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

Healthcare 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)

Healthcare 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 Healthcare 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 not 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

Location	Area	Paid/Free

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

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

Required 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.

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 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 KAMMCO, may have a bearing upon applicant's acceptability to 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 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 KAMMCO, upon its request, any information any such person or entity may have which, in the judgment of any such person or entity or KAMMCO, may have a bearing upon applicant's acceptability to 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 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 KAMMCO 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 Healthcare 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
- Skilled Care
- Intermediate Care
- Assisted Living
- Home Healthcare
- 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

623 SW 10th Avenue
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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 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**

Form **W-9** (Rev. March 2024) Department of the Treasury Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See *Specific Instructions* on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . ______

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ______

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ______

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) ______

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** **Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they