REQUEST TO DECREASE HEALTH CARE STABILIZATION FUND COVERAGE LIMITS

Any health care provider wishing to decrease the previously selected health care stabilization fund coverage limits must complete this form and submit it to the fund office by facsimile or U.S. mail (addresses are shown at the bottom of this form).

Section I - Health Care Provider Information

A. Your Full Name: ______________________________, ______________________, ________
LAST NAME or ENTITY NAME — FIRST NAME — MIDDLE INITIAL

B. Residence Address: ____________________________________ Telephone No.: ____________
LEGAL RESIDENT ADDRESS

C. City, State and Zip Code: ______________________________, __________, __________
CITY — STATE — ZIP CODE

D. Your Health Care Provider Professional Designation (M.D., D.O., RNA, Hospital, etc): ____________________

E. Your Health Care Provider License, Registration or Certification Number: ____________________

F. Name Of Your Insurance Company: ____________________

G. Name Of Your Insurance Agent: ____________________

Section II - Request Decrease In My Existing Health Care Stabilization Fund Coverage Limits

A. My **PRESENT** Fund coverage limits are: ☐ $300,000/$900,000 ***OR*** ☐ $800,000/$2,400,000

B. I am requesting the **LOWER** Fund coverage limits of: ☐ $100,000/$300,000 ***OR*** ☐ $300,000/$900,000

C. I am requesting this decrease in Fund coverage limits for the following reason(s) (if necessary use additional paper):

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D. I am requesting that the lower limits be made effective on:

☐ Date of Board approval.

OR ☐ Date subsequent to Board approval, which is: ____________, ______, ______.
MONTH — DATE — YEAR

E. I understand that the lower Fund coverage limits will become effective on the date I have requested, unless otherwise notified by the Fund☐. I also understand that changes in Fund coverage apply only to incidents which occur after the effective date of Board approval.

F. I hereby authorize the Fund to make the necessary adjustments to my Fund surcharge payment and refund any overpayment with appropriate explanations to: ☐ Myself ***OR*** ☐ The party indicated below:

*Name:*______________________ *Address:*______________________

______________ DATE SIGNED

______________________ SIGNATURE OF HEALTH CARE PROVIDER -- REQUIRED

HEALTH CARE STABILIZATION FUND OFFICE ADDRESS: 300 SW 8TH AVENUE, 2ND FLOOR, TOPEKA, KANSAS 66603
TELEPHONE: 785-291-3777 FACSIMILE: 785-291-3550 E-MAIL: hcsf@ks.gov
You should expect some form of written confirmation of your request within one week of the date submitted