

Kansas Health Care Provider Insurance Availability Act
Non-Resident Health Care Provider Certification Form (January 2022)

A CERTIFICATE OF INSURANCE IS REQUIRED

Section 1 – Health Care Provider Identification and Residency

Health care provider's name:

Last name, first name, middle initial and professional acronym

Legal residence (cannot be
Kansas):

Street address, city, state, zip code, and if not in the United States, the country

Daytime phone number:

Email address:

Mailing address (if different from residence):

Street address, city, state, zip code, and if not in the United States, the country

Section 2 – HCSF Coverage and Health Care Provider Credentials

A. Health Care Stabilization Fund coverage:

HCSF coverage limits

☐ \$500,000/\$1,500,000

B. Statutory credentials:

Kansas licensing agency

Kansas

license number

Professional specialty

HCSF classification group number

Section 3 – Insurance Policy and Information *(certificate of insurance is required for each submission)*

Insurance company name:

Insurance company address:

Street address, city, state, zip code, and if not in the United States, the country

Insurance policy

Type of
coverage:

☐

Claims made

☐

Occurrence

Renewal or effective

Expiration

Section 4 – HCSF Surcharge Calculation

Annual HCSF surcharge selected from surcharge rate tables \$_____ or annual HCSF surcharge calculated based on commercial insurance premium multiplied by HCSF surcharge percent \$_____. Percent of professional practice in Kansas ____% [This ratio may be the result of the number of days for a locum tenens assignment divided by 365 days if the primary policy is short-term (six months or less), or it may be a reasonable estimate comparing the amount of patient care provided in Kansas compared to the health care provider's total professional practice during a twelve month period. The percent should be rounded to the nearest whole number and may not be less than one percent.]

HCSF Premium Surcharge Payable: \$ _____

NOTE: The minimum surcharge payable per compliance period is \$200.

Section 5 – Health Care Provider's Certification

I hereby certify that: (1) I am maintaining a policy of professional liability insurance with limits of not less than \$500,000 per claim and \$1,500,000 annual aggregate coverage in accordance with the Kansas Health Care Provider Insurance Availability Act, (2) the above information is true and correct to the best of my knowledge, and (3) I will notify the HCSF Board of Governors in the event of any changes in my professional liability insurance coverage.

Signature:

Date signed:

HCSF USE ONLY