

**Kansas Health Care Provider Insurance Availability Act  
Non-Resident Health Care Provider Certification Form**

**CERTIFICATE OF INSURANCE REQUIRED**

**Section 1 – Health Care Provider Information**

Full Name \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_

Legal Residence (cannot be Kansas): Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if different from residence): Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Section 2 – Health Care Provider Certification**

**A. Health Care Stabilization Fund Coverage:**

Year of HCSF Compliance (select one)    \_\_\_1<sup>st</sup> yr    \_\_\_2<sup>nd</sup> yr    \_\_\_3<sup>rd</sup> yr    \_\_\_4<sup>th</sup> yr    \_\_\_5<sup>th</sup> yr

HCSF Coverage Limits (select one)    \_\_\_\$100,000/\$300,000    \_\_\_\$300,000/\$900,000    \_\_\_\$800,000/\$2,400,000

**B. Statutory Credentials: Professional Category (e.g. MD, CRNA) \_\_\_\_\_**

Kansas Licensing Agency \_\_\_\_\_ License# \_\_\_\_\_  
(or registration/cert. #)

Specialty \_\_\_\_\_ HCSF Group# \_\_\_\_\_

**Section 3 – Insurance Policy and HCSF Surcharge Information (*Certificate of Insurance Required - Each Submission*)**

Insurance Company Name \_\_\_\_\_

Insurance Company Address: Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policy Number \_\_\_\_\_ Type Coverage    \_\_\_Claims Made    \_\_\_Occurrence

Renewal or Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Percent of Professional Practice in Kansas \_\_\_\_\_% (This ratio may be based on number of patients, hours per week, or days per year as long as it measures the professional's allocation of Kansas practice compared to his or her total professional practice. The percent should be rounded to the nearest whole number and may not be less than one percent.)

HCSF Premium Surcharge Payable \$ \_\_\_\_\_ (Minimum surcharge per compliance period is \$50.00)

I hereby certify that I am maintaining a policy of professional liability insurance with limits of not less than \$200,000 per claim and \$600,000 annual aggregate coverage. Pursuant to the Kansas Health Care Provider Insurance Availability Act, I hereby represent the above information to be true to the best of my knowledge. I agree to notify the HCSF in the event of any changes in my professional liability insurance. I am not aware of any professional liability claims or lawsuits made against me based on my Kansas practice.

Date Signed \_\_\_\_\_ Signature \_\_\_\_\_

HCSF Use Only

HCSF Use Only