

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	Contact Person	
Mailing Address	Title of Contact Person	
	Contact Phone Number	
	E-mail Address	
Billing Address	Fax Number	
	Website Address	
	Federal Tax ID Number	
Physical Location	Type of Business	
	Date Established	Total Number Employees
	Total Annual Gross Receipts	
Requested Effective Date	12:01 a.m.	Requested Retroactive Date

Organization Type (check all that apply)

Individual     Joint Venture     For-Profit     Taxable     Other (describe) \_\_\_\_\_  
 Corporation     Governmental     Charitable     Non-Taxable    \_\_\_\_\_  
 Partnership     Not-For-Profit     Limited Liability Company    \_\_\_\_\_

Please attach a copy of your organizational chart.

Is any part of your company operated or leased by a management corporation?  Yes     No

If "Yes," please give the name of the corporation and details of structure on a separate sheet.

Legal, Corporate or Partnership Names \_\_\_\_\_

Assumed Name(s) or D/B/A(s): \_\_\_\_\_

List all subsidiaries below: <input type="checkbox"/> None	Description of subsidiary operations:	Coverage Effective Date:	Is coverage desired for this subsidiary?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you ever filed for bankruptcy?     Yes     No    If "Yes," when? \_\_\_\_\_ Chapter \_\_\_\_\_

What is your annual payroll? \_\_\_\_\_

Please attach a copy of your latest audited financial statement.

Geographical Area in which you operate: \_\_\_\_\_

Have you sold, acquired, or discontinued any operations in the past five years?  Yes  No  
 If "Yes," please explain on a separate sheet.

Are you considering any changes in operations or products handled in the next 12 months?  Yes  No  
 If "Yes," please explain on a separate sheet.

**PART II - LIMITS & COVERAGE REQUESTED**

	Limits Requested	Deductible Requested
<input type="checkbox"/> \$1,000,000 per claim <input type="checkbox"/> \$3,000,000 annual aggregate	<input type="checkbox"/> Other as described: _____ Per claim _____ Annual Aggregate	<input type="checkbox"/> Amount Of Deductible <input type="checkbox"/> NONE <input type="checkbox"/> \$5,000 <input type="checkbox"/> 10,000 <input type="checkbox"/> 25,000

**PART III – PRACTICE INFORMATION**

1. Do you own, operate or manage a hospital, clinic, pharmacy dispensary or other medical facility?  Yes  No  
 If "Yes," please describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 If "Yes" to the above, who provides coverage? \_\_\_\_\_

2. Please provide a list of each physician member or physician employee on a separate sheet of paper.

3. Do you have any associates?  Yes  No  
 If "Yes," please provide a list of names on a separate sheet of paper.  
 Indicate the extent of your association:  
 Share office and/or employees  
 Share calls  
 Common billings  
 Other (describe): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 If separate practices exist, are patients made aware of this?  Yes  No

4. Please indicate the number of non-physician employees:  
Please provide names and dates of hire for each individual below  
(continue on separate sheet if necessary)

Nurse Practitioners	_____	_____
Nurse Anesthetists	_____	_____
Nurse Midwives	_____	_____
Optometrists	_____	_____
Physicians Assistants	_____	_____
Other (describe)	_____	_____

Please submit copies of current certificates/licenses for all nurse practitioners, nurse anesthetists, nurse midwives, optometrists and physician assistants listed above. Also include doctor's supervisory certificate.

5. Please indicate the number of employees:

Registered Nurses	_____	Technicians	_____
Licensed Practical Nurses	_____	Pharmacists	_____
Other (describe)	_____		_____
	_____		_____



## CERTIFICATION 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.

I agree that I will notify Medical Mutual Insurance Company of Maine, in writing, within five (5) days of receiving any written notice of any adverse action, including, without limitation, any filed and served malpractice suit or arbitration action; the receipt of a Notice of Claim, any final adverse action taken or report made to the National Practitioner Data Bank as defined under the Healthcare Quality Improvement Act of 1986, any report made to the Healthcare Integrity and Protection Data Bank, any notice that I have been placed on the OIG excluded list, any temporary restraining order or interim suspension order sought or obtained in connection with my professional services, any public letter of reprimand, or any form of restriction, probation, suspension or revocation of licensure, membership, or clinical privileges by any healthcare entity; any revocation of my DEA license, a conviction for any crime, any action against my certification under the Medicare or Medicaid programs; or any cancellations, non-renewal or material reduction in medical liability insurance policy coverage.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

## BUSINESS ASSOCIATE AGREEMENT

This Agreement is executed this \_\_\_ day of \_\_\_\_\_, 2008, by Medical Mutual Insurance Company of Maine ("Business Associate"), a Maine corporation located at One City Center, 9<sup>th</sup> 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.**

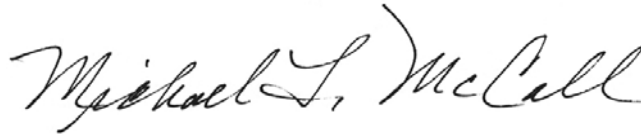
**A. HIPAA Compliance:** Business Associate has structured the Agreement so as to comply with the HIPAA Privacy Standards, and any ambiguity shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy Standards. Any provision of this Agreement found to be inconsistent 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**



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By: Michael L. McCall  
SVP Insurance Operations