KANSAS STATE BOARD OF HEALING ARTS
235 SOUTH TOPEKA BOULEVARD - TOPEKA, KANSAS 66603-3068
TELEPHONE (785) 296-7413

RENEWAL APPLICATION FOR MEDICINE AND SURGERY
JULY 1, 2000 TO JUNE 30, 2001

PLEASE REVIEW ALL ENCLOSURES BEFORE COMPLETING APPLICATION. TYPE OR PRINT USING BALLPOINT PEN. INCOMPLETE APPLICATIONS MAY RESULT IN CANCELATION OF LICENSE. COMPLETION OF ALL INFORMATION ON THIS PAGE IS REQUIRED OF ALL LICENSEES REGARDLESS OF LICENSE STATUS. REFER TO INSTRUCTIONS ON THE BACK OF THIS FORM.

1. Kansas Medical License #: 04-21596   2. Office Phone #: (316)688-0107 (785)865-3500 (primary)   3. SSN: (Confidential)
4. Name: NEUHAUS MD ANN K
5. New Mailing Address: ____________
   (if different from address block) Street Address/P.O.Box Suite/Apt.
   City State (and country if not USA) Zip Code + 4
6. Residence Address: (Confidential) Manhattan KS 66502   Residence Phone Number: (Confidential)
   Fax Number: (785) 865-[illegible]
7. Is your mailing address: __Your residence X Your practice, or __Other address?
8. Are you active in medicine and surgery in Kansas at least one hour per week? X Yes ___No
9. Are you currently enrolled in a residency program? ____Yes X No
   If yes, where? ____________
   Institution City State Zip Code
10. Are you retired? ____ Yes X No
11. Please indicate your primary practice specialty using the appropriate code listed on back. Specialty Code 18
12. Please provide street, city, county, state & zip code for each of your practice locations.

1st Location 205 W. 8th Lawrence KS 66044   Phone Number 785-865-3500
Street Address Required (No P.O. Box)
2nd Location 3013 E. Central, Wichita KS 67214   Phone Number 316-688-0107
Street Address Required (No P.O. Box)

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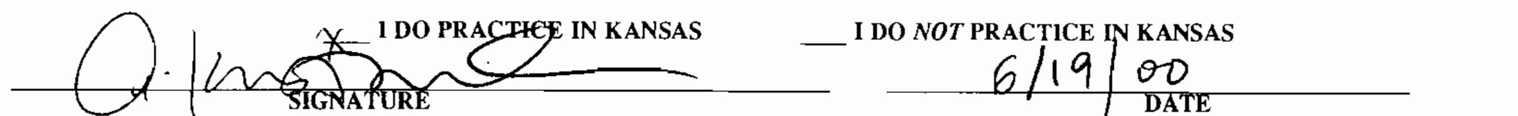
13. YOU ARE REQUIRED TO ATTACH DOCUMENTATION AND A COMPLETE EXPLANATION IF YOUR ANSWER IS "YES" TO ANY OF THESE QUESTIONS. Copied to legal 6/26/00
(a) ___ Yes X No Since May 1, 1999 has any judgment, award or settlement been paid in which you were named resulting from a professional liability Claim?
(b) ___ Yes X No Since May 1, 1999 have you been charged with or convicted of any felony or class A misdemeanor? This includes any plea to a felony or class A misdemeanor.
(c) X Yes ___ No Since May 1, 1999 has any disciplinary action been taken or initiated against you by a state licensing agency or other state or federal agency, or have you surrendered or consented to limitation of license to practice in any state?
(d) ___ Yes X No Since May 1, 1999 have you been denied a license to practice the healing arts or other health care profession?
(e) (Confidential)
(f) (Confidential)

14. PROOF OF MALPRACTICE INSURANCE COVERAGE REQUIRED FOR ACTIVE STATUS ONLY (see instructions on back).

THE INFORMATION PROVIDED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.



X I DO PRACTICE IN KANSAS   ___ I DO *NOT* PRACTICE IN KANSAS

SIGNATURE   6/19/00 DATE

IF 2000 APPEARS IN THE ADDRESS BLOCK, PROOF OF CME HOURS IS DUE WITH THIS RENEWAL FORM.

04-21596 2000 ACT
ANN K NEUHAUS MD
205 W 8TH ST
LAWRENCE KS 66044

✓	106417	3343	0

KANSAS HEALTH CARE STABILIZATION FUND NOTICE OF BASIC COVERAGE FORM

. *The insurance company is required to forward this completed form and HCSF surcharge payment to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the date the insurer receives the basic coverage premium.* A copy of this completed form must also be furnished to the health care provider.

. **Section III** requires the signature of a ***new*** health care provider who is selecting Health Care Stabilization Fund coverage limits for the first time.

For HCSF Use Only

ECTION I Individual Health Care Provider's Name (M.D., D.O., D.C., D.P.M. or R.N.A.) or the name of the health care provider entity (professional association, partnership, hospital or other health care provider organization).

Health Care Provider's Name: NEUHAUS, ANN K.
LAST NAME FIRST NAME MIDDLE INITIAL

Provider's Group Name: ____________

Residence Address: (Confidential)

Phone No. ____________

City: MANHATTAN State: KS Zip: 66502 (Confident

Business Address Of Health Care Provider: 205 W 8TH ST

** MAILING ADDRESS ** LAWRENCE KS 66044 2607

ECTION II For Health Care Providers WHO HAVE PREVIOUSLY SELECTED THEIR HEALTH CARE STABILIZATION FUND COVERAGE LIMITS The previously selected Health Care Stabilization Fund coverage limits are:
$* 300,000 */$ 900,000 *. IF AN INCREASE TO THE PREVIOUSLY SELECTED HEALTH CARE STABILIZATION FUND COVERAGE LIMITS IS DESIRED, A WRITTEN REQUEST TO CHANGE YOUR FUND COVERAGE LIMITS MUST BE SUBMITTED TO THE HEALTH CARE STABILIZATION FUND. Blank copies of the REQUEST TO CHANGE FUND COVERAGE LIMITS form are available from your insurer or the Health Care Stabilization Fund office.*

*ECTION III For **NEW** Health Care Providers Only.* Check one of the following Health Care Stabilization Fund Coverage limits, enter the date signed, completing this section with your signature:

☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

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DATE SIGNED ____________ SIGNATURE OF HEALTH CARE PROVIDER ____________

ECTION IV Insurance Policy Information And Health Care Stabilization Fund Surcharge Payment

					For Fund Classes 1 to 14	For Fund Classes 15 to 21	
HCSF Rate Classification No.	Provider's License, Registration or Certification Number	Basic Coverage Premium Amount	Number of Fund Compliance Years	HCSF Class Group No.	HCSF Surcharge Payment From Rate Tables*	HCSF Surcharge %	HCSF Percentage Based Surcharge Payment
80420	0421596	4,537	5	2	827	%	

The Medical Protective Company
ENTER THE NAME OF INSURANCE COMPANY

Cathy Harris
NAME OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

219 486-0384
PHONE NUMBER

* THE PUBLISHED SURCHARGE RATE FOR FUND CLASSES 1 TO 14 WAS REDUCED BECAUSE THIS HEALTH CARE PROVIDER WAS ISSUED A BASIC PROFESSIONAL LIABILITY INSURANCE POLICY THAT WAS:
- ☐ FOR LESS THAN ONE YEAR AND THE SURCHARGE PAYMENT WAS PRORATED. THE PRORATA FACTOR USED WAS.
- ☐ SUBJECT TO A PART-TIME PRACTICE CREDIT RATING RULE APPROVED FOR USE BY THE BASIC PROFESSIONAL LIABILITY INSURER. THE PART-TIME FACTOR USED WAS:
- ☐ THIS KANSAS RESIDENT HEALTH CARE PROVIDER IS LICENSED AND PRACTICES IN MISSOURI: YES ______ NO X

'olicy Number: 571435

Type of Basic Coverage: ☐ **Occurrence** ☒ **Claims Made**

iception ate: ____________
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

Effective Date: 5/07/2000
ENTER DATE IF PROVIDER WAS ADDED TO AN EXISTING POLICY PERIOD

xpiration ate: 5/07/2001
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

For HCSF Use Only

otice to Health Care Provider: If you should *discontinue* your basic professional liability insurance policy because you are no longer rendering professional services as a ansas resident health care provider, you should immediately contact the Kansas Health Care Stabilization Fund Board of *Governors and request information regarding the vailability of the Health Care Stabilization Fund's continuing coverage for inactive health care providers.*

Fund Surcharge Rating System Agreement Form

Fund Surcharge Rating System Agreement

For Doctors Entering Private Practice After Completing A Kansas Postgraduate Training Program
And who Participated In Outside "Moonlighting" Activities

This is a voluntary agreement to acquire the lowest possible Health Care Stabilization Fund surcharge cost when entering private practice.	Signing this agreement will require the health care provider to attain five years of Health Care Stabilization Fund private practice compliance before becoming eligible for the Fund's inactive health care provider continuing coverage ("tail") without an additional surcharge payment.

I, ______________________________ hereby request that any periods during
(Print or type the name of the health care provider.)
which I engaged in outside moonlighting activities while I participated in an approved postgraduate training program and complied with the Health Care Stabilization Fund are not considered when determining my initial private practice Health Care Stabilization Fund surcharge payment. I further understand that only those Health Care Stabilization Fund compliance periods subsequent to my completion of the approved postgraduate training program will count toward the five year Fund compliance required to be eligible for the continuing coverage ("tail") of the Fund.

______________________________ ______________________________
Date Signed Signature of Health Care Provider

This agreement Form is to be completed and attached to the initial private practice Notice of Basic Coverage Form of the applicable health care provider

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DATE SIGNED SIGNATURE OF HEALTH CARE PROVIDER

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Type of Basic Coverage: ☐ Occurrence ☒ Claims Made

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ENTER DATE IF PROVIDER WAS ADDED TO AN EXISTING POLICY PERIOD

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Attachment 5, Health Care Stabilization Fund Bulletin No. 1999-1
Revised Health Care Stabilization Fund Surcharge Rating Classification System Procedures

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