Kansas Resident
Annual Health Care Stabilization Fund Application

(All requested information required. Incomplete applications will be returned.)

Section 1 - Health Care Provider Identification and Residency

Health Care Provider's Name: ______________________ ______________________ ________ ________
Last Name First Name MI Prof. Acronym

Or Business Entity/Hospital/Other Facility Name: ______________________________

Date of Birth: _____/_____/________ Daytime Phone Number: _____-_____-________ HCP Email Address: ______________________

Legal Residence: ______________________ ____________ ______ ______ ____________
(Or facility legal address) Street address City State Zip Country if not U.S.

Mailing Address: ______________________ ____________ ______ ______ ____________
(If different from above) Street address City State Zip Country if not U.S.

Section 2 - Health Care Provider Credentials - Fund Coverage: $500,000/$1,500,000

Statutory credentials:

Kansas Licensing Agency: _____ Board of Healing Arts _____ Board of Nursing _____ Business Entity/Hospital/Other Facility

Provider's Kansas License/Registration Number: ______________________ (include dashes/hyphens)

Section 3 – Insurance Policy and Information

Insurance Company *(The insurance carrier writing the professional liability policy.)*: ______________________

Insurance Policy Number: ______________________ Effective date: ____/____/_______ Expiration date: ____/____/_______

Type of Coverage: _____ Claims Made _____ Occurrence **(Occurrence Requirement: see pg. 2 instructions)**

Company Rep.: ______________________ Phone Number: _____-_____-_______ Email Address: ______________________

Section 4 – HCSF Surcharge Calculation (Rate table/MO modification factor pg.4 of instructions.)

Class Groups 1-14 **(only complete applicable lines)**

HCSF Classification Group Number: _____	Insurance Premium Amount **(required)**: $___________	Active MO license: ____ No ____ Yes
Surcharge amount for HCSF Class Group Number above	=	$
Missouri active license modification factor, added additional 30%	=	$
Short-term policy, number of days (< 365 days) _____ ÷ 365 rounded to nearest whole percent.	_____ % x surcharge =	$
Unique Circumstance **(part-time policy)** can be no less than 50% (see pg. 2 of instructions).	_____ % x surcharge =	$

HCSF Premium Surcharge Paid = $ __________

Class Groups 15-24 **(only complete applicable lines)**

(Percent based surcharges are calculated by the **individual** annual basic professional liability coverage.)

HCSF Classification Group Number: _____	Insurance Premium Amount: **(required)** below	Active MO license: ____ No ____ Yes
Individual annual insurance premium paid $____________ x HCSF Class Group Number surcharge _____ % from table	=	$
Missouri active license modification factor, added additional 30%	=	$
(If short-term policy, the insurance premium paid above should be the prorated insurance premium amount.)		

HCSF Premium Surcharge Paid = $ __________

NOTE: The Minimum surcharge fee is $200.00 All surcharge payments must be rounded to the nearest whole dollar amount. (*The minimum surcharge fee applies to **all** Fund compliance periods, including short-term policies and surcharge refund adjustments due to mid-term cancellation or termination of existing compliance periods.)*

For insurer explanation of (e.g. locum, part-time etc...)	**HCSF USE ONLY**

Health Care Stabilization Fund
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