

P.O. Box 15275 – Portland, ME 04112-5275
(800) 942-2791 Fax: (207) 523-8320

Please answer all questions fully and completely. If you do not have enough space to provide a full answer, a separate page may be attached.

Agency Name	City, State, Zip Code	Producer
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PART I – APPLICANT INFORMATION

Applicant Name	Employer's Name <small>θ Check if not applicable</small>	
Contact Person	Title of Contact Person	
Mailing Address	Office Telephone	
Physical Location of Practice <small>o Check if same as mailing address</small>	Fax Number	
Billing Address <small>o Check if same as mailing address</small>	E-mail Address	
Home Address	Home Telephone	
Website Address, if applicable		
Date of Birth	Social Security Number	Federal DEA Number
Requested Effective Date <small>12:01 a.m.</small>	Requested Retroactive Date	Federal Tax ID Number

List the states in which you practice, including license numbers, where applicable

State	% of Practice	License Number	Is License Status Active?	
			<input type="radio"/> Yes	<input type="radio"/> No
			<input type="radio"/> Yes	<input type="radio"/> No
			<input type="radio"/> Yes	<input type="radio"/> No
			<input type="radio"/> Yes	<input type="radio"/> No

Please attach photocopies of any applicable medical licenses.

Are you an independent contractor or self-employed? Yes No

Please check your specific professional occupation:

- | | | |
|--|--|---|
| <input type="radio"/> EEG/EKG/Ultrasound | <input type="radio"/> Occupational Therapist | <input type="radio"/> Psychologist |
| <input type="radio"/> Medical Office Assistant | <input type="radio"/> Operating Room/Surgical Technician | <input type="radio"/> Respiratory Therapist |
| <input type="radio"/> Medical Technician/ Phlebotomist | <input type="radio"/> Optometrist | <input type="radio"/> Social Worker |
| <input type="radio"/> Nurse | <input type="radio"/> Paramedic/EMT | <input type="radio"/> X-ray Technician |
| <input type="radio"/> Nurse Anesthetist* | <input type="radio"/> Physical Therapist | <input type="radio"/> Other – Title: _____ |
| <input type="radio"/> Nurse Midwife | <input type="radio"/> Physician/Surgeon Assistant (certificate program only) | |
| <input type="radio"/> Nurse Practitioner | | |

If "Other" is checked, please provide a brief description of your duties (supplemental information or advertising material available explaining duties should be included.) _____

*Nurse Anesthetists, please check one: CRNA Registered Nurse Anesthetist Student Nurse Anesthetist

Check the highest level of education you have completed relating to practice in your field:

- | | | |
|---|---|--|
| <input type="checkbox"/> None Required | <input type="checkbox"/> Masters Degree | <input type="checkbox"/> Post-Doctorate Degree |
| <input type="checkbox"/> Associate Degree | <input type="checkbox"/> Doctorate Degree | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Baccalaureate Degree | | _____ |

Professional School(s) Attended:

If you are board-certified, please give name of board: _____ None

List any professional associations or organizations of which you are a member. Please show complete name and indicate whether local, state, or national organization. Check if none: None

How many hours have you completed in any continuing education for your field within the last three years?

PART II – LIMITS REQUESTED

1. Type of coverage requested (check one):

Applicant wishes to have own set of limits and own individual policy

Applicant wishes to share limits with insured physician/corporation with coverage provided by the physician/corporation policy

2. If you checked that you wish your own set of limits, please indicate limits requested and deductible below:

Primary Limits	Excess Limits	Deductible Requested
<input type="checkbox"/> \$1,000,000 per claim \$3,000,000 annual aggregate <input type="checkbox"/> Other as described: _____ Per claim _____ Per claim	If excess limits are desired, please contact the Company.	Amount Of Deductible <input type="checkbox"/> NONE <input type="checkbox"/> \$5,000 <input type="checkbox"/> 10,000 <input type="checkbox"/> 25,000

PART III – INSURANCE/CLAIMS HISTORY

1. Please list companies carrying your medical professional liability insurance in the past:

Name of company, beginning with current carrier:	Inclusive Dates of Coverage	Reason for changing	Type of Coverage	Reporting Endorsement (tail) purchased?	
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide a copy of current or most recent policy.

2. Do you have knowledge of any incidents in the past which may give rise to a claim being filed in the future which has not been reported to any previous insurance carrier? Yes No

If "Yes," complete "Claim Information" form for each claim, suit, or "incident," regardless of its outcome.

3.	Have you ever been notified of your involvement in a malpractice claim, suit, or "incident," either directly or indirectly? <i>If "Yes," complete "Claim Information" form for each claim, suit, or "incident," regardless of its outcome.</i>	<input type="radio"/> Yes	<input type="radio"/> No
4.	Has any insurer ever cancelled, declined, or modified coverage, i.e., reduced limits, assigned a deductible, restricted coverage, surcharged rates, or refused renewal for any similar coverage?	<input type="radio"/> Yes	<input type="radio"/> No
5.	Have you ever been investigated, disciplined, censured, or reprimanded by a professional society or a board of registration?	<input type="radio"/> Yes	<input type="radio"/> No
6.	Do you have any pending actions by any medical society, board of registration or credentialing body?	<input type="radio"/> Yes	<input type="radio"/> No
7.	Have you ever had your membership in any professional society or association refused, suspended, revoked, or received any criticism or reprimand from any specialty society?	<input type="radio"/> Yes	<input type="radio"/> No
8.	Have your hospital privileges ever been restricted, suspended, revoked, or has any disciplinary action/observation been taken against you?	<input type="radio"/> Yes	<input type="radio"/> No
9.	Has your medical or narcotics license ever been suspended or revoked?	<input type="radio"/> Yes	<input type="radio"/> No
10.	Have you ever been charged with a felony or misdemeanor other than minor traffic offenses?	<input type="radio"/> Yes	<input type="radio"/> No
11.	Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? <i>If "Yes," please submit a letter from your treating physician addressing your state of health and whether any conditions exist that could adversely affect the practice of your medical specialty.</i>	<input type="radio"/> Yes	<input type="radio"/> No
12.	Are you able to perform these functions without significant risk of injury to yourself or others?	<input type="radio"/> Yes	<input type="radio"/> No
13.	Are you currently engaged in the illegal use of drugs?	<input type="radio"/> Yes	<input type="radio"/> No

Please explain all "Yes" answers in the comments section and attach insurance carrier's loss experience for last five years

PART IV - CURRENT PRACTICE

1.	Do you prescribe medication?	<input type="radio"/> Yes	<input type="radio"/> No
2.	Do you perform surgical procedures? If "Yes," please describe: _____ _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
3.	Do you perform any services that might be considered alternative medicine? If "Yes," please describe _____ _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
4.	Do you participate in any peer review or utilization review activities for others? If "Yes," please explain and provide the percent of time you devote to this activity. _____ _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
5.	If you are an owner, operator, partner, administrator, or have a similar capacity for any other health care or related services organization, please identify and explain: _____ _____ _____		

Question 6 for nurse anesthetists only:

6. Where do you provide services? _____
 Who provides medical direction for your activities? _____
 What is the specialty of the individual providing medical direction? _____
 Do you have a written plan of supervision? O Yes O No

Question 7 for nurse midwives only:

7. Where do you provide services? _____
 Who is your direct supervisor? _____
 Who is the physician on-call in case of emergency? _____
 Do you perform VBACs? O Yes O No
 If you answered "Yes" to the above please complete:
 Is anesthesia immediately available? O Yes O No
 Is a surgeon immediately available to perform c-sections? O Yes O No

8. Please list any hospitals, city and state where you currently have staff privileges or are applying for staff privileges.

Facility	City/State	Are privileges active?		Send certificate of insurance?	
		O Yes	O No	O Yes	O No
		O Yes	O No	O Yes	O No
		O Yes	O No	O Yes	O No
		O Yes	O No	O Yes	O No
		O Yes	O No	O Yes	O No

PART V – EMPLOYEES

1. If you have professional employees, please complete Part III. If not, please indicate. O No professional employees
- | 2. Job Categories | Count | Job Categories | Count |
|-------------------|-------|----------------|-------|
| | | | |
3. Do you want coverage for your employees? O Yes O No
 If "Yes," please provide name(s) and title (s) _____

4. Do your employees carry their own professional insurance? O Yes O No
 If "Yes," limits required: _____
5. Do you require proof of such insurance? O Yes O No

CERTIFICATION OF INFORMATION and RELEASE OF INFORMATION

Signing this application does not bind the Company. All information requested in this application is considered material and important so it is critical that you accurately provide the information requested. All statements of the applicant are considered representations and any misrepresentation or the absence of disclosing any material information may be grounds to void the policy. This application will be incorporated by reference to the policy and will become a part thereof.

I hereby authorize any and all medical schools, hospitals, physicians, clinics, insurance companies, public or private corporations or entities, governmental agencies, and licensing authorities to disclose to Medical Mutual Insurance Company of Maine (MMIC) or its representatives any and all information concerning my medical training, practice, competence, experience, character, conduct, judgment, ethics, ability to work with others and other matters which might be of significance for insurance underwriting purposes. I expressly release and discharge all such informants, Medical Mutual Insurance Company of Maine and their agents from any liability of any kind whatsoever in any manner arising from the disclosure of such information.

I further state that I authorize that a photocopy or facsimile of this authorization be accepted with the same authority as the original.

I hereby represent that I am not aware of any fact, circumstance, or situation arising from a medical incident indicating the probability of a claim or action against which coverage is or would be afforded by the insurance for which application is now being made. If I become aware of any such fact, circumstance, or situation, I agree to notify MMIC immediately. I further agree to inform MMIC as soon as possible if I learn that any of the information I have provided in this application was inaccurate at the time or has changed since I completed this application.

I hereby represent that I am not aware of any fact, circumstance or situation, other than as disclosed in this application, that may have a material adverse impact on the risk associated with the insurance for which this application is now being made.

It is understood and agreed by all concerned that if there be any knowledge of such fact, circumstance or situation arising from a medical incident or which may have a material adverse impact on the risk associated with coverage, any claim or action subsequently emanating therefrom shall be excluded from coverage under this insurance policy.

The information requested in this application may require the applicant ("Covered Entity") to disclose protected health information covered by the Health Insurance Portability and Accountability Act (HIPAA), as amended. For the convenience of the Covered Entity, the Company ("Business Associate") has attached a Business Associate Agreement which is incorporated by reference into this application. Business Associate Agrees to use and/or disclose protected health information only in accordance with the attached Business Associate Agreement.

Applicant's Signature

Date

Signature of Employer, if Applicant is an employee

Date

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 a denial of insurance benefits. (Section 2, 24A, §2186, subsection 3, Public Laws, State of Maine)

NAME OF APPLICANT _____

CLAIM INFORMATION

(Please type or print)

1. Name of Patient: _____ 2. Age: _____ 3. Sex: _____
4. Allegation: _____

5. Date of Occurrence: _____
6. Date Reported: _____
7. Insurance Carrier: _____
8. Additional Defendants: _____
9. Location of Occurrence: _____
10. Disposition of Claim: _____
11. Amount of Settlement or Judgment: _____

The following questions should be answered in adequate clinical detail to allow proper evaluation by the Committee on Medical Review. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required.

12. Condition and diagnosis at time of occurrence: _____

13. Dates and description of treatment rendered including your involvement: _____

14. Condition of patient subsequent to treatment: _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Date: _____ Signed: _____

BUSINESS ASSOCIATE AGREEMENT

This Agreement is executed this ___ day of _____, 2008s, by Medical Mutual Insurance Company of Maine ("Business Associate"), a Maine corporation located at One City Center, 9th Floor, Portland, Maine 04101.

WHEREAS, Business Associate's insurance application process requires an applicant to disclose protected health information to Business Associate.

WHEREAS, Business Associate must use and/or disclose protected health information in the evaluation of an applicant's insurance application. Business Associate may, for any reason, decline to issue a professional insurance policy to an applicant.

WHEREAS, an applicant for insurance becomes an insured when Medical Mutual Insurance Company of Maine issues a professional liability insurance policy ("Insurance Policy"). For the convenience of Business Associate, the applicant for insurance, and the insured, this Agreement shall remain in effect and apply to an applicant for insurance ("Covered Entity") and an insured ("Covered Entity").

WHEREAS, Business Associate and its insured have an insurer/insured relationship by virtue of the Insurance Policy.

WHEREAS, Business Associate must use and/or disclose protected health information in its performance of services under the Insurance Policy.

WHEREAS, Business Associate and Covered Entity are committed to complying with the U.S. Department of Health and Human Services ("D.H.H.S.") Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996, including the so-called Privacy Rule and Security Rule codified at 45 C.F.R., Parts 160 and 164, as amended ("HIPAA Privacy Standards"). Under the HIPAA Privacy Standards, the applicant for insurance and the insured are "covered entities" and Medical Mutual Insurance Company of Maine is a "business associate" of the applicant and the insured.

WHEREAS, Business Associate agrees to abide by the assurances, terms and conditions contained herein in the performance of its obligations.

NOW, THEREFORE, Business Associate agrees as follows:

I. PROTECTED HEALTH INFORMATION.

This Agreement shall govern the use and/or disclosure of all protected health information including electronically transmitted or maintained protected health information ("PHI") that Business Associate has obtained from or created on behalf of Covered Entity. The terms business associate, covered entity, designated record set, individual, use, disclosure, security incident, and protected health information shall have the same meaning as set forth in the HIPAA Privacy Standards as amended from time to time.

II. PERMITTED USES.

Business Associate shall keep confidential and shall not use or disclose PHI except as expressly permitted by this Agreement. Business Associate shall use or disclose PHI for the following purposes only:

- A. To evaluate a Covered Entity's application for insurance before issuing an Insurance Policy. Business Associate's use and/or disclosure of PHI on behalf of the Covered Entity who is not an insured, and does not become an insured, is limited to the purpose contained in this paragraph;
- B. To provide insurance products and services ("Services") to the Covered Entity under the Insurance Policy. 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; resolution of internal grievances; placing stop-loss and excess of loss insurance; and other functions necessary to perform these Services. Except as otherwise specified herein, the Business Associate may make any uses of PHI necessary to perform its obligations under this Agreement and under the Insurance Policy. Moreover, the Business Associate may disclose PHI for the purposes authorized by this Agreement, including (i) to its employees, subcontractors, and agents, in accordance with paragraphs Section II.B through II.D of this Section below; and (ii) to others as permitted by the terms of this Agreement, or as otherwise permitted or required by law;
- C. For the proper management and administration of the Business Associate;
- D. To carry out the legal responsibilities of the Business Associate;
- E. To provide data aggregation services relating to the health care operations of Covered Entity.

Provided, however, that Business Associate shall not disclose PHI pursuant to Subsections C and D unless the disclosure is required by law, or Business Associate has obtained reasonable assurances from the person or entity to whom the PHI will be disclosed that: (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 to that person or entity; and (3) the person or entity will notify Business Associate of any instance of which the person or entity is aware in which the confidentiality of the information has been breached.

III. BUSINESS ASSOCIATE'S OBLIGATIONS AND ASSURANCES.

Business Associate hereby assures Covered Entity that it will:

- A. Not use or disclose PHI other than as permitted or required by this Agreement or as permitted or required by law;
- B. Implement appropriate administrative, technical, and physical safeguards to (1) reasonably protect the confidentiality, integrity, security, and availability of PHI obtained from or created on behalf of Covered Entity and (2) prevent a use or disclosure of PHI other than as provided for by this Agreement or as otherwise required or permitted by law;
- C. Report to Covered Entity within a reasonable time after Business Associate becomes aware of a security incident or a use or disclosure of PHI not permitted or required by this Agreement;
- D. Ensure that any agents, including a subcontractor, to whom Business Associate provides PHI, agree to the same restrictions and conditions set forth in this Agreement as they apply to Business Associate, including the implementation of reasonable and appropriate safeguards to

protect PHI, provided that such agents perform a service that Business Associate agreed to perform for, or on behalf of, Covered Entity under the Insurance Policy;

- E. To the extent the Business Associate maintains the Designated Record Set, Business Associate 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 Business Associate, at least five business days in advance, requesting such access but only to the extent required by 45 C.F.R. §164.524;
- F. To the extent the Business Associate maintains the Designated Record Set, Business Associate 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;
- G. Make information available as required to provide an accounting of disclosures, to the extent required by HIPAA Privacy Standards; and
- H. Make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. D.H.H.S. for audit as required by federal law and the HIPAA Privacy Standards.

IV. TERM.

The Term of this Agreement shall be effective on the "compliance date" for the HIPAA Privacy Standards, as amended, and shall remain effective until Business Associate declines to issue the Insurance Policy, or an applicant withdraws its insurance application, or the term of the Insurance Policy expires (so long as the HIPAA Privacy Standards, as amended, require business associate agreements). It shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy the PHI, protections are extended to such information, in accordance with the termination provisions in this Section V.

V. TERMINATION

This Agreement may be terminated by Covered Entity, upon thirty (30) days' advanced written notice of Business Associate's material breach of this Agreement, provided that no such termination notice shall be effective if Business Associate, within the 30 day notice period, cures the breach.

Upon termination of the Agreement, Business Associate shall return all PHI without retaining any copies of such information, or at Covered Entity's option, destroy all PHI, including all copies, and provide Covered Entity with acceptable written confirmation upon completion. In the event that the return or destruction of all PHI is not feasible, Business Associate shall make no further use or disclosure except for those purposes that make the return or destruction infeasible, and Business Associate shall continue to be bound by Sections II, III and VI so long as it retains possession or control of any PHI, or copies thereof.

VI. IMPERMISSIBLE REQUESTS BY COVERED ENTITY.

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

VII. MISCELLANEOUS.

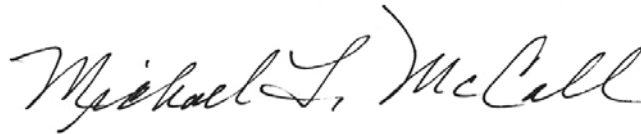
A. HIPAA Compliance: Business Associate has structured the Agreement so as to comply with the HIPAA Privacy Standards, and any ambiguity shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy Standards. Any provision of this Agreement found to be inconsistent therewith will be of no effect and will be severable without affecting the validity or enforceability of the remaining provisions of this Agreement. In the event that any subsequent regulations are promulgated by the D.H.H.S. which would be inconsistent with the structure of this Agreement, Business Associate agrees to take such action as is necessary to amend this Agreement, as determined by Business Associate, for compliance with the HIPAA Privacy Standards.

B. Notices: Any notice or other communication shall be in writing and shall be given, and be deemed to have been given, if mailed, postage prepaid, by certified mail, to the address above or such other address as Business Associate may from time to time designate in writing.

C. Survival: The rights and obligations of Business Associate under this Agreement shall survive the termination of this Agreement and the termination of the Insurance Policy, to the extent required by the HIPAA Privacy Standards, as amended.

IN WITNESS WHEREOF, Business Associate has caused this Agreement to be executed by its duly authorized officer, as of the date first written above.

**MEDICAL MUTUAL INSURANCE
COMPANY OF MAINE**



By: Michael L. McCall
SVP Insurance Operations