ProMutualGroup®

# Physicians and Surgeons Professional Liability Application

- ❑ Medical Professional Mutual Insurance Company
- ❑ ProSelect Insurance Company
- ❑ ProSelect National Insurance Company

## PART I - PRODUCER INFORMATION

| Producer Name | | Address | Telephone |
|---|---|---|---|
| Producer License Number | State | Federal Tax ID | Most Recent ProMutual Group Policy Number |

## PART II - APPLICANT INFORMATION

| Name of Applicant ❑ Male ❑ Female | Social Security Number | Date of Birth | Email Address: |
|---|---|---|---|
| | | | Website: |
| Contact Person/Insured Representative | | | Residence Phone: |
| Residence Address City State Zip | | | Residence Fax: |
| Office Address City State Zip | | | Office Phone: |
| | | | Office Fax: |

| Billing Address (if different) | Mailing Address |
|---|---|
| | ❑ Residence ❑ Office ❑ Billing |
| | ❑ Other: _____ |
| Street | Street |
| City State Zip | City State Zip |

## PART III - COVERAGE INFORMATION

Type of Coverage (choose one)

❑ Occurrence ❑ Claims Made Retroactive date desired* _____

❑ Moonlighting Only

Coverage Effective Date

From _____ To _____

Location of primary practice _____ Insurer of primary practice _____

Please attach a copy of your Declarations page with your current or previous primary insurer.
If you are a Resident or Fellow and are seeking moonlighting coverage, include a letter from your program director allowing you to moonlight.

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

## PART IV - LIMITS OF LIABILITY
**(Indicate Limits Desired)**

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
*** Copy of CV is required ***

| School of Graduation (city, state, country) | | Name & Location where internship served |
|---|---|---|
| Degree | Year | Name & Location where residency served |

| If foreign medical school graduate, are you certified by the educational council for foreign medical graduates? ❑ Yes ❑ No | Month/Year residency or fellowship completed _____ / _____ |
|---|---|

## PART V - EDUCATION (continued)
*** Copy of CV is required ***

Have you participated in any continuing medical eduction within the last five years? ❑ Yes ❑ No

If yes, please attach a description or a copy of a certificate of completion.

Are you certified by an approved specialty board? ❑ Yes ❑ No

If so, list specialty and attach a copy of the certificate(s): _____ Date certified: _____ / _____

What professional organizations are you a member of?

❑ AMA ❑ State Medical ❑ County Medical (list counties): _____

❑ Other (indicate): _____

## PART VI - CURRENT PRACTICE

Type of Practice: ❑ Individual ❑ Postgraduate year one (intern) ❑ Resident ❑ Fellow
❑ Partnership ❑ Professional Corporation ❑ Solo Corporation

| Residents and Fellows *(complete this section)* | Partnership or Corporation *(complete this section)* |
|---|---|
| Indicate specialty this year | Name of Partnership or Corporation |
| Date program ends | Name of partner(s) or other members |

Name of Employer

Are you employed full time by the Federal Government or are you in military service? ❑ Yes ❑ No

Do you practice less than 21 hours per week or 80 hours per month in direct patient care services? ❑ Yes ❑ No

Do you hold a full time teaching appointment with regular clinical supervision responsibilities? ❑ Yes ❑ No

Do you use Locum Tenens Physicians? ❑ Yes ❑ No

If yes, indicate number of days per year: _____ days

Please list the following for any physicians, surgeons, or certified nurse midwives you employ.

| Name | Specialty | Surgery Performed None | Minor | Major | Procedures | Independent Contractor |
|---|---|---|---|---|---|---|
| | | | | | | ❑ Yes ❑ No |
| | | | | | | ❑ Yes ❑ No |
| | | | | | | ❑ Yes ❑ No |
| | | | | | | ❑ Yes ❑ No |

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

| Job Title/Specialty | Number of Employees |
|---|---|
| | |
| | |
| | |
| | |

Does any one physician supervise more than two 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.

## PART VII - PRACTICE LOCATION(S)

| License Number/State(s) in which you practice | % of Activities in each state |
|---|---|
| | |
| | |
| | |

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: _____ hrs.

| Name and location of all healthcare facilities where you have medical staff or courtesy privileges: | JCAHO Accredited? |
|---|---|
| | ❑ Yes ❑ No |
| | ❑ Yes ❑ No |
| | ❑ Yes ❑ No |

Do you provide professional services at a correctional facility? ❑ Yes ❑ No

If so, list where _____

## PART VIII - PRACTICE ACTIVITIES

General Surgeons, please provide breakdown of surgical activities:

**% (Surgery)**

_____ Abdominal
_____ Cardiac
_____ Colon/Rectal
_____ General
_____ Gynecology
_____ Hand
_____ Head/Neck
_____ Laparoscopic Surgery*
_____ OB/GYN
_____ Laser Surgery
_____ Orthopedic (incl. spinal surgery)
_____ Orthopedic (no spinal surgery)
_____ Otorhinolaryngology
_____ Plastic
_____ Plastic Otorhinolaryngology
_____ Thoracic
_____ Traumatic
_____ Urological
_____ Vascular

Please state your medical specialty: _____

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

| % | % | % |
|---|---|---|
| _____ Administrative | _____ Hematology/Oncology | _____ Otorhinolaryngology |
| _____ Aerospace | _____ Hospitalist | _____ Pain Management |
| _____ Allergy/Immunology | _____ Hypnosis | _____ Pathology |
| _____ Anesthesiology | _____ Infectious Disease | _____ Pediatrics |
| _____ Broncho-esophagology | _____ Intensive Care (including patients of others) | _____ Pharmacology - clinical |
| _____ Cardiovascular | _____ Internal Medicine | _____ Physiatry |
| _____ Dermatology | _____ Laryngology | _____ Physical Medicine & Rehabilitation |
| _____ Diabetes | _____ Neoplastic Disease | _____ Podiatry |
| _____ Emergency Medicine | _____ Nephrology | _____ Psychiatry |
| _____ Endocrinology | _____ Neurology | _____ Psychoanalysis |
| _____ Family Practice (excludes all OB) | _____ Nuclear Medicine | _____ Psychosomatic Medicine |
| _____ Family Practice (includes prenatal care only) | _____ Nutrition | _____ Public Health |
| _____ Forensic | _____ Obstetrics | _____ Pulmonary Diseases |
| _____ Gastroenterology | _____ OB/GYN | _____ Radiology |
| _____ General Preventive | _____ Occupational Medicine | _____ Radiation Oncologist |
| _____ Geriatric Medicine | _____ Ophthalmology | _____ Rhinology |
| _____ Gynecology | _____ Orthopedics (office practice only) | _____ Urgent Care/Intensivist |
| | _____ Otology/Neurology | _____ Otology/Neurology |
| | _____ Other, Specify: _____ | _____ Urology (office practice only) |

* Please list type of Laparoscopic procedures performed: _____

_____

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

If yes, please explain how the specialty/procedure, etc., has changed and give the dates of changes.

_____

Select one of the following as applicable:

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

❑ 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, plastic surgery, and any operation done using general anesthesia.

❑ 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.)*

## PART VIII - PRACTICE ACTIVITIES (continued)

**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: _____
C-Section Assists: _____
Are you assisting on your own patients or patients of others?
_____

**Otorhinolaryngologists -** Do you:

Perform plastic surgery? ❑ Yes ❑ No
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 _____

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

_____ Angiography
_____ Arteriography
_____ Bariatric Surgery
_____ 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
_____ Laparoscopy (diagnostic)
_____ Lasers - used in therapy
_____ 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)
_____ Radiation Therapy
_____ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae
_____ Other: _____
❑ None of the Above

Have you ever performed any of these techniques/procedures in the past? If yes, please explain: _____
_____

Explain any telemedicine activities in which you take part:
Operating a website? ❑ Yes ❑ No Reviewing charts, films, or other media? ❑ Yes ❑ No
Other: _____

Do you participate on any committees that conduct quality assurance, peer or utilization review? ❑ Yes ❑ No
If yes, is coverage provided by the entity for your medical malpractice insurance? ❑ Yes ❑ No
Name of Entity: _____ Location: _____
What specific duties do you perform on behalf of the entity? _____
_____

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? ❑ Yes ❑ No
If yes, please describe below and provide copies of any protocols and informed consent documents. _____
_____

## 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** | **Insurer** | **Policy #** | **Location** (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

## PART IX - HISTORY (continued)

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 an investigation by a regulatory 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 _____

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.

**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**.

**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 (except in PA). 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**.

This coverage cannot be purchased for employed physicians, surgeons or dentists.

**Professional Contractual Liability (not available in PA)** ❑ Yes ❑ No

Protects you against 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 professional liability premium. No application required; complete section below.

Please list the Health Maintenance Organizations or Managed Care Organizations with which you have signed provider agreements.

_____ _____

_____ _____

_____ _____

## PART X - OPTIONAL COVERAGES (continued)

**Commercial General Liability**

Do you wish to purchase Commercial General Liability coverage? ❑ Yes ❑ No

(A separate application is available for Commercial General Liability. Additional premium is charged for this coverage.)

If yes, please complete and submit **APP 007 Commercial General Liability New Business Application**.

**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 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

***PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:***

- ❑ Copy of current Declaration Page
- ❑ Curriculum vitae (C.V.) for each 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 can be used when necessary*
- ❑ Copies of each physician's license to practice and board certification
- ❑ Signed Notice to New Applicants (APP 028 or 029) for claims made policies
- ❑ Signed Anti-Fraud Statement (Maine and New Jersey)
- ❑ Prior Acts Application (APP 015), if applicable

**NO FACT, CIRCUMSTANCE OR SITUATION INDICATING THE PROBABILITY OF A "CLAIM" OR ACTION AGAINST WHICH INDEMNIFICATION WOULD BE AFFORDED BY THE PROPOSED INSURANCE IS NOW KNOWN BY ANY PERSON OR ENTITY APPLYING FOR THIS INSURANCE OTHER THAN THAT WHICH IS DISCLOSED IN THIS APPLICATION. IT IS AGREED BY ALL CONCERNED, WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE COMPANY, THAT IF ANY PERSON OR ENTITY APPLYING FOR THIS INSURANCE HAS ANY KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY "CLAIM" SUBSEQUENTLY EMANATING THEREFROM SHALL BE EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE AS TO ALL INSURED PERSONS.**

**BY SIGNING THIS APPLICATION, THE APPLICANT CERTIFIES THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF THE APPLICANT'S KNOWLEDGE AND BELIEFS, AND ACKNOWLEDGES THAT PROVIDING TRUTHFUL AND ACCURATE INFORMATION IS A CONDITION PRECEDENT TO OBTAINING THE INSURANCE REQUESTED IN THIS APPLICATION. THE APPLICANT FURTHER ACKNOWLEDGES THAT ANY INSURANCE WHICH MAY BE ISSUED UPON RECEIPT OF THIS APPLICATION WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED, AND IF SUCH INFORMATION IS MISLEADING OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.***

**SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO COMPLETE THE INSURANCE BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS APPLICATION WILL BE PART OF SUCH POLICY, IF ISSUED AND ATTACHED THERETO. THE COMPANY IS HEREBY AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT MAY DEEM NECESSARY.**

**IT IS AGREED THAT IN THE EVENT THERE IS ANY MATERIAL CHANGE IN THE ANSWERS TO THE QUESTIONS CONTAINED HEREIN PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY AND, AT THE SOLE DISCRETION OF THE COMPANY, ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN.**

***NOTICE TO 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, AT ANY TIME INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS INSURANCE.

**NOTICE TO PENNSYLVANIA 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.

Date _____ Signature of Applicant _____

# MEDICAL PROFESSIONAL MUTUAL INSURANCE COMPANY

# PROSELECT INSURANCE COMPANY

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE TERMS AND CONDITIONS

Effective: April 14, 2003, and amended as of April 20, 2005

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) ("HIPAA") establishes federal requirements for the use, disclosure, and security of individually identifiable health information;

WHEREAS, HIPAA's implementing regulations require healthcare 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, 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), 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 in favor of the Insured on the terms and 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 premises 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. 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, brokers, 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. 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 healthcare operations of the Insured;

(iii) use and/or disclose Protected Health Information for the proper management and administration of the Company;

(iv) "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;

(v) use Protected Health Information to carry out the legal responsibilities of the Company;

(vi) disclose Protected Health Information as required by law; and

(vii) 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 as of April 20, 2005 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 Inappropriate Disclosures of Protected Health Information. The Company shall report to the Insured any use or disclosure of Protected Health Information in violation of this Agreement by the Company or its Representatives, in the event that the Company's management becomes aware of such use or disclosure. Effective as of April 20, 2005, the Company shall report to the Insured any Security Incident of which it becomes aware; provided, however, that the timing, content, scope of such reports and reporting shall be as mutually determined by the parties.

(d) Agreements by Third Parties.

(i) With respect to each agent or subcontractor who (1) performs a Service that the Company has agreed to perform for, or on behalf of, the Insured, and (2) 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 2(a)(iii) or 2(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 2(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 (i) to the same person or entity, or (ii) 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 2(b), Section 2(c), and Section 2(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 5 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 2(j) shall survive termination of this Agreement.

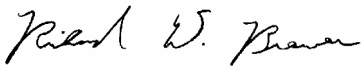
3. Obligations of the Insured. The Insured shall have obtained all necessary consents and/or authorizations required under state law to enable the Insured to

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.

4. 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.

5. 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 2 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.



By: Richard W. Brewer
Title: President & CEO