

# Kansas Health Care Stabilization Fund

## HELPFUL INFORMATION FOR COMPLETING AND SUBMITTING THE HEALTH CARE STABILIZATION FUND REFUND REQUEST FORM

### IMPORTANT

Information, guidelines and other explanations of the Health Care Provider Insurance Availability Act, K.S.A. 40- 3401 et. seq, provided in this brochure are intended to assist insurers and others in gaining a general, non-technical understanding of only certain portions of the Fund law. This brochure and its contents are not intended to alter or replace the statutory requirements or any court decision regarding the Fund law or the administration of any of the requirements of that law.

The Fund law requires that insurers notify the Board of Governors within ten days of canceling a policy at the request of the insured health care provider. If for some reason the notice to the Board is not consistent with the statutory ten-day notice requirement, the refund will be based on the postmark date of the notice minus ten days.

The refund request form on page 2 is self explanatory. We are furnishing the following suggestions and information which may be of assistance when you are seeking a return or refund of Health Care Stabilization Fund surcharge payments due to overpayment, a mid-coverage period cancellation or termination, lower rating classification change or other situation for which you believe you may be eligible to receive a surcharge refund.

- The minimum amount that will be refunded is \$50.00.
- Surcharge payments are attributed to the individual health care provider. If you are not the individual health care provider but you are seeking the return or refund of a surcharge, you must complete the information in the box at the bottom of the form.
- We need the federal taxpayer identification number or social security number of the person that will be the payee on the refund check. If this information is not provided our accounting personnel may need to call you for this information and your refund may be delayed.
- The State of Kansas does withhold any refund amount if other amounts are owed to the State of Kansas. This is the policy of the State of Kansas, not the Health Care Stabilization Fund.
- Often we will receive a refund request before we have received the coverage documentation and original surcharge payment. In many situations, such as a termination or rating classification change, we need to have the additional documentation submitted to us by the insurance company. When we are aware of situations that will delay the refund, we will try to advise you that there is a problem and what action we have taken to resolve that problem.
- After being received in our office, refunds are processed in about three weeks if the form is properly completed and if we have received all of the supporting documents. (Supporting documents can include: the original coverage document and surcharge payment; a mid-term termination or cancellation notice from the insurance company; a rate classification change document from the insurance company; or, a corrected Notice of Basic Coverage Form from the insurance company.)
- If the required information is not available to the HCSF, refund requests may be delayed several weeks. Please provide the needed material in a timely manner.

**If You Have Questions or Need Additional Assistance:** Please contact the Fund office for any additional assistance you may feel is needed.



FACSIMILE  
785-291-3550

INTERNET  
[www.hcsf.org](http://www.hcsf.org)



TELEPHONE  
785-291-3777



MAIL  
Health Care Stabilization Fund  
300 SW 8th Ave, 2nd Floor  
Topeka, KS 66603-3912



# HEALTH CARE STABILIZATION FUND REFUND REQUEST FORM

WHEN COMPLETED MAIL TO: KANSAS HEALTH CARE STABILIZATION FUND, 300 S.W. 8<sup>th</sup> Avenue, 2<sup>nd</sup> Floor, Topeka, KS 66603-3912

Name of Health Care Provider		ID#	License Number
Address of Health Care Provider			Telephone Number
City	State	Zip Code	Federal Tax Payer ID# or Social Security Number (This information is needed to complete the refund)

## INFORMATION FOR PROFESSIONAL LIABILITY POLICY REQUIRING REFUND:

- Name of Insurance Company: \_\_\_\_\_
- Policy Number: \_\_\_\_\_
- Inception Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
- Date of Midterm Termination or Change: \_\_\_\_\_
- Reason For Refund Request: \_\_\_\_\_
- Original Premium Amount: \$ \_\_\_\_\_
- Original Surcharge Amount: \$ \_\_\_\_\_
- Revised Premium Amount: \$ \_\_\_\_\_
- Revised Surcharge Amount: \$ \_\_\_\_\_
- Refund Amount (Due to Overpayment, Cancellation, or Class Code Change): \$ \_\_\_\_\_ (Amounts less than \$50.00 will not be refunded)
- Premium/Surcharge was financed through: \_\_\_\_\_  
(Name of Finance Company)

<b>Signature of health care provider:</b> _____	<b>Date:</b> _____	This signature is required for refund requests that are being made by the individual health care provider.
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**Complete this section for a refund that is to be sent to a person/organization other than the health care provider.**

Name: _____	Federal Tax Payer ID # _____	Or Social Security # _____	(This information is needed to complete the refund)
Address: _____	City _____	ST _____	Zip _____

**I agree to hold the Board of Governors and the Health Care Stabilization Fund harmless should the insured health care provider make the same request.**

Signature of person making this request: _____	Date: _____
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(IN THE SPACE BELOW, PLEASE TYPE OR PRINT THE NAME OF PERSON SIGNING THIS REQUEST)