bank account (e- check).

The HCSF Classification System

The statutory definition of health care provider includes most doctors (physicians, chiropractors, and podiatrists) and physician assistants. It also includes registered nurse anesthetists, advanced practice nurse-midwives, and a few dentists who are certified by the Board of Healing Arts to administer anesthesia. The definition also includes hospitals, ambulatory surgery centers, community mental health centers, assisted living facilities, nursing facilities, and residential health care facilities. Optometrists, pharmacists, and physical therapists are listed in the statutory definition, but they are no longer required to comply with the Health Care Provider Insurance Availability Act.

The definition also includes certain professional corporations and limited liability companies that are organized by health care providers for the purpose of providing health care services. (See chart on page 7).

For questions regarding these instructions or assistance regarding the NBC Form or HCSF surcharge rates, please contact the HCSF office via email at hcsf@ks.gov or contact us at (785) 291- 3777.

The HCSF Classification System

The statutory definition of health care provider includes most doctors (physicians, chiropractors, and podiatrists) and physician assistants. It also includes registered nurse anesthetists, advanced practice nurse-midwives, and a few dentists who are certified by the Board of Healing Arts to administer anesthesia. The definition also includes hospitals, ambulatory surgery centers, community mental health centers, assisted living facilities, nursing facilities, and residential health care facilities. Optometrists, pharmacists, and physical therapists are listed in the statutory definition, but they are no longer required to comply with the Health Care Provider Insurance Availability Act.

The definition also includes certain professional corporations and limited liability companies that are organized by health care providers for the purpose of providing health care services.

HCSF Rate Classification Numbers and Corresponding Classification Groups

Description	HCSF Rate Classification Number	HCSF Class Group Number
Aerospace Medicine	80230	2
Allergy	80254	1
Anesthesiology	80151	7
Angiography	80422	3
Arteriography	80422	3
Broncho-Esophagology	80101	5
Cardiovascular Disease - no surgery	80255	2
Cardiovascular Disease - minor surgery	80281	3
Catheterization - arterial, cardiac, or diag - other than 3 exceptions	80422	3
Certified Registered Nurse Anesthetists`	80960	13
Chiropractors	80410	12
Colonoscopy	80443	3
Dermatology - minor surgery	80282	3
Dermatology - No Surgery	80256	1
Diabetes - minor surgery	80271	3
Diabetes - no surgery	80237	2
Discograms	80422	3
Emergency Medicine - including major surgery	80157	8
Emergency Medicine - no major surgery	80102	6
Endocrinology - minor surgery	80272	3
Endocrinology - no surgery	80238	2
ERCP (endoscopic retrograde cholangiopancreatography)	80443	3
Family Physicians or G.P. - minor surgery, no ob procedures	80423	3
Family Practice or G.P. - major surgery, includes ob procedures	80117	5
Family Practice or G.P. - minor surgery, includes obstetrics, but no c-sections	80421	4
Family Practice or G.P. - no surgery	80420	2
Forensic Medicine	80240	1
Gastroenterology - minor surgery	80274	3
Gastroenterology - no surgery	80241	2
General Practice - no surgery	80242	2
General Preventive Medicine - no surgery	80231	2
General Practice - minor surgery	80275	3
Geriatrics - minor surgery	80276	3
Geriatrics - no surgery	80243	2
Gynecology - minor surgery	80277	3
Gynecology - no surgery	80244	2
Hematology - minor surgery	80278	3
Hematology - no surgery	80245	2
Hypnosis	80232	2
Infectious Diseases - minor surgery	80279	3
Infectious Diseases - no surgery	80246	2
Intensive Care Medicine	80283	3

Description	HCSF Rate Classification Number	HCSF Class Group Number
Internal Medicine - no surgery	80257	2
Invasive Procedures - major	80422	3
Invasive Procedures - minor	80443	3
Laryngology - minor surgery	80285	3
Laryngology - no surgery	80258	2
Lasers - Used in therapy	80422	3
Legal Medicine	80240	1
Neoplastic Diseases - minor surgery	80286	3
Neoplastic Diseases - no surgery	80259	2
Nephrology - minor surgery	80287	3
Nephrology - no surgery	80260	2
Neurology - including child - minor surgery	80288	3
Neurology - including child - no surgery	80261	2
Nuclear Medicine	80262	2
Nutrition	80248	2
Occupational Medicine	80233	2
Ophthalmology - minor surgery	80289	3
Ophthalmology - no surgery	80263	2
Otology - no surgery	80264	2
Otorhinolaryngology - no surgery	80265	2
Otology - minor surgery	80290	3
Otorhinolaryngology - minor surgery	80291	3
Pathology - minor surgery	80292	3
Pathology - no surgery	80266	1
Pediatrics - minor surgery	80293	3
Pediatrics - no surgery	80267	2
Pharmacology - clinical	80234	2
Phlebography	80422	3
Physiatry	80235	2
Physical Medicine and Rehabilitation - no surgery	80235	2
Physicians - minor surgery - N.O.C.	80294	3
Physicians - no surgery - N.O.C.	80268	2
Pneumatic or mechanical esophageal dilation (not with bougie or olive)	80443	3
Podiatrists	80993	14
Psychiatry - including child	80249	1
Psychoanalysis	80250	1
Psychosomatic Medicine	80251	1
Public Health	80236	1
Pulmonary Diseases - no surgery	80269	2
Radiology - diagnostic - minor surgery	80280	3
Radiology - diagnostic - no surgery	80253	2
Rheumatology - no surgery	80252	2
Rhinology - minor surgery	80270	3
Rhinology - no surgery	80247	2
Surgery - abdominal	80166	8
Surgery - bariatric	80142	8
Surgery - cardiac	80141	9
Surgery - cardiovascular disease	80150	9
Surgery - colon and rectal	80115	5
Surgery - endocrinology	80103	5
Surgery - gastroenterology	80104	5
Surgery - general	80143	8
Surgery - general practice or family practice	80117	5
Surgery - geriatrics	80105	5
Surgery - gynecology	80167	8
Surgery - hand	80169	8
Surgery - head and neck	80170	8
Surgery - laryngology	80106	6
Surgery - neoplastic	80107	5
Surgery - nephrology	80108	5
Surgery - neurology - including child	80152	11
Surgery - obstetrics	80168	10

Description	HCSF Rate Classification Number	HCSF Class Group Number
Surgery - obstetrics - gynecology	80153	10
Surgery - ophthalmology	80114	3
Surgery - orthopedic	80154	9
Surgery - otology	80158	6
Surgery - otorhinolaryngology	80159	6
Surgery - plastic - N.O.C.	80156	8
Surgery - plastic - otorhinalaryngology	80155	8
Surgery - rhinology	80160	6
Surgery - thoracic	80144	9
Surgery - traumatic	80171	9
Surgery - urological	80145	5
Surgery - vascular	80146	9
Urgent Care Physicians - not involving emergency care medicine	80424	2

HEALTH CARE STABILIZATION FUND CLASSIFICATION GROUPS	
FUND CLASS GROUPS	**CLASS GROUP DESCRIPTIONS** – ***Important Note: Class Group 15 is the only classification available for providers insured by the Kansas Health Care Provider Insurance Availability Plan.***
1	**Physicians-No Surgery** - Includes: Allergy, Dermatology, Forensic Medicine, Legal Medicine, Pathology, Psychiatry (both adult and child), Psychoanalysis, Psychosomatic Medicine, Public Health.
2	**Physicians-No Surgery** - Includes: Aerospace Medicine, Cardiovascular Disease, Diabetes, Endocrinology, Family Practice, Gastroenterology, General Practice, General Preventive Medicine, Geriatrics, Gynecology, Hematology, Hypnosis, Infectious Diseases, Internal Medicine, Laryngology, Neoplastic Diseases, Nephrology, Neurology (including child), Nuclear Medicine, Nutrition, Occupational Medicine, Ophthalmology, Otology, Otorhinolaryngology, Pediatrics, Pharmacology, Physiatry, Physical Medicine & Rehabilitation, Pulmonary Diseases, Radiology, Rheumatology, Rhinology, Urgent Care Physicians or other Physicians who are not performing surgery and are not otherwise classified.
3	**Physicians-Performing Minor Surgery or Assisting in Surgery** - Includes: Cardiovascular Disease, Dermatology, Diabetes, Endocrinology, Family Practice (no OB procedures), Gastroenterology, General Practice, Geriatrics, Gynecology, Hematology, Infectious Diseases, Internal Medicine, Intensive Care Medicine, Invasive Procedures (as defined and classified by the basic coverage insurer), Laryngology, Neoplastic Diseases, Nephrology, Neurology (including child), Ophthalmology (including minor and major surgery), Otology, Otorhinolaryngology, Pathology, Pediatrics, Radiology, Rhinology, Shock Therapy or other Physicians who are performing minor surgery and are not otherwise classified.
4	**Family Physicians or General Practitioners-Performing Minor Surgery or Assisting in Surgery** - Includes obstetrical procedures, but not Cesarean Sections.
5	**Surgical Specialists** - Includes: Broncho-Esophagology, Colon and Rectal, Endocrinology, Gastroenterology, Geriatrics, Neoplastic, Nephrology, Urological, Family Physicians or General Practitioners performing Major Surgery.
6	**Surgical Specialists** - Includes: Emergency Medicine (no major surgery), Laryngology, Otology, Otorhinolaryngology, or Rhinology.
7	**Specialists In Anesthesiology** - Includes: Physicians or DDS certified by the Board of Healing Arts to administer anesthetics.
8	**Surgical Specialists** - Includes: Emergency Medicine (including major surgery), Abdominal, Bariatric, Gynecology, Hand, Head and Neck, Plastic (Otorhinolaryngology), Plastic (Not Otherwise Classified), or General (This classification does not apply to any family or general practitioner or to any specialist who occasionally performs major surgery).
9	**Surgical Specialists, includes** - Includes: Cardiac, Cardiovascular Disease, Orthopedic, Thoracic, Traumatic, or Vascular.
10	**Surgical Specialists, includes** - Includes: Obstetrics, Obstetrics & Gynecology, or Perinatology.
11	**Surgical Specialists, includes** - Includes: Neurology (both adult and child).
12	**All Chiropractors**
13	**All Nurse Anesthetists**
14	**All Podiatrists**
15	All health care providers insured by or subject to the rating rules of the Kansas Health Care Provider Insurance **Availability Plan**, including authorized basic professional liability self-insurers.
16	Professional corporations, partnerships, limited liability companies and not-for-profit corporations as included in the definition of health care provider in K.S.A. 40-3401(f).
17	**Medical Care Facilities** (includes special hospitals, general hospitals, surgical centers or recuperation centers).
18	**Mental Health Centers** or Mental Health Clinics.
19	**Psychiatric Hospitals** (selected facilities only).
20	Persons engaged in approved residency training programs.
21	**Physician Assistants**
22	**Nurse-Midwives**
23	**Assisted Living Facilities** and **Residential Health Care Facilities**
24	**Nursing Facilities**

Summary of HCSF Surcharge Procedures	
	For guidance or assistance, send a question to hcsf@ks.gov or call 785 291 3777
1.	**Identify Fund Coverage Limits:** Coverage amounts are $500,000 / $1,500,000.
2.	**Determine Appropriate HCSF Classification Group:** This will be one of the 24 categories listed in the surcharge rate table.
3.	**Health Care Providers, Who Completed an Approved Kansas Postgraduate Training Program** and also provided professional services in outside "moonlighting" activities for which basic professional liability insurance coverage was obtained are somewhat unique. a. If the resident was insured under an occurrence policy, the moonlighting year or years are not taken into account and the physician's surcharge is based on the first year of compliance. b. If the resident was insured under a claims-made policy, the moonlighting year or years are taken into account and the physician's surcharge is based on the second or subsequent year of compliance.
4.	**Determine the Annual Premium Surcharge Amount:** Surcharge rates for classification groups 1 – 14 are specific dollar amounts depending on the level of HCSF coverage selected by the health care provider. Surcharge rates for classification groups 15 – 24 also vary based on the level of HCSF coverage selected. Because commercial insurers normally increase their premiums annually until the fifth year, the actual surcharge payment will also increase even though the percentage rate is the same for each year of compliance.
5.	**Modification of the Annual Premium Surcharge Amount** is permitted for the following reasons only: a. **Pro-rata basis for policy periods of less than one year.** Pro-rata adjustment will be based on an annual period of 365 days—do not make any adjustments based on a 366 day leap-year. Round the ratio to the nearest whole percent. b. **Part-time practice adjustments** may be applied to the annual dollar surcharge rates only when there are unique circumstances and the basic professional liability insurance company has issued a part-time policy. This does not apply to health care providers who practice in more than one state. c. **Missouri Modification Factor, Applicable to All Fund Class Groups:** An additional surcharge amount equal to 30% of the annual dollar surcharge rate shall be added to the surcharge payment of the Kansas resident health care provider who has an active license (registered, etc.) to provide professional services in Missouri. This includes Kansas health care provider business entities rendering professional services in Missouri. The nature of the modification to the annual dollar surcharge rate for individual health care providers must be identified and explained on the Notice of Basic Coverage form submitted by the professional liability insurer. The surcharge should not be adjusted because the health care provider practices in Kansas part time and practices in another state part time.
6.	**Rounding Rule for All Surcharge Payments:** All surcharge payments must be rounded to the nearest whole dollar amount. Amounts of *49 cents* or less shall be rounded down to the next lowest whole dollar. Amounts of *50 cents* or more shall be rounded up to the next highest whole dollar.
7.	**Minimum $200 Fund Surcharge Payment Per Compliance Period is Required.** The minimum surcharge is applicable to all Fund compliance periods, including short-term policy periods and surcharge refund adjustments due to mid-term cancellation or termination of existing Fund compliance periods.
8.	**Fund Surcharge Rating for Authorized Self-Insured Health Care Providers:** Fund surcharge payments for health care providers who have been issued a Certificate of Basic Professional Liability Self-Insurance in accordance with K.S.A. 40-3414 will continue to be an amount equal to a percentage of the amount the self-insurer would pay for the basic coverage as calculated in accordance with the self-insured rating procedures adopted by the HCSF Board of Governors.

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form

(for policy periods effective on and after Jan. 1, 2023)

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 Kansas Residence: | Kansas |
Street Address and City (For a hospital or other facility, or a business entity, this should be the legal location.) Zip Code

Daytime Phone Number:

Health Care Provider's Email Address:

Mailing Address:
(Optional, if not the same as legal residence) Street Address or P.O. Box, City, State, Zip Code

SECTION II - HCSF Coverage Limit

❑ $500,000/$1,500,000

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

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

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or 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 (rounded to the nearest whole percent) was ____ %.

☐ The policy is a unique part-time policy issued by the primary professional liability insurer (requires explanation below under "extraordinary circumstances"). 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

623 SW 10th Avenue
Topeka, KS 66612
1.800.232.2259
www.kammco.com

Collaborative Practice Agreement / Statement of Responsible Physician

(This document must be completed, signed, and returned with your completed application.)

Applicant's Name: _____ **License Number** ***(if applicable)*****:** _____

Collaborative or Responsible Physician's Name: _____

1. Provide a description of the physician's practice and the way in which the applicant is to be utilized—include applicant's routine duties, the type of practice, and the practice setting.

2. Identify the practice location(s) at which the applicant will routinely render professional services—include hospitals, if applicable.

I understand the collaborative or 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 statement contained herein are true and correct.

_____ _____

Collaborative or Responsible Physician's Signature **Applicant's Signature**

_____ _____

Date **Date**

623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
www.kammco.com

Telemedicine Supplemental Questionnaire

Name (First, MI, Last): _____ **KAMMCO Policy #** (if applicable): _____

Name of Employer (if applicable): _____

Definition of Telemedicine
The delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. Telemedicine is to be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology, to provide or support health care and delivery that facilitates the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. ***K.S.A.40-2,211**

1. Do you practice telemedicine? ☐ Yes ☐ No
   - If yes, fill out this form in its entirety.
   - If no, it is not necessary to complete this form.

2. What specialty to do you practice? _____

3. What percentage of your medical practice is—or will be—dedicated to telemedicine: _____

4. List the state and the percentage of telemedicine you practice in each state.

5. Do you hold a medical license for each state in which you practice telemedicine? ☐ Yes ☐ No
   - If no, explain why below.

6. Identify the types and scope of telemedicine services you provide.

7. Have you been named in a claim tied to the telemedicine services you provide? ☐ Yes ☐ No
   – If yes, explain why below.

8. Do you have a written agreement or contract to provide telemedicine services? ☐ Yes ☐ No

9. Do you have additional or specialized procedures for ensuring privacy and security of patient information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) with regard to telemedicine? ☐ Yes ☐ No

10. Have policies and protocols been established which provide a means of maintaining and documenting e-visit records for continuity of care? ☐ Yes ☐ No

11. Do you use an informed consent specifically for the telemedicine encounter? ☐ Yes ☐ No

12. Have policies and protocols been established to identify when face-to-face visits may be necessary? ☐ Yes ☐ No

Signature of Applicant **Date**

Return this form together with your completed application to KAMMCO.

If you work with a KAMMCO agent, submit this form along with your completed application to your agent.