Cancellation/termination notice requirements of the Health Care Stabilization Fund law

K.S.A. 40-3402(a)(2) In the event of termination of basic coverage by cancellation, nonrenewal, expiration or otherwise by either the insurer or named insured, notice of such termination shall be furnished by the insurer to the board of governors, the state agency which licenses, registers or certifies the named insured and the named insured. Such notice shall be provided no less than 30 days prior to the effective date of any termination initiated by the insurer or within 10 days after the date coverage is terminated at the request of the named insured and shall include the name and address of the health care provider or providers for whom basic coverage is terminated and the date basic coverage will cease to be in effect. No basic coverage shall be terminated by cancellation or failure to renew by the insurer unless such insurer provides a notice of termination as required by this subsection.

> The cancellation/termination requirements of K.S.A. 40-3402(a) were the focus of the Kansas Supreme Court's decision in Bell v. Simon, 246 Kan. 473 (1990). Insurers should review this court decision carefully.

There is additional information included in the Frequently Asked Questions on the HCSF Internet web site.

Because insurers are required to submit their policy form filings to the Kansas Insurance Department, the Fund has not published a specific cancellation, non-renewal, expiration or termination notice form. The following is sample wording of the information that is required by the Fund law and some added policy information that assists the Fund in processing the notice.

SAMPLE NOTICE OF TERMINATION OF BASIC COVERAGE BY CANCELLATION, NONRENEWAL, EXPIRATION OR OTHERWISE – K.S.A. 40-3402(a)(2)
KANSAS HEALTH CARE PROVIDER INSURANCE AVALABILITY ACT

Insurer: ______________________________ Policy Number: ____________

Policy Period: ______________ to ______________

Date of Termination of basic coverage by cancellation, nonrenewal,
expiration or otherwise: ______________________________

If applicable, please provide the revised basic coverage premium amount: ________________________

Date this notice was issued by the insurer: ______________________________

This Termination was due to the:

- ☐ Cancellation request of the named insured health care provider
- ☐ Nonrenewal or expiration
- ☐ Cancellation of existing policy period by the insurer
- ☐ Other termination action which was: ______________________________

Copies Sent To:

Named Insured __________________________ License Number: ___________
Address ______________________________
City ____________________________ State ____________ Zip _____________

Licensing Agency ______________________________
Address ______________________________
City ____________________________ State ___________ Zip ______________

Health Care Stabilization Fund
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