COVERYS®

Physicians and Surgeons
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 ❑ Male ❑ Female	Social Security Number	Date of Birth

Email Address	Website
Contact Person/Insured Representative	**National Provider Identifier**

Office Address One
Percentage of practice: _____
Address One
Address Two
City State Zip
Phone Fax

Residence Address
Address One
Address Two
City State Zip
Phone Fax

Office Address Two
Percentage of practice: _____
Address One
Address Two
City State Zip

Mailing Address
(if different than Office Address One)
Address One
Address Two
City State Zip

Office Address Three
Percentage of practice: _____
Address One
Address Two
City State Zip

Billing Address
(if different than Office Address One)
Address One
Address Two
City State Zip

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed	Additional Malpractice Insurance
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ 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?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ 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)*

Name of location where internship was served:

City: State: Country: Graduated: *(month)* *(year)*

Name of location where residency was served:

City: State: Country: Graduated: *(month)* *(year)*

Name of location where fellowship was served:

City: State: Country: Graduated: *(month)* *(year)*

If foreign medical school graduate, are you certified by the educational council for foreign medical graduates? ❑ Yes ❑ No

Have you participated in any continuing medical education within the last five years? If yes, please attach a description or a copy of a certificate of completion. ❑ Yes ❑ No

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)*

Which professional organizations are you a member of? ❑ AMA ❑ State medical ❑ County medical (list counties): _____

❑ Other _____

PART VI - CURRENT PRACTICE

Type of practice: ❑ Individual ❑ Postgraduate year one (intern) ❑ Resident ❑ Fellow

❑ Partnership ❑ Professional Corporation ❑ Solo Corporation ❑ Locum Tenens

Residents and Fellows *(complete this section)*

Indicate specialty this year

Date program ends *(month)* *(year)*

Separate Limit of Liability for Partnership or Corporation ❑ Yes ❑ No

Not available on solo corporations (except in PA). Current practice must be partnership or corporation.

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
	❑ Employee ❑ Independent Contractor
	❑ Employee ❑ Independent Contractor
	❑ Employee ❑ 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 20 hours or less a week or 80 hours or less a month in direct patient care? ❑ Yes ❑ No

(If yes, please complete and submit APP 020, Limited Practice Credit.)

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

Surgeons, please provide breakdown of surgical activities:

% (Surgery)

_____Abdominal
_____Bariatric
_____Cardiac
_____Colon/Rectal
_____General
_____Gynecology
_____Hand
_____Head/Neck
_____Laparoscopic Surgery
_____Neurosurgery
_____OB/GYN
_____Ophthalmology
_____Orthopedic (incl. spinal surgery)
_____Orthopedic (no spinal surgery)
_____Otorhinolaryngology
_____Plastic
_____Plastic Otorhinolaryngology
_____Podiatric
_____Thoracic
_____Traumatic
_____Urological
_____Vascular

Please state your medical specialty: _____

Indicate below the percentage of time devoted to the following medical activities.

%	%	%
_____Aerospace	_____Hematology/Oncology	_____Otorhinolaryngology
_____Allergy/Immunology	_____Hospitalist	_____Pain Management
_____Anesthesiology	_____Hypnosis	_____Pathology
_____Broncho-esophagology	_____Infectious Disease	_____Pediatrics
_____Cardiovascular	_____Intensive Care (including patients of others)	_____Pharmacology - clinical
_____Dermatology		_____Physiatry/Physical Medicine & Rehab
_____Diabetes	_____Intensivist (hospital based only)	_____Podiatry
_____Emergency Medicine	_____Internal Medicine	_____Psychiatry
_____Endocrinology	_____Neoplastic Disease	_____Psychoanalysis
_____Family Practice (excludes all OB)	_____Nephrology	_____Psychosomatic Medicine
	_____Neurology	_____Public Health
_____Family Practice (includes OB)	_____Nuclear Medicine	_____Pulmonary Diseases
	_____Nutrition	_____Radiation Oncologist
_____Forensic	_____Obstetrics	_____Radiology - diagnostic
_____Gastroenterology	_____OB/GYN	_____Radiology - interventional
_____General Preventive	_____Occupational Medicine	_____Rheumatology
_____Geriatric Medicine	_____Ophthalmology	_____Urgent Care
_____Gynecology	_____Orthopedics (office practice only)	_____Urology
_____Other, specify: _____		

Please list type of Laparoscopic procedures performed: _____

Do you perform robotic surgery? ❑ Yes ❑ No

Have your practice specialties/procedures, etc., changed in the past five years? ❑ Yes ❑ No

Specialty/Procedure	Describe Change	Date of Change

Select one of the following as applicable:

❑ No Surgery - Includes incision of boils and superficial abscess, or suturing of skin or superficial fascia, or Mohs surgery.

❑ Minor Surgery - Includes obstetrical procedures not constituting major surgery, or assisting in major surgery on your own patients. Tonsillectomies and adenoidectomies are considered minor surgery; cesarean sections are considered *major surgery*. If assisting on own patients, indicate average time per month: _____

❑ Major Surgery - Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures, the removal of any gland or organ, and plastic surgery.

❑ Assisting in Major Surgery - On the patients of others. If assisting, indicate the percentage of total practice spent assisting: _____ %
(Do not include if you occasionally assist on an emergency basis.)

All Specialties: Identify the medical techniques/procedures that you perform by indicating the number per month.

_____ Angiography - aortic
_____ Angiography - cerebral, extremity
_____ Arteriography
_____ Catherization: cardiac OR
_____ Insertion of permanent pacemakers
_____ Catherization: arterial, diagnostic, swan ganz, or umbilical OR
_____ Insertion of temporary pacemakers
_____ Circumcisions
_____ Colonoscopy
_____ Cryosurgery - other than use on benign or pre-malignant dermatological lesions
_____ ERCP (Endoscopic retrograde cholangiopancreatography)
_____ Hair transplants
_____ Lasers - ablative
_____ Laser lithotripsy
_____ Liposuction/suction lipectomy
_____ Lymphangiography
_____ Mohs micrographic surgery
_____ Myelography
_____ Needle biopsy - other than liver, breast, kidney, or bone marrow biopsy. Indicate type: _____
_____ Phlebography
_____ Pneumatic or mechanical esophageal dialation (not with bougie or olive)
_____ Polypectomy
_____ Purcutaneous lithotripsy
_____ Radiation therapy
_____ Rigid bronchoscopy
_____ Other: _____
_____ None of the Above

Have you ever performed any of these techniques/procedures in the past five years? ❑ Yes ❑ No

Obstetricians, Family & General Practitioners

Give the number of the following you perform per year

Deliveries: Babies delivered by normal vaginal delivery only: _____ Babies delivered by C-Section: _____

Babies delivered vaginally after a C-Section: _____ C-Section Assists: _____

Are you assisting with C-Sections on patients of others? ❑ Yes ❑ No Are you a laborist only? ❑ Yes ❑ No

Otorhinolaryngologists

Do you perform plastic surgery? ❑ Yes ❑ No Do you perform cosmetic plastic surgery? ❑ Yes ❑ No

If yes, do you do reconstructive or any other plastic surgery procedure in an area of the anatomy other than the ear, nose, throat area? ❑ Yes ❑ No

If yes, please specify or attach an explanation: _____

_____

All Specialties

Do you perform surgical procedures in your office? ❑ Yes ❑ No

Do you own, operate or use surgi-center facilities? ❑ Yes ❑ No

Do you normally staff an emergency room? ❑ Yes ❑ No

If yes, are you board certified in emergency medicine? ❑ Yes ❑ No

Give number of hours in emergency medicine per month: _____ hours

Do you or any of your employees perform Botox or Collagen injections? (If yes, please complete and submit APP 042, Botox/Cosmetic Procedures Addendum.) ❑ Yes ❑ No

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 at a correctional facility? ❑ Yes ❑ No

(If yes, list where: _____)

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

Do you participate on any committees that conduct quality assurance, peer, or utilization review? ❑ Yes ❑ No

(If yes, please complete the chart below.)

Name	City	State	Type of Review
			❑ Quality Assurance ❑ Peer Review ❑ Utilization Review
			❑ Quality Assurance ❑ Peer Review ❑ Utilization Review
			❑ Quality Assurance ❑ Peer Review ❑ Utilization Review

PART VIII- EMPLOYEES/ADDITIONAL INSUREDS

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	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Coverys Insured	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

(continued next page)

Applying for Coverys Coverage	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Specialty				
Surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery
Assisting with Surgery	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ 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

Does any one physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives? ❑ Yes ❑ No

If yes, please submit either a letter outlining practice guidelines or a copy of practice guidelines.

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**.

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	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Retroactive Date				
Limit				
Facility				
State				
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ 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 medical license? ❑ Yes ❑ No

Has your medical license ever been restricted, suspended, voluntarily surrendered or revoked in any state? ❑ Yes ❑ No

Has your DEA certification ever been restricted, suspended, voluntarily surrendered or has probation been invoked? ❑ 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 any local, state or federal investigation or proceeding 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

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

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

Do you know of any pending claims, incidents or activities, including any request for patient records, that might give rise to any claim in the future? ❑ 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.

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)

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. ❑ Yes ❑ No

Commercial General Liability

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

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 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? ❑ Yes ❑ No

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 each physician's 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.

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

***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:** THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN MARYLAND. HOWEVER, COVERAGE WILL NOT BE PROVIDED IF WE DISCOVER CONCEALMENT, MISREPRESENTATION, OR FRAUD. 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.

PENNSYLVANIA AND RHODE ISLAND 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)***	
Printed Name	**Date**

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 Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act and their implementing regulations as amended from time to time (collectively, "HIPAA") establishes federal requirements for the use, disclosure, and security of individually identifiable health information;

WHEREAS, HIPAA requires 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 is a Business Associate of Insured when Company receives, creates, maintains, uses, discloses or transmits Insured's Protected Health Information, including Electronic PHI, on behalf of Insured in the performance of services provided in connection with Company's provision of insurance coverage to 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 conditions set forth herein, pursuant to HIPAA, 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.

[1] For example, many states define Personal Information as 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.

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. The following terms shall have the meanings ascribed thereto for purposes of this Agreement:

"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.

"**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 parties acknowledge and agree that the Health Information Technology for Economic and Clinical Health Act and its implementing regulations impose requirements with respect to privacy, security and breach notification applicable to Business Associates (collectively, the "**HITECH BA Provisions**"). The HITECH BA Provisions and any other future amendments to HIPAA affecting Business Associate agreements are hereby incorporated by reference into this Agreement as if set forth in this Agreement in their entirety, effective on the later of the effective date of this Agreement or such subsequent date as may be specified by HIPAA.

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 shall not use or disclose Protected Health Information received from the Insured in any manner that would constitute a violation of HIPAA if so used or disclosed by the Insured. To the extent that the Company carries out any of the Insureds obligations under the HIPAA privacy standards, the Company shall comply with the requirements of the HIPAA privacy standards that apply to the Insured in the performance of such obligations. 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;

(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

(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. The Company shall comply with the HIPAA Security Rule with respect to Electronic PHI.

(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) **Subcontractors.**

(i) Except as otherwise provided herein, the Company shall enter into a written agreement meeting the requirements of 45 C.F.R. §§ 164.504(e) and 164.314(a) (2) with each Subcontractor (including, without limitation, a Subcontractor that is an agent under applicable law) that creates, receives, maintains or transmits Protected Health Information on behalf of

the Company. The Company shall ensure that the written agreement with each Subcontractor obligates the Subcontractor to comply with restrictions and conditions that are at least as restrictive as the restrictions and conditions that apply to the Company under this Agreement.

(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 about an Individual contained in any Designated Record Set of the Insured maintained by the Company, 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 contained in a Designated Record Set of the Insured maintained by the Company, 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. 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 Administrative Simplification Provisions.

(i) **Use of Limited Data Set.** In the event that the Company receives or creates a limited data set (as described in 45 C.F.R. § 164.514(e)), 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.

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