REQUEST TO INCREASE HEALTH CARE STABILIZATION FUND COVERAGE LIMITS

Any health care provider wishing to increase previously selected Health Care Stabilization Fund coverage limits must complete this form and submit it to the HCSF office. The signed form may be sent via U.S. Postal Service, facsimile, or may be scanned and attached to an email message. The addresses and fax number are listed below.

Section I - Health Care Provider Information

A. Your Full Name: _____ (LAST NAME or ENTITY NAME), _____ (FIRST NAME), _____ (MIDDLE INITIAL)

B. Residence Address: _____ (LEGAL RESIDENT ADDRESS) Telephone No.: _____

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 - Requested Increase In Existing Health Care Stabilization Fund Coverage Limits

A. My **PRESENT** Fund coverage limits are: ☐ $100,000/$300,000 ***OR*** ☐ $300,000/$900,000

B. I am requesting the **HIGHER** Fund coverage limits of: ☐ $300,000/$900,000 ***OR*** ☐ $800,000/$2,400,000

C. I am requesting this increase in Fund coverage limits for the following reason(s). Must provide a detailed explanation.:

_____

_____

_____

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

☐ Date request received.

OR ☐ Date of next renewal, which is: _____ (MONTH), _____ (DATE), _____ (YEAR).

E. Upon notification by the Fund Board of Governors I will pay any additional surcharge payment for the higher Fund coverage limits I have requested within thirty days of the effective date of the requested higher Fund coverage limits.

F. I understand that the higher Fund coverage limits will not become effective until my request is approved by the Fund Board of Governors. I also understand that changes in Fund coverage apply only to incidents which occur after the effective date of Board approval.

Section III – Statement Regarding Known Claims (You must select one of the two options).

☐ At this time I have no knowledge of any imminent or pending professional liability claims or lawsuits made against me (or the health care provider I represent).

☐ Currently there is an imminent or pending professional liability claim or lawsuit against me (or the health care provider I represent).

Date of the alleged incident (cause of action) _____

Claimant's name _____

_____ _____

SIGNATURE OF HEALTH CARE PROVIDER -- REQUIRED **DATE SIGNED**

HEALTH CARE STABILIZATION FUND OFFICE ADDRESS: 300 SW 8TH AVENUE, 2ND FL, TOPEKA, KANSAS 66603-3912
TELEPHONE: 785-291-3777 FACSIMILE: 785-291-3550 E-MAIL: hcsf@ks.gov