Health Care Stabilization Fund Refund Request Directions

The Kansas Department of Administration **requires** an IRS W-9 form for all refunds. The following instructions may be of assistance when seeking a refund from the Health Care Stabilization Fund due to overpayment, a mid-coverage period cancellation or termination, lower rating classification change or other situations that may be eligible to receive a surcharge refund.

- **Minimum Refund** - Pursuant to state law, the minimum refund amount is $5.00.

- **Minimum Surcharge of $200.00** – A minimum $200.00 surcharge **(will not be refunded)** must be retained for each compliance period. The minimum surcharge applies to **all** Fund compliance periods, including short-term policies and surcharge refund adjustments due to mid-term cancellation or termination of existing compliance periods.

- **FEIN Number/Social Security Number -** The federal taxpayer identification number **or** social security number of the person that will be the payee on the refund check is **required**. Unless the payee has already filed an IRS W-9 form with the State of Kansas, we must obtain a completed and signed W-9 form. **If this information is not provided, a refund cannot be processed.**

- **Withholdings -** The State of Kansas withholds any refund amount if other debts, such as back taxes, are owed to the State of Kansas. This is the policy of the State of Kansas, not the Health Care Stabilization Fund.

- **Notice of Cancellation -** A notice of cancellation must be submitted to the HCSF prior to the issuance of any refund request. Cancellations should be sent to HCSFcancellationrequest@ks.gov.

- **Designated Payee -** Surcharge payments are attributed to the individual health care provider. Section 3 must be completed if payment should be refunded to another person or organization.

- **Signature -** A signature is **required** on the refund request form before a refund can be processed.

- In circumstances where a refund request is received before the actual surcharge payment is received, HCSF staff may require additional documentation causing delays in the refund being issued. HCSF class code change & terminations require additional documentation and processing times may be affected.

- Typical processing times are approximately three weeks if the form is properly completed and if all of the supporting documents have been received. Supporting documents include the original coverage document and surcharge payment; a mid-term termination or cancellation notice from the insurance company; a rate classification change document from the insurance company or, a corrected Notice of Basic Coverage Form from the insurance company.

- Expect delays if required information is missing or incomplete.

Important

Information, guidelines and other explanations of the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 et. seq, provided in this document are intended to assist insurers and others in gaining a general understanding of certain features of the law governing the Health Care Stabilization Fund. This document is not intended to alter or replace the statutory requirements or any court decision regarding the Fund law or the administration of any of the requirements of that law.

Note: The Fund law requires that insurers notify the Board of Governors within ten days of canceling a policy at the request of the insured health care provider. If for some reason the notice to the Board is not consistent with the statutory ten-day notice requirement, the refund will be based on the **postmark date of the notice minus ten business days**.

Please contact the HCSF office if you have questions or need additional assistance, at the email address listed below.

Health Care Stabilization Fund
300 SW 8th Ave, 2nd Floor, Topeka, KS 66603
Phone: (785) 291-3777; Fax: (785) 291-3550; Email: HCSFrefundrequest@ks.gov

Refund Request for HCSF Surcharge Payment

(In order to process a refund, an IRS W-9 form must accompany this request.)

Section 1

HCSF ID# (Optional)**:** _____

Health Care Provider's Name: _____ _____ _____
Last Name First Name Kansas License Number

Daytime Phone Number: _____-_____-_____ FEIN Number **or** Social Security Number: _____

HCP Residence: _____ _____ _____ _____ _____
Street Address City State Zip Country if not U.S.

Contact Person: _____ Email address: _____

Section 2

Name of Insurance Company: _____

Insurance Policy Number: _____ Effective Date: _____/_____/_____ Expiration Date: ____/____/_____

Date of Midterm Cancellation: _____/_____/_____ Reason for Refund Request: _____
(e.g., overpayment, cancellation, or class code)

Original Premium Amount: $_____ Original Surcharge Amount: $_____

Revised Premium Amount: $_____ Revised Surcharge Amount: $_____

Refund Amount: $_____

Premium & Surcharge were financed by: _____
Name of Finance Company

Section 3

Optional Release of Refund Payment – Complete this section **only** if you want your refund paid to another person or organization.

Designated Payee: _____ FEIN Number: _____
Name of Payee

Mailing address: _____ _____ _____ _____
Street Address City State Zip

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

(An IRS W-9 form for the designated payee must accompany this request.)

Section 4

Signature (digital signatures are accepted): _____ Date: ____/____/_____
(Refund cannot be processed without a signature.)

Note: 10-day rule - Subsection (a) (2) K.S.A. 40-3402 requires that insurers notify the Board of Governors of cancellation of basic coverage in a timely manner. In the event of late notice of cancellation of basic coverage by an insurer, the Board of Governors will calculate the unearned Health Care Stabilization Fund surcharge based on the date of the notice of cancellation was postmarked minus ten business days.

Cancellation notices need to be sent separately to HCSFcancellationrequest@ks.gov. **Refunds will not be processed until receipt of cancellation notice is received**.

Mail or email completed form with W-9 to address below.

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Phone: (785) 291-3777; Fax: (785) 291-3550; Email: HCSFrefundrequest@ks.gov

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