Health Care Stabilization Fund Request for Refund

Please note that in order to process a refund, an IRS form W-9 must accompany this request. Otherwise a refund cannot be paid.

HCSF ID# (Optional) | Name of Health Care Provider | Kansas License Number

Street Address of Health Care Provider | Telephone Number

City | State | Zip Code | Federal Taxpayer ID# or Social Security#

Contact Person | Email address

INFORMATION REGARDING PROFESSIONAL LIABILITY INSURANCE POLICY

1. Name of Insurance Company:

2. Policy Number:

3. Effective Date:

4. Expiration Date:

5. Date of Midterm Cancellation:

6. Reason For Refund Request:
(e.g., overpayment, cancellation, or class code)

7. Original Premium Amount: $

8. Original Surcharge Amount: $

9. Revised Premium Amount: $

10. Revised Surcharge Amount: $

11. Refund Amount: $

12. Premium & surcharge were financed by:
(Name of Finance Company)

Optional Release of Refund Payment

(Complete this section and an IRS W-9 if you want your refund paid to another person or organization.
An IRS W-9 form for the designated payee must accompany this request.)

Please process my HCSF refund payment to:

Name of Payee | Federal Taxpayer ID #

Address | City | State | Zip Code

If the insured submits the same request, I agree to hold harmless the HCSF Board of Governors and the Health Care Stabilization Fund.

Signature: | **Date:**

WHEN COMPLETED MAIL TO: Kansas Health Care Stabilization Fund, 300 S.W. 8th Avenue, 2nd Floor, Topeka, KS 66603-3912. If signed with a digital signature, this completed form may be attached to an email message addressed to *HCSFrefundrequest@ks.gov*.