Kansas Health Care Stabilization Fund Notice of Basic Coverage Form

(for policy periods effective on and after Jan. 1, 2018)

Kansas law requires the insurance company to forward this completed form to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the effective date of the basic policy. A copy of this completed form must also be given to the health care provider.

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SECTION I – Health Care Provider Identification and Residency

Health Care Provider's Name:

Last name, first name, middle initial, and professional acronym, or full name of medical care facility or other type of health care provider

Health Care Provider's Legal Kansas Residence: | Kansas |

Street Address and City (For a hospital or other facility, or a business entity, this should be the legal location.) Zip Code

Daytime Phone Number:

Health Care Provider's Email Address:

Mailing Address:
(Optional, if not the same as legal residence) Street Address or P.O. Box, City, State, Zip Code

SECTION II - Coverage Limit Selection (Health care provider's signature is required if this is the first NBC or if this NBC reflects coverage limits lower than those currently in effect. HCSF coverage limits cannot be increased using this form. A request for HCSF coverage limits increase may be submitted to the Board of Governors for consideration.)

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

Date Signed

Health Care Provider's Signature

Notice to Health Care Provider: *If you discontinue your professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact your licensing agency and request that your license be made inactive.*

SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information

					For Fund Classes 1 to 14	For Fund Classes 15 to 24	
HCSF Rate Classification Number	Provider's License Number	Basic Coverage Premium Amount	Fund Compliance Year	HCSF Class Group Number	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment
		$			$	%	$

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or reasons:

☐ The policy is issued for only part of a year and the surcharge was prorated based on the number of days divided by 365. The proration (rounded to the nearest whole percent) was ____ %.

☐ The policy is a unique part-time policy issued by the primary professional liability insurer (requires explanation below under "extraordinary circumstances"). The part-time factor used was ____ %.

☐ This Kansas resident health care provider has an active Missouri license. The applicable Missouri modification factor was included in the surcharge calculation and the factor used was ____ %.

Type of Primary Coverage Professional Liability Insurance Policy: ☐ Occurrence ☐ Claims Made

Insurance Company Name:

Name of Agent or Other Company Representative:

Policy Number:

Agent or Company Rep. Email Address:

Coverage Effective Date:

Agent or Company Rep. Phone Number:

Coverage Expiration Date:

For insurer explanation of extraordinary circumstances:

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