KANSAS HEALTH CARE STABILIZATION FUND NOTICE OF BASIC COVERAGE FORM (FY 2008)

The insurance company is required to forward this completed form and HCSF surcharge payment to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the date the insurer receives the basic coverage premium. A copy of this completed form must also be furnished to the health care provider.

FOR HCSF USE ONLY

SECTION I Individual Health Care Provider's Name, designation of M.D., D.O., D.C., D.P.M. or R.N.A. or the name of the health care provider entity (professional association, partnership, hospital or other health care provider organization).

Health Care Provider's Name _____ Provider's Group Name: _____

LAST NAME (OR FULL NAME OF HEALTH CARE PROVIDER ENTITY), FIRST NAME, MIDDLE INITIAL AND PROFESSIONAL DESIGNATION

Resident Address: _____ Phone: Number: _____

City: _____ State: _____ Zip: _____

Business Address Of Health Care Provider: _____

SECTION II For Health Care Providers WHO HAVE PREVIOUSLY SELECTED THEIR HEALTH CARE STABILIZATION FUND COVERAGE LIMITS. The previously selected Fund Coverage limits are:

☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

NOTE: A request to change Fund coverage limits form must be submitted to the Fund if an INCREASE or DECREASE to the previously selected Fund coverage limits is desired. The Fund Board of Governors MUST APPROVE all requests for INCREASED Fund coverage limits before such becomes effective. Blank copies of the REQUEST TO INCREASE OR DECREASE FUND COVERAGE LIMITS forms are available from your insurer or the Fund office.

SECTION III For **NEW** Health Care Providers Only. Check one of the following Health Care Stabilization Fund Coverage limits, enter the date signed, completing this section with your signature:

☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

_____ DATE SIGNED

_____ SIGNATURE OF HEALTH CARE PROVIDER

SECTION IV Insurance Policy Information And Health Care Stabilization Fund Surcharge Payment

					For Fund Classes 1 to 14	For Fund Classes 15 to 21	
HCSF Rate Classification Number	Provider's License, Registration or Certification Number	Basic Coverage Premium Amount	Number of Fund Compliance Years	HCSF Class Group No.	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge %	HCSF % Based Surcharge Payment

_____
ENTER NAME OF INSURANCE COMPANY

_____
NAME OF INSURANCE AGENT OR COMPANY REPRESENTITIVE

_____
TELEPHONE NUMBER OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

THE PUBLISHED SURCHARGE RATE FOR FUND CLASSES 1 TO 15 WAS MODIFIED BECAUSE THIS HEALTH CARE PROVIDER WAS ISSUED A BASIC PROFESSIONAL LIABILITY INSURANCE POLICY THAT WAS:

☐ FOR LESS THAN ONE YEAR AND THE SURCHARGE PAYMENT WAS PRORATED. THE PRORATA FACTOR USED WAS: _____

☐ SUBJECT TO A PART-TIME PRACTICE CREDIT RATING RULE APPROVED FOR USE BY THE BASIC PROFESSIONAL LIABILITY INSURER. THE PART-TIME FACTOR USED WAS : _____

☐ THIS KANSAS RESIDENT HEALTH CARE PROVIDER IS LICENSED (REGISTERED, ETC.) AND PRACTICES IN MISSOURI (25% has been added to surcharge shown above).

Policy Number: _____

Type Of Basic Coverage Professional Liability Policy

☐ Occurrence ☐ Claims Made

Inception Date: _____
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

Coverage Effective Date: _____
ENTER DATE THIS HEALTH CARE PROVIDER WAS ADDED TO AN EXISTING POLICY PERIOD

Expiration Date: _____
OF THE BASIC PROFESSIONAL LAIBILITY INSURANCE POLICY PERIOD

FOR HCSF USE ONLY

Notice to Health Care Provider: If you should discontinue your basic professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact the Kansas Health Care Stabilization Fund Board of Governors and request information regarding the availability of the Health Care Stabilization Fund's continuing coverage for inactive health care providers.