COVERYS®

Healthcare Facility
Application

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

PART I - PRODUCER INFORMATION

Agency Name		Address	Telephone
Agency License Number	State	Federal Tax ID	Email Address

PART II - APPLICANT INFORMATION

Name of Facility	Name of Facility D/B/A
Contact Person	Telephone
Fax	Business Address
Mailing Address	Billing Address, if different
Email Address	Website
Risk Management Contact Person	Telephone

PART III - COVERAGE INFORMATION

Coverage Effective Date

From: _____

To: _____

Coverage Type

- ❑ Occurrence
- ❑ Claims Made

Most Recent Coverys Policy Number

For claims made, enter retroactive date desired _____

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, please complete and submit **APP 015, Prior Acts Professional Liability Addendum** and **APP 028, Notice to New Applicants**

PART IV - LIMITS OF LIABILITY
(Indicate Limits Desired)

Professional Liability

$ _____ Each Claim $ _____ Annual Aggregate

Deductible/Annual Aggregate (*select one*)

❑ 100K/300K ❑ 250K/750K ❑ no annual aggregate ❑ no deductible

❑ Other _____ (note: 100K/300K is the minimum, except in New Jersey)

Self-Insured Retention

❑ Yes ❑ No

Is there a self-insured retention program?
To what line of coverage will a self-insured apply? _____

$ _____ Each Claim $ _____ Aggregate

What organization handles the claims? _____

What legal firm is responsible for defending claims against the insured? _____

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**

Excess/Umbrella Liability

Do you wish to purchase Excess/Umbrella Liability Coverage? ❑ Yes ❑ No

If yes, please complete and submit **APP 022, Excess Medical Professional and Umbrella Liability Application**

PART V - FACILITY INFORMATION

Type of Facility

❑ Hospital-General ❑ Clinic-MD Owned ❑ Laboratory ❑ Other _____
❑ Hospital-Children ❑ Community Health Center ❑ Surgical Center

❑ Hospital-Specialized (*please indicate which below*)
❑ Psychiatric ❑ Teaching ❑ Detox ❑ Geriatric ❑ Rehabilitation ❑ Women's ❑ Other _____

Services

Does the facility own, operate or anticipate acquiring any of the following?

❑ Abortion Clinic
❑ Ambulance
❑ Blood Bank
❑ Burn Unit
❑ Coronary Rescue
❑ Day Care
❑ Dialysis
❑ Dietary
❑ Emergency Center, Freestanding
❑ Gift Shop
❑ Heliport # of landings _____
❑ Inhalation Therapy
❑ Morgue
❑ Nursery
❑ Obstetrical
❑ Open Heart
❑ Pathology
❑ Pharmacy
❑ Physical Fitness Center
❑ Radiation Therapy
❑ Radiology
❑ Robotic Surgery
❑ Self-Care/Wellness
❑ Shock Trauma
❑ Substance Abuse Center, Freestanding
❑ Surgical Center

Which of the following are performed at your facility?

❑ Experimental surgery ❑ Neurosurgery ❑ Open-heart surgery ❑ Weight reduction surgery ❑ Bariatric Surgery

Will any new services be provided in the next 12 months? ❑ Yes ❑ No

Will any services be discontinued in the next 12 months? ❑ Yes ❑ No

Have any services been discontinued in the last 24 months? ❑ Yes ❑ No

If yes to any of the above, provide details _____

Operations/Ownership

❑ Individually Owned ❑ Partnership ❑ Corporate ❑ Municipal ❑ Non-Profit ❑ For Profit ❑ Other _____

Do you have any revenue affiliations (e.g., Joint ventures, PPSs, HMOs, etc.)?
If yes, please provide details:

Name of Entity	**Relationship** (e.g., Joint Venture, Owner, etc.)

Affiliations/Accreditations

❑ JCAHO Accredited Date _____ ❑ Medicare Approved ❑ Member AHA
❑ AAAHC Accredited Date _____
❑ AAASF Accredited Date _____

Please list any medical school affiliations or allied healthcare school affiliations below: _____

_____

Type of Patients (Indicate % of each)

_____ Medical _____ Substance Abuse _____ Surgical _____ Psychiatric

_____ Obstetrical _____ Rehabilitation _____ Long Term _____ Other

Owned Nursing Homes

Do you own a Nursing Home? ❑ Yes ❑ No

Please indicate distance between main hospital facility and nursing home. _____

If coverage is desired, please complete **APP 013, Long-Term Care Facility Professional Liability Application**, and indicate services provided.

Explain any telemedicine activities in which your entity takes part.

_____

_____

PART V - FACILITY INFORMATION (continued)

Clinical Research

Describe the aims and specific objectives of any human clinical trials to be performed and by whom.

_____

_____

_____

Is this research clinical or academic in nature? ❑ Clinical ❑ Academic

What are the risks and potential benefits of the research to the subjects?

_____

_____

_____

What primary coverage is in place for clinical research exposure?

_____

Please provide a copy of the following:

❑ Study protocols ❑ Conflict of interest policy ❑ Patient selection criteria

❑ Informed consent policy ❑ Institutional Review Board Rules and Regulations as they relate to your entity

PART VI - HISTORICAL FACILITY INFORMATION

Beds

For each category below please indicate the **number of available beds** and **number of patient days.**

Facility		**Current Facility Year** Year	**Prior Facility Year** Year	**2 Years Ago** Year	**3 Years Ago** Year	**4 Years Ago** Year	**5 Years Ago** Year
Acute Care	Beds						
	Days						
Bassinets/Cribs	Beds						
	Days						
Clinic	Beds						
	Days						
Extended Care	Beds						
	Days						
ICU/CCU	Beds						
	Days						
Maternity	Beds						
	Days						
Neonatal	Beds						
	Days						
Psychiatric	Beds						
	Days						
Rehabilitation	Beds						
	Days						
Substance Abuse	Beds						
	Days						
TCU	Beds						
	Days						

PART VI - HISTORICAL FACILITY INFORMATION (continued)

Utilization

	Current Facility Year	Prior Facility Year	2 Years Ago	3 Years Ago	4 Years Ago	5 Years Ago
	Year	Year	Year	Year	Year	Year
Outpatient Threshold Visits						
Acute Care						
Clinic						
Community Health Center						
Emergency Room						
Home Health Care						
Psychiatric						
Rehabilitation						
Substance Abuse						
Physician Visits						
Other						
TOTAL						
Inpatient Surgery						
Via Local Anesthesia						
Via IV Sedation						
Via Regional Sedation						
Via General Anesthesia						
TOTAL						
Outpatient Surgery						
Via Local Anesthesia						
Via IV Sedation						
Via Regional Sedation						
Via General Anesthesia						
TOTAL						
Deliveries						
Via Cesarean Section						
Via VBAC						
Vaginal (excluding VBACs)						
TOTAL						
Total Operating Rooms						
Total 3rd Party Lab Receipts						

Third party lab receipts are lab receipts provided on behalf of unaffiliated individuals/entities.

For utilization purposes, please include procedures such as endoscopies and colonoscopies under the appropriate outpatient visits classification, not under surgery.

PART VII - STAFF

Employees: Non-Physician, Non-Dentist (Indicate the number of the following types of employees in your facility)

_____ Lab Technicians _____ Perfusionists _____ Registered Nurses _____ Pharmacists _____ CRNAs
_____ Paramedics/EMTs _____ X-ray Technicians _____ Volunteer Workers _____ Heart-Lung Technicians _____ LPNs
_____ Nurse Practitioners _____ Physician Assistants _____ Students _____ Traveling Nurses

Do you wish to include the individuals listed above as additional insureds sharing in the facility's limit? ❑ Yes ❑ No

Contracted Physicians/Services

Are your physicians/dentists or any other services contracted? ❑ Yes ❑ No

If contracted, name of group/physician(s) _____

How often does the staff work at the entity? _____

Is the staff obligated to follow entity rules and procedures? ❑ Yes ❑ No

Does the staff have the right to refuse patients? ❑ Yes ❑ No

Employed Physicians/Dentists

Indicate the number of employed physicians/dentists in your facility:

Surgeons _____ Physicians _____ Dentists _____ Interns/Externs _____ Residents/Fellows_____

Is coverage to be provided to the individuals listed? ❑ Yes ❑ No

If yes, please complete and submit **APP 001, Physicians and Surgeons Professional Liability Application.**

Do the individuals share the limits? ❑ Yes ❑ No

Do excess limits apply? ❑ Yes ❑ No

Professional Liability Requirements for Physicians/Dentists

Do the medical staff by-laws require each employed or contracted physician or dentist to maintain Professional Liability insurance?
❑ Yes ❑ No

If yes, what are the minimum limits of liability required? _____

How many physicians are credentialed and on staff?_____

How is coverage verified (e.g., Certificate of Insurance required?) _____

Please describe the monitoring system to ensure malpractice policies of physicians are kept current. _____

Has the license of any physician been restricted or suspended in the last two years? ❑ Yes ❑ No

If yes, was the employee employed or contracted? ❑ employed ❑ contracted Name: _____

Have the privileges of any physician been restricted or suspended in the last year? ❑ Yes ❑ No

If yes, was the employee employed or contracted? ❑ employed ❑ contracted Name: _____

Risk Management

Is there a designated Risk Manager? ❑ Yes ❑ No

If yes, please provide a copy of the Risk Manager's C.V. and answer the following:

Does the Risk Manager have support from the board of directors? ❑ Yes ❑ No

Does the Risk Manager have the authority to implement change? ❑ Yes ❑ No

Does the entity have a written Risk Management Program? ❑ Yes ❑ No

If yes, please provide.

PART VIII - SPECIFIC DEPARTMENTS

Anesthesia ❑ Contracted ❑ Employed

If contracted, name of group/physician(s) _____

Are CRNAs always supervised by an anesthesiologist? ❑ Yes ❑ No _____ Number of Anesthesiologists

Are Family Practitioners administering anesthesia? ❑ Yes ❑ No _____ Number of CRNAs

If yes, indicate the number administering anesthesia _____

Obstetrics ❑ Contracted ❑ Employed

If contracted, name of group/physician(s) _____

Total number of OB on staff? _____

Level of OB Unit:

❑ **Level I** is usually categorized as a basic or well-newborn unit. It provides care for low-risk infants born in the hospital and for stable, growing, or recovering infants who are returned to their birth hospital from a Level II or Level III facility. The service must have a professional staff member skilled in neonatal resuscitation on site, and a pediatrician on call 24 hours a day.

❑ **Level II** is usually categorized as a specialty unit. It provides all Level I services and offers specialized services to moderately ill infants either born in the hospital or transferred from Level I facilities. They must provide certain medical specialty and support services including on site, 24 hour coverage by a pediatrician, and specially trained laboratory and radiology staff.

❑ **Level III** is usually categorized as a Perinatal Center and/or Neonatal Intensive Care Unit. It provides services to newborns of all risk levels, including babies with unusual or severe complications and anomalies, in addition to Level I and II services. They offer a comprehensive range of specialty and subspecialty services to maternal and newborn patients at the center, and to others referred to it from Level I or II facilities.

Do family/general practice physicians have OB privileges? ❑ Yes ❑ No

If yes, how many? _____

What is the number of deliveries per individual practitioner? _____

Do midwives practice in labor and delivery? ❑ Yes ❑ No

If yes, are there written protocols for privileges? ❑ Yes ❑ No

Do you follow ACOG guidelines concerning VBACs? ❑ Yes ❑ No

Who provides anesthesia during labor and delivery? _____

Emergency ❑ Contracted ❑ Employed

If contracted, name of group/physician(s) _____

If your facility does not operate an Emergency Room, check here: ❑

If there is no Emergency Department, how does the facility arrange for treatment of trauma patients? _____

_____

If there is a JCAHO accredited Emergency Department, select the level of service provided:

- ❑ Level I (Tertiary)
- ❑ Level II (Comprehensive)
- ❑ Level III (Basic)
- ❑ N/A
- ❑ Other _____

If the Emergency Department is not JCAHO accredited, what is the designated level of service provided? _____

_____

Does the ER have a trauma center designation? (If yes, attach protocol) ❑ Yes ❑ No

Does the ER have a fast track service? ❑ Yes ❑ No

(If yes, who provides care? _____)

Does the Emergency Department have 24 hour in-house physician coverage? ❑ Yes ❑ No

PART IX - PREVIOUS INSURANCE CARRIERS

PROFESSIONAL LIABILITY	YEARS:	YEARS:	YEARS:	YEARS:	YEARS:
CARRIER					
POLICY NUMBER					
POLICY TYPE (select a choice)	❑ CLAIMS MADE ❑ OCCURRENCE	❑ CLAIMS MADE ❑ OCCURRENCE	❑ CLAIMS MADE ❑ OCCURRENCE	❑ CLAIMS MADE ❑ OCCURRENCE	❑ CLAIMS MADE ❑ OCCURRENCE
LIMITS					
RETRO DATE					
PREMIUM PAID					

Has any insurance company ever:

a) declined ? ❑ Yes ❑ No

b) failed to renew ? ❑ Yes ❑ No

c) conditionally renewed ? ❑ Yes ❑ No

d) cancelled your policy ? ❑ Yes ❑ No

If yes to any of the above, please indicate the name of the company, date and brief explanation below.

Name _____ Date _____

Explanation _____

_____

_____

If necessary, attach information for additional companies.

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION FOR ALL FACILITIES:

- ❑ Financial statements for the last two years
- ❑ Copy of brochures and marketing information
- ❑ Copy of contract for contracted physicians/dentists
- ❑ Written procedures for claims handling and risk management
- ❑ Most recent JCAHO survey and the status of any Requirements for Improvements
- ❑ If not insured with Coverys, a complete copy of current policy and endorsements
- ❑ Copy of AAASF or AAAHC accreditation report
- ❑ Copies of hold harmless agreements
- ❑ Minimum of 10 years loss history
- ❑ Copy of AHA Annual Survey
- ❑ Medical staff by-laws
- ❑ Organizational chart
- ❑ Copy of license
- ❑ Schedule of Named Insureds with relationship to applicant
- ❑ Most recent Medicare recertification survey, statement of deficiencies and plan of correction

Self-insured Retention (SIR) Programs Only

Please include these additional documents if applicable:

- ❑ Copy of trust agreement
- ❑ Copy of SIR coverage wording
- ❑ Financial statement of trust fund
- ❑ Most recent actuarial review supporting the funding of the self-insured retention

PART IX - PREVIOUS INSURANCE CARRIERS (continued)

Additional Comments: _____

_____

_____

PART X - OPTIONAL COVERAGES

Billing Errors and Omissions

Do you wish to purchase Billing Errors and Omissions coverage? ❑ Yes ❑ No

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

This endorsement is automatically attached to all healthcare facility policies. It requires the Company to obtain your written consent before settling any claims brought against you. In accordance with New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for a 1% premium credit to your policy.

Would you like to remove this endorsement? ❑ Yes ❑ No

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 BECOVERED 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. THE APPLICANT AGREES 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.

Applicant *(print name of entity)*	Title
By *(signature of duly authorized officer or employee)*	Date
Printed Name of Applicant	
Signature of Producer *(signature is required for N.H. producers only)*	Date
Printed Name of Producer	

COVERYS®

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.

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By: Gregg L. Hanson
Title: Chief Executive Officer