Send Completed Application to:

Physicians Standard Insurance Company
287 N. Lindbergh Boulevard
St. Louis, MO 63141

Ph.: 314-587-8050 or Toll Free 866-262-4030
Fax: 314-587-8001

www.physiciansstandardinsurance.com

Producer: _____

Agency/Broker: _____

_____

_____

Application for Medical Professional Liability Insurance Claims Made Policy

IMPORTANT: You are applying for CLAIMS MADE COVERAGE. For your own protection, report to your CURRENT insurer BEFORE YOUR CURRENT POLICY EXPIRES ANY:

- Incident which might lead to a claim;
- Request for medical records;
- Unfavorable result in treatment;
- Knowledge of a patient or family member who might consider bringing a claim against you.

THIS APPLICATION AND ANY COMPLETED FORMS SUBMITTED WITH THE APPLICATION WILL BECOME A PART ANY POLICY THAT MAY BE ISSUED

1. Applicant must personally complete this application.
2. Please type or print legibly in black ink.
3. You **MUST** attach a curriculum vitae (CV) to this Application. Your CV will be incorporated into this application and any policy that may be issued.
4. You **MUST** attach the declaration page of your current policy.
5. You **MUST** report all circumstances that might reasonably be expected to result in a claim or suit to Physician Standard Insurance Company (the "Company"), even if you believe that the claim or suit would be without merit.
6. If the applicant or claimant knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for insurance, the applicant is guilty of a crime and may be subject to fines and confinement in prison.
7. **EVERY** question must be answered. If a question does not apply to you, mark it "N/A" (not applicable).
8. If space is insufficient for a complete reply, please attach a separate sheet.
9. Incomplete answers and/or missing attachments may delay the processing of your application.

All of our forms referenced are available on our website: www.physiciansstandardinsurance.com.

This is an Application only. Completion of this Application or its receipt by the Company or agent or broker does not bind the Company to issue a policy to you. Before coverage can be bound or a policy issued, this Application must be approved by the Company's underwriting department and the initial payment must be received by the Company or its agent.

GENERAL INFORMATION

Name of Insured:

_____

First Middle Last M.D./D.O./other

Email: _____

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____

ADDRESSES

Primary Office Address:

_____

Number Street City State Zip County

Mailing Address:

_____

Number Street City State Zip County

Residential Address:

_____

Number Street City State Zip County

TELEPHONE/FAX NUMBERS

Office: ( ) _____ - _____ Office fax: ( ) _____ - _____ Residence: ( ) _____ - _____

Cell: ( ) _____ - _____ Direct Dial: ( ) _____ - _____

Please identify a contact person the Company may contact relating to the information contained in this application as well as future claims or incidents.

Contact Name: _____ Title: _____

Direct Dial Phone Number: ( ) _____ - _____ Email: _____

Please provide the name of all professional and/or medical societies of which you are a member:

_____

EDUCATIONAL BACKGROUND - PLEASE ATTACH A COMPLETE COPY OF YOUR CURRENT C.V.

State(s) where currently licensed:

State _____ License # _____ % of Practice _____

State _____ License # _____ % of Practice _____

State _____ License # _____ % of Practice _____

DEA License #

INFORMATION REGARDING YOUR PRACTICE

A complete and accurate description of the nature of your practice is a condition precedent to coverage under any policy issued as a result of this application. Areas of your practice not fully and accurately described in this application will not be covered by any policy issued as a result of this application.

Are you Board Certified in a Specialty or Subspecialty **(Must be recognized by the American Board of Medical Specialist or the American Osteopathic Association)**?

Specialty _____ % Percent of Practice _____ Board Certified? ☐**Yes** ☐**No**

Subspecialty _____ % Percent of Practice _____ Board Certified? ☐**Yes** ☐**No**

Per Week: # of Hours Worked _____ # Patients _____ **(if less than 20 hours, complete Form G)**

FOREIGN MEDICAL SCHOOL GRADUATES

Are you certified by Education Commission for Foreign Med School Graduates (ECFMG)? ☐**Yes** ☐**No**

Do you hold the foreign equivalent of board certificates? ☐**Yes** ☐**No**

If YES, please explain _____

TYPE OF PRACTICE ☐ Solo ☐ Partnership ☐ Employee ☐ Professional Corp ☐ Independent Contractor

EMPLOYEES/ASSOCIATES

Please provide the information requested below for all medical doctors, doctors of osteopathy, dentists, anesthetists, physicians' assistants, optometrists, clinical psychologists, licensed practical nurses, registered nurses, advanced practice registered nurses (including all nurse practitioners, certified nurse anesthetists, certified nurse midwives and midwives), emergency medical technicians, pharmacists, podiatrists, chiropractors, physical therapists, audiologists, acupuncturists and athletic trainers employed by or associated with you or your group:

Name	Dates of Employment	Present Insurer	Policy Number	Expires

Are any of the individuals listed independent contractors? ☐**Yes** ☐**No**

If YES, do the independent contractors have their own individual coverage? ☐**Yes** ☐**No**

If YES, please provide a certificate of insurance. If NO, describe the coverage arrangements:

_____

CHANGES IN PRACTICE

Have your practice procedures, specialty or location changed in the last ten years? ☐**Yes** ☐**No**

If YES, please explain _____

Changes in practice procedures, specialty or location during the period of any policy issued as a result of this application will not automatically be covered. You must notify the Company of any change in your practice within 30 days of any such change. Changes will not be covered unless endorsed onto the policy.

Please explain any breaks of more than 3 months in your training or practice: _____

COLLABORATIVE AGREEMENTS

Since the Retro Date requested, do you or have you employed or provided supervision to, whether pursuant to a collaborative agreement or other arrangement, any other person (including advanced practice registered nurses and physicians' assistants) licensed, certified or otherwise authorized to provide advanced health care services in the absence of direct supervision by a licensed physician? ☐**Yes** ☐**No**

If YES, and you are seeking coverage for your liability arising out of that agreement or arrangement, please provide the following information for each such person, complete **Form F**, and attach a copy of such agreement or arrangement:

Name	Specialty	Employee	Supervise Only
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

Any policy issued as a result of this application will not provide coverage for collaborative practice agreements or arrangements unless such agreements or arrangements are disclosed to the Company and endorsed onto the policy. If you enter into any such agreement or arrangement after a policy is issued, and you desire coverage for such agreement or arrangement, you must contact your broker prior to entering into such agreement or arrangement to seek an endorsement to the policy.

In the last 5 years:

Do you or have you engaged in any "moonlighting" activity? ☐**Yes** ☐**No**

Do you or have you worked in an "urgent care" center, free-standing emergency center, or similar setting? ☐**Yes** ☐**No**

Do you or have you worked in a free-standing "birthing clinic" or similar facility? ☐**Yes** ☐**No**

Do you or have you functioned as a hospitalist? ☐**Yes** ☐**No**

Do you or have you served on a trauma team? ☐**Yes** ☐**No**

If you answered YES to any of the above questions, please explain (include in explanation the name of entity, location, duties, number of hours worked and whether separate malpractice insurance was provided for such activity):

_____

OTHER AFFILIATIONS

Do you have any affiliations where you practice medicine or have an ownership interest, affiliation, joint venture or other arrangement outside your private office practice? ☐**Yes** ☐**No**

If YES, Name of facility _____ Department _____

Are you: ☐Sole owner ☐Executive officer ☐Partial Owner

☐Department or ancillary service director ☐Administrator ☐Medical Director

☐Physician with teaching responsibilities

Is insurance coverage provided by the entity? ☐**Yes** ☐**No**

Is insurance provided by any entity in which you have a contractual agreement? ☐**Yes** ☐**No**

If NO, is coverage being sought under this policy? If YES, give full details of practice.

_____

_____

_____

_____

PROCEDURES

PLEASE CHECK THE APPROPRIATE BOX, INDICATING THE EXTENT OF SURGERY YOU PERFORM:

☐ No surgery except incisions, boils, cysts, or other superficial abscesses or suturing or minor lacerations

☐ Minor surgery includes most procedures performed under local anesthesia

☐ Assisting in Major Surgery on your own patients # Annually _____

☐ Assisting in Major Surgery on patients other than your own # Annually _____

☐ Major Surgery includes all procedures done under general, spinal or caudal anesthesia, and specifically includes tonsillectomy, appendectomy, D&C cesarean section, abortion and open reduction of fractures

In the past 5 years:
Do you or have you performed any surgery in other non-hospital facilities? **☐Yes ☐No**

If YES, facilities: _____

In the course of any surgery, has general anesthesia been administered: by you? **☐Yes ☐No** by others? **☐Yes ☐No**

PLEASE CHECK THE PROCEDURES, WHICH YOU PERFORM FOR WHICH YOU ARE REQUESTING COVERAGE.
PLEASE CHECK ANY PROCEDURE YOU HAVE PERFORMED IN THE LAST THREE YEARS.

☐ Abortions # ___ of Therapeutic Abortions Practice
over last 12 months
☐ Amniocentesis
☐ Angiography, Angioplasty, Arteriography
☐ Arthroscopy
☐ Spinal Surgery – Please list types and Frequency
_____
_____
_____
_____

☐ Blepharoplasty – Brow Lifts
- ☐ Cosmetic
- ☐ Reconstruction

☐ Breast Implants
- ☐ Cosmetic
- ☐ Reconstruction

☐ Cosmetic Surgery
- ☐ Major
- ☐ Minor

☐ Scar Revisions
☐ Sclerotherapy
☐ Bronchoscopy
☐ Blepharopigmentation
☐ Cardiac Catheterization
Where
- ☐ Right Heart
- ☐ Left Heart

☐ Cataract Surgery
☐ Cryosurgery (other than external lesions
☐ Sigmoidoscopy
- ☐ Less than 60 cm
- ☐ Greater than 60cm
- ☐ Colonoscopy
- ☐ Polypectomy
- ☐ ERCP

☐ Electroconvulsive Therapy

☐ Endoscopy

☐ General Anesthesia
☐ Laparoscopic Procedures
☐ Laser Surgery-Please list types and Procedures
_____
_____
_____
_____

☐ Liposuction
☐ Major Gynecological Surgery
☐ Needle Biopsy
☐ Chelation Therapy
☐ Prescribe Non FDA approved drugs
☐ Nerve blocks
- ☐ Lumbar
- ☐ Epidural
- ☐ Steroid

☐ Paraspinal
- ☐ Sciatic
- ☐ Facet
- ☐ Paravertebral
- ☐ Peripheral
- ☐ Occipital
- ☐ Triggerpoint Injection

☐ Pain Management
☐ Paracentesis
☐ Phlebography
☐ Radial/Laser Keratotomy
☐ Urological Implants
- ☐ Radiation Therapy

☐ Sex-Reassignment Surgery
- ☐ Silicone Injections

☐ Skin Flaps/Grafts
- ☐ Cosmetic
- ☐ Reconstruction

☐ Swan-Ganz Catheterization

☐ Weight Control ____% of

☐ Surgery/Therapy - List Drugs:
_____
_____
_____
_____

☐ Gastric Band
☐ Gastric Stapling
☐ Phenol/Chemical Facial Peel
☐ Diagnostic Embolization
☐ Fracture Reductions
- ☐ Open
- ☐ Close

☐ Tubal Ligations
☐ Vasectomies
☐ Prenatal Practice
- ☐ 1st Trimester
- ☐ 2nd Trimester

☐ 3rd Trimester
- ☐ See Patients but do not perform delivery

☐ Vaginal Obstetric Deliveries___/year
Vag ____ #C-Sect _____

☐ Telemedicine - List Specialty &
_____
_____

☐ Procedures not Customary to Your Specialty. Please list:
_____
_____
_____

CLAIM, INCIDENT AND INSURANCE HISTORY

IMPORTANT: The Company will rely on the accuracy of all statements made in determining whether or not to issue a policy of insurance. Incomplete or incorrect information given by you, in the event of a claim, may lead to the denial of insurance coverage. In addition, any policy issued as a result of this Application will not cover any claims, conduct, circumstances, occurrences, accidents, or medical incidents likely to give rise to a claim which are known to you or which should have been known to you on the date of this application, unless such is endorsed onto the policy.

Have you ever:

a. been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, not renew, or revoke your privileges? ☐**Yes** ☐**No**

b. had your membership in any professional society or association ever been suspended or revoked? ☐**Yes** ☐**No**

c. had your license to practice medicine or your permit to dispense or prescribe drugs been disciplined/limited, suspended, revoked, placed on probation, or been voluntarily surrendered in any state? ☐**Yes** ☐No

d. been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct? ☐**Yes** ☐**No**

e. been charged with or convicted of a felony or misdemeanor other than minor traffic violations? ☐**Yes** ☐**No**

f. been evaluated, treated or hospitalized for any of the following (check if YES):

☐ **alcoholism** ☐ **mental or emotional disorders** ☐ **central nervous system stimulants or depressants** ☐ **drug addiction**

g. had or become aware of having an illness or physical disability which impairs or could impair your ability to practice? ☐**Yes** ☐**No**

If YES, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect your practice.

h. had Medicare/Medicaid fraud charges filed against you? ☐**Yes** ☐**No**

i. been refused board certification? ☐**Yes** ☐**No**

j. been contacted by any hospital committee or group (other than an official peer review committee) that has reviewed (i) any issue regarding your delivery of medical services which you know or should have reason to know was of significant concern to a hospital where you have or had privileges, or (ii) any issue which arose out of any unexpected occurrence involving death or serious physical or psychological injury? ☐**Yes** ☐**No**

If you answered YES to any of the above questions, please explain in the Notes Section of this application.

In the past 10 years, have you ever:

a. been a party to a lawsuit alleging medical malpractice or negligence? ☐**Yes** ☐**No**

b. had a claim for medical malpractice settled on your behalf with or without the filing of a lawsuit? ☐**Yes** ☐**No**

c. received a demand or lien letter from an attorney alleging negligence in care provided to a patient? ☐**Yes** ☐**No**

d. received a demand letter from a patient alleging negligence in care provided to a patient? ☐**Yes** ☐**No**

e. been under punitive or disciplinary observation, preceptorship, or sponsorship in a hospital? ☐**Yes** ☐**No**

f. had a grievance filed against you with any medical society, or have you been censured or received a private reprimand from any such organization? ☐**Yes** ☐**No**

g. signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? (If so, please note the Company excludes indemnifications or hold harmless agreements from coverage under its policies and, accordingly, will not be responsible for any liability incurred under such agreements.) ☐**Yes** ☐**No**

If you answered YES to any of the above questions, please complete Form A for each affirmative answer.

Do you know of any facts or circumstances relating to or arising out of any patient care provided by you or others at your request or referral or direction which could possibly result in a claim being made against you, or your corporation, even if it is only a remote possibility in your mind and even if you believe the claim or suit would be without merit? ☐**Yes** ☐**No**

A complete and accurate description of the procedures you have performed is a condition precedent to coverage under any policy issued as a result of this application. Procedures not fully and accurately described in this application will not be covered by any policy issued as a result of this application.

ANESTHESIOLOGISTS
Please complete **Form E.**

DENTAL RELATED FIELDS
Please complete **Form C.**

PODIATRISTS
Please complete **Form H.**

GENERAL, THORACIC, VASCULAR and CARDIAC SURGERY
Since the Retroactive Date requested, have you performed organ transplants? ☐**Yes** ☐**No**

OBSTETRICS AND GYNECOLOGY
Please complete **Form B.**

OPHTHALMOLOGY
Provide a complete written description of your practice, including all procedures, and complete **Form D.**

POLICY OPTIONS

Retroactive Date Requested for you: ____/____/____ Desired Effective Date: ____/____/____

Limit of Liability Requested for individual applicant – Each medical incident/annual aggregate (check one)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $500,000/$1,000,000
☐ $500,000/$1,500,000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000

Do you want prior acts coverage? ☐**Yes** ☐**No** **If YES,** attach Declaration Page.

If your current policy is, or any previous policies are, claims made, and you cancel the policy without purchasing an extended reporting endorsement (tail coverage), there will be no coverage for any claim from any act or omission that took place during that period of claims made coverage. However, you may apply for a policy with a Retroactive Date back to the first day of your previous claims made policy.

Regarding entities you seek to insure, select one:

☐ Additional insured (no separate limit: no additional premium)
☐ Separate limit of coverage (additional premium required)

Retroactive Date Requested for entity:

Name of Entity: _____ **Retroactive Date:** ____/____/____

Name of Entity: _____ **Retroactive Date:** ____/____/____

Name of Entity: _____ **Retroactive Date:** ____/____/____

Limit of Liability Requested for entities you seek to insure-Each medical incident/annual aggregate (check one)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $500,000/$1,000,000
☐ $500,000/$1,500,000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000

Deductible requested (check one)

☐ None ☐ $5,000 ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $50,000 Other_____

THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF ANY POLICY THAT MAY BE ISSUED.

I hereby declare that my statements in this application and any attachments hereto are true and accurate and complete, and that I have not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application for professional liability insurance. Up to the effective date of the policy for which I am applying, I agree to immediately notify the Company of any information, fact or circumstance that amends, modifies or changes any information contained in this application. I further agree to be bound by the Company's underwriting guidelines.

I hereby state that I acknowledge and understand that the Company has published standard rates for coverage and that, due to underwriting, marketplace, type of practice, area of practice and past history reasons I may not be charged such rate by the Company for coverage and may be charged an increased rate. I hereby acknowledge and consent to such increased rate to be charged by the Company for medical malpractice coverage under the Company Policy.

I hereby authorize the present and prior professional liability insurance carriers and any and all attorneys who have represented me in connection with any claim of professional liability to release to the Company upon its request for information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

I also authorize all medical associations and medical societies in which I am or have been a member, all hospitals in which I now hold or have held staff privileges, the State Board of Medical Examiners for the State of Missouri and any other State in which I have practiced, or resided, and any and all entities and physicians having information regarding me, to release to the Company, upon its request, any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

I hereby release and agree to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I hereby acknowledge that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to me. I agree that I shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and I hereby expressly waive any right I may have to compel such disclosure.

I further agree that the Company and all persons and organizations described above may rely upon a photostatic copy of the foregoing authorization, which shall be of equal validity with the signed original.

I acknowledge that I am responsible for payment of all premiums regardless of whether anyone has agreed to pay premiums on my behalf.

I understand and acknowledge upon acceptance of this application by the Company, this application shall become a part of the Policy and operate as a contract between me and the Company.

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application – regardless of whether or not I am granted insurance – and for the duration of the insurance which may be issued to me: To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, Physicians Standard Insurance Company, Corporate Insurance Services, and all of their respective directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's underwriting committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant. I further acknowledge that acceptance of advance payment does not bind the Company to provide insurance.

I authorize the Company to release and discuss all information contained in this application and any information relating to any future claim or incident to the person I have designated as my contact in this application.

Other than the incidents, events and claims disclosed on Form A attached hereto, since the Retroactive Date requested, there are no circumstances, acts, errors or omissions, known to me or of which I should reasonably be aware which could result in a professional liability claim against me or against any entity of which I am an employee, equity holder, officer or director.

Additional signature is required for the Business Association Agreement, page 11, of this Application.

Signature: _____ **Date:** _____

By my signature, I understand and agree that any policy issued to me will be issued in reliance upon the representations made herein which are warranted to be true and complete. I further understand and agree that failure to provide true and complete responses to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is executed in favor of the Company and shall be effective as of the effective date of any Policy issued by the Company as a result of this Application.

Recitals

The Company and the Insured have an insurer/insured relationship by virtue of a professional liability policy issued by the Company to the Insured (the "Policy"). The Company and the named Insured(s) on the Policy are committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under the Privacy Regulations, the Insured(s) is(are) a "covered entity," and, as defined by 45 C.F.R. § 164.502(e) and 45 C.F.R. § 164.504(e), the Company is a Company of the Insured(s). The Company must use and/or disclose Protected Health Information in its performance of services under the Policy. The Company agrees to abide by the assurances, terms, and conditions contained herein in the performance of its obligations. This Agreement sets forth the manner in which Protected Health Information that is provided to, or received by, the Company, from or on behalf of the Insured(s) will be handled. The Company agrees as follows:

Section 1 Definitions

1.1 ***Company:*** "Company" shall mean Physicians Standard Insurance Company.

1.2 ***Covered Entity:*** "Covered Entity" shall mean the Insured(s) named in the Policy.

1.3 ***Designated Record Set:*** "Designated Record Set" means "Designated Record Set" as defined in 45 C.F.R. § 164.501.

1.4 ***Individual:*** "Individual" shall have the same meaning as the term "Individual" in 45 C.F.R. § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.5 ***Privacy Rule:*** "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts § 160 and § 164, subparts A and E.

1.6 ***Protected Health Information (PHI):*** "Protected Health Information" (PHI) shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 164.501, limited to the information received by the Company from, or on behalf of, Covered Entity.

1.7 ***Required by Law:*** "Required by Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.501.

1.8 ***Secretary:*** "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

Section 2 Obligations and Activities of the Company

The Company agrees to the following:

2.1 ***Not to Use or Disclose PHI Unless Permitted.*** The Company agrees not to use, or further disclose, PHI other than as permitted or required by the Agreement or as Required by Law.

2.2 ***Use Safeguards.*** The Company agrees to use reasonable and appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or as otherwise Required by Law.

2.3 ***Report Inappropriate Disclosures of PHI.*** The Company agrees to report to Covered Entity any use or disclosure of the PHI not permitted by this Agreement or Required by Law of which it becomes aware.

2.4 ***Compliance of Agents.*** The Company agrees to require and ensure that any agents, including subcontractors, to whom it provides PHI received from, or created or received by the Company on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to the Company with respect to such information.

2.5 ***Access.*** To the extent the Company maintains the Designated Record Set, the Company agrees to provide access to PHI in the original Designated Record Set, during normal business hours, provided the Covered Entity delivers prior written notice to the Company, at least five business days in advance, requesting such access but only to the extent required by 45 C.F.R. § 164.524.

2.6 ***Amendments.*** To the extent the Company maintains the Designated Record Set, Company agrees to incorporate any amendment(s) to PHI in the original Designated Record Set that the Covered Entity directs, pursuant to 45 C.F.R. § 164.526.

2.7 ***Disclosure of Practices, Books, and Records.*** Unless otherwise prohibited by law, the Company agrees to make internal practices, books, and records which are directly related to the protection of PHI available to the Covered Entity or to the Secretary, during normal business hours, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule. The Company shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after the Company's receipt of such request.

2.8 ***Accounting.*** The Company agrees to maintain sufficient documentation of any disclosures of PHI and information related to such disclosures as would be required for the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

2.9 ***Release of Documentation of Disclosures.*** The Company agrees to provide to Covered Entity information collected in accordance with Section 2.8 of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R.§ 164.528. The Company shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after the Company's receipt of such request.

2.10 ***Security of Electronic Protected Health Information (EPHI).*** The Company agrees to: (1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains or transmits on behalf of Covered Entity; (2) ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and (3) report to the Covered Entity any security incident of which it becomes aware.

Section 3 **Permitted Uses and Disclosures by the Company**

3.1 ***Use of PHI for Specified Purposes***

Under the Insurance Policy, the Company provides the Covered Entity with insurance products and services, hereinafter "Services" that involve the use and disclosure of PHI as defined by the Privacy Regulations. These Services may include, among others, the provision of professional liability insurance; receiving and evaluating incidents, claims, and lawsuits; quality assessment; quality improvement; loss prevention tools; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of health care practitioners and providers; credentialing, conducting or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance and other functions necessary to perform these Services. Except as otherwise limited in this Agreement, the Company may use or disclose PHI on behalf of, or to provide services to, Covered Entity that are necessary for Company to perform its obligations under this Agreement, under law, and under the Insurance Policy. Moreover, the Company may disclose PHI for the purposes authorized by this Agreement: (i) to its employees, subcontractors, and agents, in accordance with paragraphs Section 3.2 through 3.4 of this Section below; or (ii) as otherwise permitted by the terms of this Agreement. All other uses not authorized by this Agreement are prohibited.

3.2 ***Use of PHI for Company Management and Administration.*** The Company may use PHI for the proper management and administration of the Company or to carry out the legal responsibilities of the Company.

3.3 ***Disclosure Required by Law or With Reasonable Assurances.*** The Company may disclose PHI for the proper management and administration of the Company and to carry out its legal responsibilities, provided that disclosures are Required by Law, or provided that the Company obtains the following reasonable assurances from the person or entity to whom the PHI is disclosed: 1) the PHI will remain confidential; 2) the PHI will be used or further disclosed only as required by law or for the purposes for which it was disclosed; and, 3) the person or entity will notify the Company of any instances of which the person or entity is aware in which the confidentiality of the information has been breached.

3.4 ***Data Aggregation Services.*** Company may use PHI to provide data aggregation services to the Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

Section 4 Impermissible Requests by Covered Entity

The Company understands that the Covered Entity shall not request Company to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except that, despite this Section 4, Company may use or disclose PHI for data aggregation or management and administrative activities of Company as is otherwise permitted by this Agreement.

Section 5 Term and Termination

5.1 ***Term.*** The Term of this Agreement shall be effective during the term of the Insurance Policy between the Company and the Covered Entity, and shall terminate when all of the PHI provided by Covered Entity to Company, or created or received by Company on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

5.2 ***Termination for Cause.*** Upon Covered Entity's knowledge of a material breach by Company of this Agreement, Covered Entity shall provide an opportunity for Company to cure the breach. If Company fails or is unable to cure the breach after a reasonable period of time Covered Entity may terminate this Agreement.

5.3 ***Effect of Termination.*** Upon termination of this Agreement or the Insurance Policy, the protections of this Agreement will remain in force and Company shall make no further uses and disclosures of PHI except for the proper management and administration of its business or to carry out its legal responsibilities or as Required by Law.

Section 6 Miscellaneous Provisions

6.1 ***Regulatory References.*** A reference in this Agreement to a section in the Privacy Rule means the Section in effect or as amended, and for which compliance is required.

6.2 ***Amendment.*** The Company agrees to take such action as is necessary to amend this Agreement from time to time as is necessary, as determined by the Company, for compliance with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

6.3 ***Survival.*** The rights and obligations of the Company under this Agreement shall survive the termination of this Agreement and the termination of the Policy.

6.4 ***Interpretation.*** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

Signature: _____ **Date:** _____

NOTES