



**Allied Healthcare Professional (AHP)
Professional Liability Application**

- Medical Professional Mutual Insurance Company
- ProSelect Insurance Company
- ProSelect National Insurance Company, Inc.

PART I - PRODUCER INFORMATION

Agency Name		Submitted By	
Agency License Number	State	Telephone	Most Recent Coverys Policy Number

PART II - APPLICANT INFORMATION

First Name	Middle Initial	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth
Email Address				Website	
Contact Person/Insured Representative				National Provider Identifier	
Office Address One			Residence Address		
Address One			Address One		
Address Two			Address Two		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	
Office Address Two			Mailing Address <i>(if different from office address one)</i>		
Address One			Address One		
Address Two			Address Two		
City	State	Zip	City	State	Zip
Office Address Three			Billing Address <i>(if different from office address one)</i>		
Address One			Address One		
Address Two			Address Two		
City	State	Zip	City	State	Zip

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed	Additional Malpractice Insurance
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there any part of your practice that is covered by any other professional liability? Yes No
 If yes, please provide details and copy of declaration page of policy: _____

Name and location of all healthcare facilities where you have medical staff or courtesy privileges:

Facility Name	City	State	JCAHO Approved?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV - COVERAGE INFORMATION

Type of Coverage (choose one)
 Occurrence Claims Made Retroactive date desired* _____
 Moonlighting Only (When selected, please complete and submit APP 017, Moonlighter Credit Addendum.)
 Coverage Effective Date
 From _____ To _____
 Do you wish to purchase Prior Acts Coverage? Yes No (If yes, please complete and submit APP 015, Prior Acts Application.)

*The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, a 'no known loss' letter is required.

Professional Liability
 Each Claim \$ _____ Annual Aggregate \$ _____

For New Jersey Applicants Only

In accordance with the New Jersey Medical Care Access and Responsibility Patients First Act, you may choose to have a deductible apply to your limit of liability for a premium credit. Deductible amounts range from \$5,000 to \$1 million per claim with an aggregate of three times the per claim amount. Prior to adding a deductible to your policy the deductible must be fully collateralized. Would you like more information on deductibles? Yes No

PART V - EDUCATION

Country	State/Province	School of Graduation	Type of Degree:
			Graduated: (month) _____ (year) _____

List any post-graduate programs completed: _____ Month: _____ Year: _____
 Have you participated in any CEU programs within the last five years? If yes, please attach a description or a copy of a certificate of completion. Yes No
 Which professional organizations are you a member of? ACNM National Nursing State Nursing Other _____
 Are you certified by an approved specialty board? Yes No
 If so, list specialty and attach a copy of the certificate(s): _____ Date Certified: (month) _____ / (year) _____

PART VI - CURRENT PRACTICE

Type of practice: Individual Partnership Solo Corporation Professional Corporation or Association Locum Tenens
Nurse Practitioners only: Do you practice as an employee or are you self-employed? Employee Self-employed

Separate Limit of Liability for Partnership or Corporation
 Not available on solo corporations (except in PA). Current practice must be partnership or corporation. Yes No
 If yes, please complete and submit **APP 008, Partnership & Corporation Professional Liability Application.**

Partnership or Corporation (complete this section)
 Name of Partnership or Corporation _____
 Name of partner(s) or other members _____

If you are employed by others, or perform services on behalf of others as an independent contractor, list the names of those other persons or entities.	Employment Status
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor

Are you covered by the Federal Tort Claims Act? (If yes, please complete and submit APP 024, FTCA Restricted Coverage.) Yes No
 Do you practice less than 21 hours per week in direct patient care services? (If yes, please complete and submit APP 020, Limited Practice Credit.) Yes No
 Do you hold a full time teaching appointment with regular clinical supervision responsibilities? (If yes, please complete and submit APP 021, Academic Credit.) Yes No
 Do you use Locum Tenens? Yes No
 If yes, indicate the number of days per year: _____ days

PART VII - PRACTICE ACTIVITIES

Nurse Practitioners, please indicate your practice activities below:
 ___ Specialize in Adult, Adult Oncology, Family Planning, Geriatric, Gynecology or Women's Healthcare
 ___ Specialize in Psychiatric Care
 ___ Specialize in Acute Critical Care, Family Practice, School Nurse, Pediatric or Neonatal Care
 ___ Specialize in Acute Critical Care OB/GYN, Obstetrics/Gynecology or Perinatal Care
 If your specialty is OB/GYN, are you responsible for any labor or delivery? Yes No N/A
 Do you perform any invasive surgical procedures? Yes No
 If yes, please list procedures: _____
 Do you have a written collaborative agreement with the physician(s) with whom you practice? Yes No N/A

Physician Assistants, please indicate your practice activities below:

___ PA 1: Carry out duties generally performed by a licensed physician and practice under the direction and supervision of a licensed physician to assist in the diagnosis and treatment of patients. No surgical procedures.

___ PA 2: Select if your practice includes any of the following:
 Assist a licensed physician in surgery, have any practice exposure in an operating room other than for observation; practice 10 hours a week or less in trauma/emergency room; provide obstetrical-prenatal or postnatal care only; assist a physician in anesthesiology.

___ PA 3: Select if your practice includes any of the following:
 Assist in surgery; practice 10 hours or more per week in trauma/emergency room; provide obstetrics including prenatal/postnatal care and delivery room responsibilities; have contact or exposure with cardiac catheterization labs; assist in cosmetic/aesthetic procedures.

Does your supervising physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives? Yes No

Do you want employee coverage under separate limits? Yes No

Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. To purchase separate limits for employees under your professional liability coverage for a premium charge, check "Yes" and complete APP 026, Employee Limit of Liability Application.

Nurse Practitioners and Physician Assistants, please answer the following questions:

Have you completed a risk management course in the last 12 months? (If yes, please attach a copy of the certificate) Yes No

Do you or any of your employees perform any type of cosmetic procedures such as Botox, Collagen or dermal filler injections, etc.? Yes No
 (If yes, please complete and submit APP 042, Botox/Cosmetic Procedures Addendum.)

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? Yes No
 (If yes, please complete and submit APP 040, Clinical Trials Addendum)

Do you provide services in a correctional facility? Yes No
 If yes, please list the name of the facility: _____

Do you participate in any telemedicine activities? (If yes, please complete and submit APP 043, Telemedicine Addendum.) Yes No

PART VIII - EMPLOYEES/ADDITIONAL INSURED

Please list the following for any physicians, surgeons or certified nurse midwives you employ. (Use additional space if necessary.) For each employee identified as an independent contractor please complete APP 041, Independent Contractor Addendum.

First Name				
Middle Initial				
Last Name				
Insurer				
Policy #				
Social Security #				
NPI #				
Date of Birth				
Independent Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coverys Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Applying for Coverys Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty				
Surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery
Assisting with Surgery	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Graduation Date	month year	month year	month year	month year
Residency Date	month year	month year	month year	month year
Fellowship Date	month year	month year	month year	month year

If you employ non-physician healthcare providers, please list job category and number of each. If you employ nurses, please specify between RNs, LPNs, Nurse Practitioners, etc.

Job Title/Specialty	Number of Employees

PART IX - HISTORY

(Practice/Claims/Insurance for a minimum of the last 15 years - Start with the most recent, and attach additional sheet if necessary.)

Dates	From	To	From	To	From	To	From	To
Insurer								
Policy #								
Coverage								
Premium								
Tail Purchased	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Retroactive Date								
Limit								
Facility								
State								
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Attach an entire loss history which includes: policy number, claim number, report dates, description of loss and settlement amount.

- Have you ever been denied a nursing license or been denied certification by a specialty board? Yes No
- Has your professional license ever been restricted, suspended, voluntarily surrendered or revoked in any state? Yes No
- Has any hospital ever brought complaints or actions against you such as restriction, suspension, revocation of privileges or probation? Yes No
- Have you ever been involved in or are you aware of any future involvement in an investigation by a regulatory agency or peer review board? Yes No
- Have you ever had a complaint or claim brought against you for sexual misconduct? Yes No
- Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree? Yes No
- Have you ever been indicted and/or convicted of a crime other than minor traffic violations? Yes No
- Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)? Yes No

If you answered yes to any of the above questions, you must provide a detailed written narrative.

- Do you now or have you ever had a drug or alcohol addiction or dependency or sought treatment for such? Yes No

If yes, please accompany this application with a letter outlining dates of treatment, results of treatments, and current status. This letter should be from your treating physician or institution.

- Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? (If yes, please list company, date and reason for this action below.) Yes No

Company _____ Date _____ Reason _____

Company _____ Date _____ Reason _____

PART X - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the company.

- Professional Contractual Liability (not available in PA or VA)** Yes No
Protects you against certain hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance.* There is a charge based on a percentage of your professional liability premium.

- Commercial General Liability** Yes No
Do you wish to purchase Commercial General Liability coverage?
If yes, please complete and submit **APP 007, Commercial General Liability Application.**

- Billing Errors and Omissions** Yes No
Do you wish to purchase Billing Errors and Omissions coverage?
Billing Errors and Omissions Coverage is a claims made coverage which provides a separate limit for claims made by both public and private entities with respect to billing errors.

- For New Jersey Applicants Only - Consent to Settle** Yes No
This endorsement is automatically attached to all individual and group policies. It requires the Company to obtain your written consent before settling any claims brought against you. In accordance with the New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for 1% premium credit to your policy. Would you like to remove this endorsement?

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:

- Copy of current Declaration Page
- Curriculum vitae (C.V.) for applicant and each employed or contracted physician
- Loss runs from all carriers for prior 15 years, or since the start of the practice, whichever is greater
- A narrative of all past claims - a *Claim Information Form* may be used when necessary
- Signed Notice to New Applicants (APP 028 or 029) for claims made policies
- Signed Anti-Fraud Statement (Maine and New Jersey)
- Copies of license to practice and board certification

READ CAREFULLY BEFORE SIGNING

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

**REPRESENTATIONS AS TO ACCURACY OF APPLICATION, THE AUTHORITY OF PERSON SIGNING,
AND APPLICANT'S OBLIGATION TO SUPPLEMENT INFORMATION**

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.*

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NO OBLIGATION TO ISSUE OR PURCHASE INSURANCE

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

AUTHORIZATION TO OBTAIN INFORMATION

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

***MAINE APPLICANTS:** THE COMPANY WILL NOT RESCIND OR VOID ANY POLICY ISSUED IN MAINE DUE TO FRAUD OR A MISREPRESENTATION WITHOUT FIRST OBTAINING A COURT RULING THAT VOIDANCE OR RESCISSION OF THE POLICY IS PERMITTED. HOWEVER, IN THE EVENT OF A MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT IN THIS APPLICATION OR INFORMATION PROVIDED TO US TO OBTAIN INSURANCE, THE COMPANY MAY CANCEL THE POLICY AND/OR DENY COVERAGE FOR ANY CLAIM IF SUCH MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT WAS FRAUDULENT OR MATERIAL.

IN ACCORDANCE WITH 24-A M.R.S.A. 2186(3), IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

MARYLAND APPLICANTS: WE ARE NOTIFYING YOU THAT THE BINDER OR POLICY YOU HAVE JUST AGREED TO PURCHASE IS SUBJECT TO A 45 DAY UNDERWRITING PERIOD BEGINNING ON THE EFFECTIVE DATE OF YOUR COVERAGE. YOUR COVERAGE MAY BE CANCELLED DURING THE UNDERWRITING PERIOD IF YOUR RISK DOES NOT MEET OUR UNDERWRITING STANDARDS. IF WE DECIDE TO CANCEL THE BINDER OR POLICY, WE WILL SEND YOU A WRITTEN NOTICE OF CANCELLATION ADVISING YOU OF THE REASON(S) FOR THE CANCELLATION AND THE DATE ON WHICH YOUR POLICY WILL BE CANCELLED.

ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

***NEW HAMPSHIRE APPLICANTS:** THE COMPANY WILL NOT VOID ANY POLICY OR DENY COVERAGE TO ANY INSURED(S) IN NEW HAMPSHIRE IF THE INSURED(S) HAD NO KNOWLEDGE OF CONCEALMENT, MISREPRESENTATION OR FRAUD. HOWEVER, THE COMPANY WILL NOT COVER ANY CLAIMS AGAINST ONE OR MORE INSUREDS WHO HAS INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS INSURANCE.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

DELAWARE, PENNSYLVANIA, RHODE ISLAND AND OTHER NON-SPECIFIED STATE APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

VIRGINIA APPLICANTS: IN ACCORDANCE WITH VIRGINIA CODE 52-40, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

SIGNATURE OF APPLICANT

TITLE

PRINTED NAME

DATE

SIGNATURE OF PRODUCER (*signature is required for N.H. producers only*)

DATE

PRINTED NAME OF PRODUCER



MEDICAL PROFESSIONAL MUTUAL INSURANCE COMPANY

MHA INSURANCE COMPANY

PROSELECT INSURANCE COMPANY

WASHINGTON CASUALTY COMPANY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE TERMS AND CONDITIONS

WHEREAS, the Standards for Privacy and Security of Individually Identifiable Health Information regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-1329d-8; 42 U.S.C. 1320d-2) and its implementing regulations, as amended by the Health Information Technology for Economic and Clinical Health Act and its implementing regulations, (collectively, "HIPAA") establishes federal requirements for the use, disclosure, and security of individually identifiable health information;

WHEREAS, HIPAA's implementing regulations require health care providers to enter into written agreements or other arrangements with business associate(s) that govern the business associate's use and/or disclosure of individually identifiable health information;

WHEREAS, the Insured, a health care provider, is seeking, or has obtained, insurance coverage from one of the companies identified above (the "Company");

WHEREAS, many states have implemented laws that establish certain requirements governing the protection of personal information of state residents ("Personal Information"), some of which may be applicable to the Company;¹

WHEREAS, in connection with the Insured obtaining or maintaining such insurance coverage, or in connection with the Insured obtaining benefits under such insurance coverage, the Insured may disclose Protected Health Information, including Electronic PHI (each as defined herein), and/or Personal Information to the Company;

WHEREAS, pursuant to HIPAA, the Company's receipt, use, and redisclosure of such Protected Health Information, including Electronic PHI, in connection with providing such insurance coverage and services related thereto is considered a business associate function of the Insured; and

WHEREAS, the Company desires to enter into or amend and restate, as the case may be, a business associate agreement (this "Agreement") in favor of the Insured on the terms and

¹ For example, Massachusetts has laws and regulations governing the protection of Personal Information of its residents (*See M.G.L. c. 93H et seq; 201 CMR 17.00 et seq*). Massachusetts defines Personal Information as a Massachusetts resident's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "Personal information" does not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

conditions set forth herein, pursuant to 45 CFR 164.504(e), to govern the Company's use and disclosure of Protected Health Information, including Electronic PHI, received directly from, or received on behalf of, the Insured.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Company hereto agrees as follows:

1. **Definitions.** Capitalized terms used in this Agreement that are not defined in this Section 1 or elsewhere in this Agreement shall have the respective meanings assigned to such terms in the administrative simplification section of HIPAA and its implementing regulations. The following terms shall have the meanings ascribed thereto for purposes of this Agreement:

“Electronic Media” means the mode of electronic transmissions, and includes the Internet, extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.

“Electronic PHI” means Protected Health Information which is transmitted by Electronic Media or maintained in Electronic Media.

“Insured” means the first named insured and any other insureds as defined under the coverage provided by the Company or the first applicant listed on the application and any other applicants seeking coverage under the same application, provided however, that neither this definition nor this agreement should be construed as an offer of coverage.

“Privacy and Security Standards” means the privacy and security standards contained in HIPAA and all regulations promulgated thereunder, including all applicable requirements contained in 45 C.F.R. Parts 160 and 164 currently in effect or as amended.

“Protected Health Information” means information that:

- (i) relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and (a) identifies the individual, or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and
- (ii) the Company (a) has received from the Insured, or (b) has received on behalf of the Insured.

“Representatives” means with respect to the Company or the Insured, as the case may be, its affiliates, managers, trustees, directors, officers, controlling persons, members, shareholders, employees, producers (including brokers and agents), advisors (including but not limited to accountants, attorneys and financial advisors) and other representatives.

“Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

“Services” include, without limitation, the business management and general administrative activities of the Insured (including the provision of professional liability insurance coverage, placing stop-loss and excess of loss or re-insurance, receiving and evaluating incidents, claims, and lawsuits relating to such insurance coverage, and providing data analyses for the Insured); conducting quality assessment and quality improvement activities, including outcomes evaluation and the development of clinical guidelines and loss prevention tools; reviewing the competence or qualifications of the Insured’s health care professionals; evaluating the Insured’s practitioner and provider performance; conducting training programs to improve the skills of the Insured’s health care practitioners and providers; conducting credentialing activities; conducting or arranging for medical review; arranging for legal services; and resolution of internal grievances.

2. **HIPAA Amendments.** The Company acknowledges and agrees that the Health Information Technology for Economic and Clinical Health Act and its implementing regulations (collectively, “HITECH”) impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the Department of Health and Human Services. The HITECH provisions applicable to business associates will be collectively referred to as the “HITECH BA Provisions.” The provisions of HITECH and the HITECH BA Provisions are hereby incorporated by reference into this Agreement as if set forth in this Agreement in their entirety. Notwithstanding anything to the contrary, the HITECH BA Provisions are automatically effective and incorporated herein: (a) with respect to any security breach notification provision, September 23, 2009; and (b) with respect to the other HITECH BA Provisions, February 17, 2010 or such subsequent date as may be specified in HITECH or applicable final regulations.
3. **Obligations of the Company.** The Company shall not use or disclose Protected Health Information other than as permitted in accordance with the terms of this Agreement.
 - (a) **Permitted Purposes for Use and/or Disclosure of Protected Health Information.** The Company may only:
 - (i) use and/or disclose Protected Health Information in providing the Services to the Insured in connection with the Insured obtaining and maintaining any insurance coverage offered by the Company, including the Insured obtaining any benefits under such insurance coverage; provided that, in connection with the Company’s provision of such Services, the Company shall not, and shall ensure that its Representatives do not, use or disclose Protected Health Information received from the Insured or its Representatives in any manner that would constitute a violation of the Privacy and Security Standards if done by the Insured;
 - (ii) use Protected Health Information for the provision of data aggregation services relating to the health care operations of the Insured;

- (iii) use Protected Health Information for the proper management and administration of the Company;
 - (iv) disclose Protected Health Information to a third party for the Company's proper management and administration, provided that the disclosure is required by law or the Company obtains reasonable assurances from the third party to whom the Protected Health Information is to be disclosed that the third party will (a) protect the confidentiality of the Protected Health Information, (b) only use or further disclose the Protected Health Information as required by law or for the purpose for which the Protected Health Information was disclosed to the third party and (c) notify the Company of any instances of which the person is aware in which the confidentiality of the Protected Health Information has been breached;
 - (v) "de-identify" Protected Health Information or create a "limited data set," and to use "de-identified" information in a manner consistent with and permitted by HIPAA;
 - (vi) use Protected Health Information to carry out the legal responsibilities of the Company;
 - (vii) disclose Protected Health Information as required by law;
 - (viii) to the extent required by the "minimum necessary" requirements of HIPAA, request, use and disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, use or disclosure and, to the extent practicable, omit Direct Identifiers from any request, use or disclosure of Protected Health Information consistent with the HIPAA Limited Data Set standard; and
 - (ix) use and/or disclose Protected Health Information as otherwise agreed to in writing by the Insured.
- (b) **Safeguards Against Misuse of Information.** The Company agrees that it will use appropriate safeguards to prevent the use or disclosure of Protected Health Information in a manner contrary to the terms and conditions of this Agreement and will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic PHI that the Company creates, receives, maintains, or transmits on behalf of the Insured.
- (c) **Reporting of Improper Disclosures of PHI.**
- (i) If the Company becomes aware of a use or disclosure of Protected Health Information in violation of this Agreement by the Company or a third party to which the Company disclosed Protected Health Information, the Company shall report the use or disclosure to the Insured without unreasonable delay.
 - (ii) The Company shall report any Security Incident involving Protected Health Information of which it becomes aware in the following manner:

(a) any actual, successful Security Incident will be reported to the Insured in writing without unreasonable delay, and (b) any attempted, unsuccessful Security Incident directly affecting a system that stores Protected Health Information of which the Company becomes aware will be reported to the Insured orally or in writing on a reasonable basis, as requested by the Insured. If the HIPAA security regulations are amended to remove the requirement to report unsuccessful attempts at unauthorized access, the requirement hereunder to report such unsuccessful attempts will no longer apply as of the effective date of the amendment.

(iii) The Company shall: (a) following the discovery of a Breach of Unsecured Protected Health Information, notify the Insured of the breach without unreasonable delay and in no case later than 60 days after discovery of the breach; and (b) following a breach of Personal Information under any applicable state law, provide any required notifications in accordance with such law.

(d) **Agreements by Third Parties.**

(i) Except as otherwise provided herein, with respect to each agent or subcontractor who (a) performs a Service that the Company has agreed to perform for, or on behalf of, the Insured, and (b) has or will have access to Protected Health Information, the Company shall obtain and maintain an agreement pursuant to which such agent or subcontractor shall agree to be bound by the same types of restrictions, terms and conditions that apply to the Company pursuant to this Agreement with respect to such Protected Health Information.

(ii) With respect to any third party to whom the Company discloses Protected Health Information for a purpose described in Section 3(a)(iii) or 3(a)(v) of this Agreement, the Company shall obtain reasonable assurances from such third party that the Protected Health Information will be held confidentially and will be used or further disclosed only as required by law or for the purpose for which the Company disclosed the Protected Health Information to the third party and that it will implement reasonable and appropriate safeguards to protect it. In addition, such third party shall agree to notify the Company of any instances of which it is aware in which the confidentiality of the information has been breached.

(e) **Access to Information.** In the event that the Company receives a written request by the Insured for access to Protected Health Information, the Company shall, in a timely manner in order to permit the Insured to comply with its obligations under HIPAA, make available to the Insured such Protected Health Information. This obligation shall continue only for so long as such information is maintained by the Company. In the event that any individual requests access to Protected Health Information pertaining to such individual directly from the Company, the Company shall forward such request to the Insured. The provision of access to the individual of such Protected Health Information and/or denial of the same (including the creation and/or maintenance of any notifications and/or documents in connection therewith) shall be the sole responsibility of the Insured.

- (f) **Availability of Protected Health Information for Amendment.** In the event that the Company receives a written request from the Insured for the amendment of an individual's Protected Health Information, the Company shall, in a timely manner in order to permit the Insured to comply with its obligations under HIPAA, make available such Protected Health Information to the Insured. This obligation shall continue only for so long as such information is maintained by the Company. In the event that the Insured agrees to comply with an individual's request to amend such Protected Health Information, the Company shall incorporate any such amendments designated by the Insured. In the event that the Insured denies an individual's request to amend such Protected Health Information, the Company shall incorporate into the Protected Health Information any of the statements and/or documents that the Insured has created or received with respect to such denial; provided that, the Insured has provided the Company with a copy of such statement and/or documents. In the event that any individual requests an amendment to Protected Health Information pertaining to such individual directly from the Company, the Company shall forward such request to the Insured. The determination of whether to amend such Protected Health Information pursuant to an individual's request and/or the denial of such request (including the creation and/or maintenance of any notification and/or creation of documents in connection therewith) shall be the sole responsibility of the Insured.
- (g) **Accounting of Disclosures.** The provisions of this Section 3(g) apply solely to those accountings of disclosures of Protected Health Information that are required of a health care provider pursuant to 45 C.F.R. § 164.528. In the event that the Company receives a written request from the Insured for such an accounting, the Company shall provide the following information to the Insured with respect to each disclosure the Company has made: (a) the date of the disclosure, (b) the name of the entity or person who received the Protected Health Information, and if known, the address of such entity or person, (c) a brief description of the Protected Health Information disclosed, and (d) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure. The Company shall provide such information with respect to each disclosure made for the period of time noted in the Insured's request, which shall not exceed six (6) years from the date of Insured's request. If, during the period covered by the accounting, the Company has made multiple disclosures of Protected Health Information either (a) to the same person or entity, or (b) for a particular research purpose, the accounting information provided to the Insured may be modified as described in 45 CFR 164.528(b)(3) or 45 CFR 164.528(b)(4), as applicable. The Company shall provide such accounting to the Insured in a timely manner in order to permit the Insured to comply with its obligations under HIPAA. In the event that the request for an accounting is delivered directly to the Company, the Company shall forward such request to the Insured. The provision of such accounting of such disclosures to the individual (including the creation and/or maintenance of any notifications and/or documents in connection therewith) shall be the sole responsibility of the Insured.
- (h) **Availability of Books and Records.** Except as otherwise prohibited by law, the Company hereby agrees to make its internal practices, books and records relating to the use and disclosure of Protected Health Information in connection with its obligations under this Agreement available to the Secretary of Health and Human

Services for purposes of determining the Insured's compliance with the Privacy and Security Standards.

- (i) **Use of Limited Data Set.** In the event that the Company receives or creates a limited data set (as defined under HIPAA), then the Company shall only use and disclose such limited data set for research purposes, public health purposes or as otherwise required by law. In addition, the Company shall comply with Section 3(b), Section 3(c), and Section 3(d)(i) of this Agreement in the same manner as though such Sections referenced a limited data set, instead of Protected Health Information. Finally, except as otherwise permitted pursuant to this Agreement, the Company shall not re-identify the limited data set such that the limited data set becomes Protected Health Information and shall not contact any individual who is the subject of the limited data set.
 - (j) **Maintenance of Records.** Subject to Section 7 below, the Company shall maintain all records created pursuant to this Agreement for a period of at least six (6) years from the date of the creation of such records. This Section 3(j) shall survive termination of this Agreement.
4. **Personal Information.** To the extent that the Company has access to Personal Information, the Company agrees that it has implemented and maintains appropriate security measures for the protection of Personal Information in accordance with applicable state laws.
5. **Obligations of the Insured.** The Insured shall have obtained all necessary consents and/or authorizations required under state law to enable the Insured to lawfully disclose the Protected Health Information to the Company and to enable the Company to use and disclose the Protected Health Information in accordance with the terms of this Agreement. In addition, to the extent the Protected Health Information contains any psychotherapy notes (as defined under HIPAA), the Insured agrees to obtain all necessary authorizations to enable the Insured to lawfully disclose the Protected Health Information to the Company and to enable the Company to use and disclose the Protected Health Information in accordance with the terms of this Agreement.
6. **Term and Termination.** This Agreement shall remain in full force and effect until one of the following occurs (each, a "Termination Event"): (a) the Company denies either the Insured's application for insurance coverage or the Insured's application for renewal of insurance coverage; (b) the Company or the Insured terminates the Insured's insurance coverage; (c) the Insured's insurance coverage with the Company expires; or (d) the Insured determines that the Company has breached a material term of this Agreement.
7. **Return or Destruction of Protected Health Information.** After the occurrence of a Termination Event, the Company shall either return or destroy all Protected Health Information, if any, which the Company still maintains. The Company shall not retain any copies of such Protected Health Information. Notwithstanding the foregoing, to the extent that the Company determines it is not feasible to return or destroy such Protected Health Information, the terms and provisions of Section 3 shall survive termination of this Agreement and such Protected Health Information shall be used or disclosed solely for such purpose or purposes which prevented the return or destruction of such Protected Health Information.

IN WITNESS WHEREOF, and intending to be legally bound, the Company affixes its signature below.

A handwritten signature in black ink, consisting of stylized, overlapping loops and a long horizontal line extending to the right.

By: Gregg L. Hanson
Title: Chief Executive Officer