Medical Mutual Insurance Company of MAINE

ALLIED HEALTHCARE PROFESSIONAL AND GENERAL LIABILITY INSURANCE APPLICATION

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

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: o None	Description of subsidiary operations:	Coverage Effective Date:	Is coverage desired for this subsidiary?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Have you ever filed for bankruptcy? o Yes o 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? If "Yes," please explain on a separate sheet. ☐ Yes ☐ No

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

PART II – ACCREDITATIONS, CERTIFICATIONS AND LICENSURE

1. Accreditations and Certifications (Check any and all that apply)

☐ Medicaid Certified*
☐ Medicare Certified*
☐ Licensed/Approved by State Board of Health*
*If Not, please explain in the Comment Section
☐ NCQA
☐ AABB
☐ CAP
☐ CARF
☐ CHAP

☐ Accredited by JCAHO
Date of Accreditation ____________
Duration of Accreditation ________
____
Please attach copy of report

☐ Conditional Accreditation by JCAHO
If conditional accreditation, please attach a copy of any Type 1 recommendations made at the last accreditation visit.

Other (describe) ________________

2. List all licenses held by your facility, including type and expiration dates:

License	Type of License	Expiration Date

3. Has your license ever been suspended, revoked or placed under probation? If "Yes," provide details in the Comment Section. ☐ Yes ☐ No

4. Are you currently being investigated for any actions that may result in suspension, revocation or probation of your license? ☐ Yes ☐ No

5. Memberships in Professional Organizations (please include membership number if applicable):

☐ AHA # ☐ AOHA # ☐ HIDA #
☐ FAH # ☐ NAHC #
Other (describe) ________________

PART III - RISK MANAGEMENT/QUALITY ASSURANCE

1. Do you have a formal written Quality Assurance and Risk Management Program in place? If "Yes," please attach. ☐ Yes ☐ No

   If "No," please explain: ____________________

2. Is the overall responsibility for Risk Management activities assigned to one individual in your organization? ☐ Yes ☐ No

   If "Yes," please list name and title: ____________________

   If "No," please describe how these functions are monitored: ____________________

3. Do you conduct patient/client surveys? (If "Yes," please attach a sample.) ☐ Yes ☐ No

4. Are the results of patient/client surveys used to improve day-to-day operations? ☐ Yes ☐ No

5. Is an "informed consent" document placed in the patient's medical record? ☐ Yes ☐ No

PART IV - HIRING/SCREENING AND EMPLOYMENT PROCEDURES

1.	Are employees'/contractors' references contacted before being hired/placed?	☐ Yes ☐ No
2.	Do you verify certification and/or professional licensure status of employees and independent contractors?	☐ Yes ☐ No
3.	How are references checked? ☐ Written ☐ Verbal ☐ Both If verbal only, please explain: ______	
4.	Do you check references of previous employers?	☐ Yes ☐ No
5.	Do you check personal references?	☐ Yes ☐ No
6.	Do you screen prospective employees for criminal records? If "No," please explain: ______	☐ Yes ☐ No
7.	Do you screen employees to rule out drug, alcohol and sexual abuse?	☐ Yes ☐ No
8.	Do you verify the following when hiring professionals and clinical support staff to provide patient care services at your facility (please explain any "No" answers on the Comments page.	
	• Check of educational background, or residency program, when applicable.	☐ Yes ☐ No
	• Confirm hospital privileges for physicians, oral surgeons and dentists. How often do you update your list of specific privileges? ______	☐ Yes ☐ No
	• Confirm that they have no pending license suspensions or revocations, or any pending disciplinary actions by other facilities.	☐ Yes ☐ No
	• Require information on any medical professional liability or work-related claim that has previously been made against any individual	☐ Yes ☐ No
9.	If an individual has had a previous medical professional claim, describe how this would affect your hiring of that person.______	
10.	What training do you provide for new paraprofessionals (e.g., aides)?______	
11.	Are all medical staff members required to maintain professional liability coverage?	☐ Yes ☐ No
12.	Is there such a requirement stated in the staff bylaws?	☐ Yes ☐ No
13.	What limits of liability are required? ______	
14.	What evidence of compliance is required? ______	
15.	For whom do you have written job descriptions? o Professionals o Paraprofessionals	
16.	In the past 12 months, what percentage of your nursing staff was provided by a staffing agency? ______	

PART V – CONTRACTUAL AGREEMENTS

1.	Do you enter into any contractual agreements (e.g., with hospitals, nursing homes or other health care facilities)?	☐ Yes ☐ No
	a. If "Yes," please list and attach copies of all agreements:______	
	b. Do these agreements contain a hold harmless or indemnification clause favorable to the applicant?	☐ Yes ☐ No

2. If the facility has any contracted professional services performed as shown below, please check and indicate the minimum professional liability limits required.

	Limit		Limit
☐ Anesthesiology	$________	☐ Respiratory Therapy	$________
☐ Home Health Care	________	☐ Emergency Room	________
☐ Lab/Pathology	________	☐ Other professional services	________
☐ Pharmacy	________	________	
☐ Physical/Occupational Therapy	________	________	
☐ Radiology/Nuclear Medicine	________	________	

Please submit a copy of each contract

3. Do you lease any equipment from others? ☐ Yes ☐ No

If "Yes," please list: ________________________________

____

4. Who services the equipment listed above? ________________________________

____

Do you service any of the equipment yourself? ☐ Yes ☐ No

How often is the equipment serviced? ________________________________

Do you indemnify (hold harmless) the owner for liability? ☐ Yes ☐ No

If "Yes," is it a mutual hold harmless agreement? ☐ Yes ☐ No

If "No," please explain for each on a separate sheet.

5. Are certificates of insurance obtained from all subcontractors? ☐ Yes ☐ No

Please provide a list of all subcontractors

6. Are there any other service contracts in effect? ☐ Yes ☐ No

If "Yes," please describe services: ________________________________

____

____

Do you indemnify (hold harmless) the service provider? ☐ Yes ☐ No

If "Yes," please submit a copy of the contract.

7. Do you have any contract(s) to provide management services to other facilities? ☐ Yes ☐ No

If "Yes," please provide name(s) and address(es) and a copy of each contract.

8. Does another facility or entity provide management services to you? ☐ Yes ☐ No

If "Yes," please provide name(s) and address(es) and a copy of each contract.

9. List all entities to be named as Additional Insureds, including names and insurable interest.

Please attach a copy of each contractual agreement (excluding agreements with landlords.)

________________ Name	________________ Name
________________ Address	________________ Address
________________ Insurable Interest	________________ Insurable Interest

PART VI – LOCATION OF SERVICES

1. Are any professional services provided on your premises? ☐ Yes ☐ No

   If "Yes," please explain: ______________________________

2. Are any bed or board or overnight services provided? ☐ Yes ☐ No

   If "Yes," please explain: ______________________________

3. Location where services are provided (%) – total must equal 100%

☐	Private Homes	______ %	☐	Clinics	______ %
☐	Nursing Homes	______ %	☐	Doctor's Office	______ %
☐	Hospitals	______ %	☐	Other Locations (please specify) ______________	______ %

4. Types of services provided (%) – total must equal 100%

☐	Personal Care, Chore or Companion	______ %	☐	Radiation Therapy	______ %
☐	Rehabilitation	______ %	☐	Skilled Nursing Care	______ %
☐	Infusion Therapy	______ %	☐	Training Consultants	______ %
☐	Hospice	______ %	☐	Infant Care	______ %
☐	Supplemental Staffing (Complete section IX below)	______ %	☐	Pediatric Care	______ %
☐	Obstetrical Services	______ %	☐	Retail Pharmacy	______ %
☐	Adult Day Care	______ %	☐	Closed Pharmacy	______ %
☐	Child Day Care	______ %	☐	Clinics Owned/Operated	______ %
☐	Medical Equipment Supplier	______ %	☐	Other Services (please specify)	______ %
☐	Meals on Wheels	______ %		______________	______ %
☐	Respiratory Therapy – trach care / ventilator care (please circle)	______ %		______________	______ %

PART VII – SERVICES PROVIDED

1. Do you provide any "high tech" services (i.e., trach care, ventilator care, chemotherapy, etc.)? ☐ Yes ☐ No

   If "Yes," please explain: ______________________________

2. SERVICES PROVIDED:

   Directions: Check each box that applies; also please provide requested information for each classification. Provide projected information for next 12 months.

   Visits: Use a threshold count. Count each patient each time they enter your facility for health related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.

   Beds: Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.

   Annual Receipts: This figure can be found on your financial statement. Do not adjust this figure for items such as profit, uncollectible amounts or amounts billed but not paid by third party payors.

2. SERVICES PROVIDED: (continued)

Counseling/Rehabilitation	Visits	Beds
☐ Cardiac Rehabilitation	______	______
☐ Developmental Disability	______	______
☐ Mental Health/Counseling	______	______
☐ Physical or Occupational Rehab	______	______
☐ Substance Abuse		
Counseling	______	______
Residential	______	______
Skilled Medical Services	______	______
☐ Trauma Rehabilitation		
Therapy	______	______
Transitional Living	______	______
Skilled Medical	______	______
☐ Weight Loss Center	______	______

Surgical Center	Visits	Beds
☐ Birthing Center	______	______
☐ Emergicenter	______	______
☐ Surgicenter	______	______

*Home Care/Hospice	Visits	Beds
☐ Hospice Care	______	______
☐ Intravenous Therapy	______	______
☐ Personal/Companion Care	______	______
☐ Rehabilitation Therapy	______	______
☐ Respiratory Therapy	______	______
☐ Skilled Care	______	______
☐ Durable Equipment	______	______
☐ Other	______	______

Treatment	Visits	Beds
☐ College or University Health Ctr.	______	______
☐ Crisis Stabilization	______	______
☐ Dialysis	______	______
☐ Health Department	______	______
☐ Urgicenter	______	______
☐ Infirmary	______	______

Other

☐ Day Care – Number of Attendees ______

☐ Adult Day Care – Number of Attendees ______

Laboratory	Annual Receipts
☐ Dental	______
☐ Medical	______
☐ Ocular	______
☐ Optical Establishment	______
☐ Pathology	______
☐ Pharmaceutical	______
☐ Pharmacy	______
☐ Quality Control/Reference	______
☐ Research/Development	______
☐ X-Ray/Imaging Center	______
☐ Durable Medical Equipment	______
☐ Pharmacy within Home Health Agency	______

Organ-Blood Tissue	Annual Receipts
☐ Organ or Tissue Procurement (No Direct Processing or Contact)	______
☐ Organ or Tissue Procurement (Direct Processing or Contact)	______

For the following services, describe your operations in the "Other" section below

Schools for Health Care Professionals

	# Students		# Students
☐ Dental	______	☐ Optometry	______
☐ Medical	______	☐ Other	______
☐ Nursing	______		

Ambulance Companies

Do you operate a helipad? ☐ Yes ☐ No

Staff

☐ Air Ambulance

# of Helicopters & Planes _______

☐ Ambulance Service Company

# of Vehicles _______

Other: ____

If "Other" is selected, please attach a separate page with a complete description of operations.

*If you provide Home Health Care, what is the annual payroll of the employees providing this care? ________________

SECTION VIII– EMPLOYED AND CONTRACTED PHYSICIANS, SURGEONS AND OTHER PROFESSIONAL EMPLOYEES

1. Please provide total number in each category.

Position		Employed	Contracted			Employed	Contracted
a.	Dentists*	______	______	o.	Other Employees	______	______
b.	Employed Physicians*	______	______	p.	Paramedics	______	______
c.	Employed Surgeons*	______	______	q.	Pharmacists	______	______
d.	Externs*	______	______	r.	Physicians Assistants*	______	______
e.	Heart-Lung Technicians	______	______	s.	Podiatrists*	______	______
f.	Interns*	______	______	t.	Psychologists	______	______
g.	Lab Technicians	______	______	u.	Registered Nurses	______	______
h.	LPNs	______	______	v.	Residents*	______	______
i.	Mental Health Counselors	______	______	w.	Respiratory Therapists	______	______
j.	Nurse Anesthetists* (CRNAs)	______	______	x.	Social Workers	______	______
k.	Nurse Midwives*	______	______	y.	Student Nurses	______	______
l.	Nurse Practitioners*	______	______	z.	Teaching Doctors*	______	______
m.	Occupational Therapists	______	______	aa.	X-ray technicians	______	______
n.	Chiropractors*	______	______		Volunteers	______	______

* If coverage is requested for any of the above categories, please provide a listing of names and specialties, including date of hire. Individual applications are required if coverage is requested

2. ANESTHESIA SERVICES

a. Anesthesia Department staffing is by:

☐ Employed Physicians ☐ Contracted Physicians ☐ Residents ☐ Certified Registered Nurse Anesthetists (CRNAs)

b. Are all physicians board certified/eligible? ☐ Yes ☐ No

If "No," please explain ____

____

c. If under contract, to whom is staffing contracted? ____

d. Are contracted physicians required to carry professional liability insurance? ☐ Yes ☐ No

If "Yes," what limits are required? ____

Do you obtain a certificate of insurance? ☐ Yes ☐ No

e. Describe the minimum qualifications required for administration of general anesthesia:

____

____

____

f. Is an anesthesiologist immediately available on a 24 hour basis? ☐ Yes ☐ No

If "No," please explain:

____

____

g. Do CRNAs provide anesthesia services? ☐ Yes ☐ No

If "Yes," are they: Employed by you? ☐ Yes ☐ No

Employed by the Anesthesiologist? ☐ Yes ☐ No

Employed by the Surgeon? ☐ Yes ☐ No

Independent? ☐ Yes ☐ No

h. Do CRNAs work under the medical direction of an anesthesiologist? ☐ Yes ☐ No

If "No," please submit written guidelines for supervision

3. RADIOLOGY SERVICES

a. Radiology Department staffing is by:

☐ Employed Physicians ☐ Contracted Physicians ☐ Residents

b. Are all physicians board certified eligible? ☐ Yes ☐ No

If "No," please explain ______________________________

____

c. If under contract, to whom is staffing contracted? ______________________________

d. Are contracted physicians required to carry professional liability insurance? ☐ Yes ☐ No

If "Yes," what limits are required? ______________________________

Do you obtain a certificate of insurance? ☐ Yes ☐ No

e. Please state the number of X-ray machines owned or operated and whether they are used for diagnosis, or treatment or both. Please state by whom the treatment is given:

____

____

____

PART IX - SUPPLEMENTAL STAFFING (Providing health care providers to other facilities for a fee)

Do you provide supplemental staffing? ☐ Yes ☐ No

If "Yes," please indicate below locations where services are provided (%) – total must equal 100%

☐ Nursing Homes ______ %

☐ Hospitals ______ %

☐ Clinics ______ %

☐ Physicians' Offices ______ %

☐ Other Facilities (please specify) ______________________________ ______ %

☐ Other Facilities (please specify) ______________________________ ______ %

TOTAL: 100%

PART X - PREMISES

1. List all buildings owned, controlled or occupied by you. Where mixed features exist for a building, please list wings, floors, or areas separately. Extended care areas should be separately described. Attach separate page if more space is needed.

Location (address, city, state)	Owned or Leased?	Use	Year Built	# of Stories	Type (Brick, Fire Resistive, etc.)	Complete Sprinkler System	Area (Total Sq. Feet)
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

2.	Does your facility meet applicable NFPA building codes? If "No," provide comments in the Comment Section.	☐ Yes ☐ No
3.	Do you anticipate any new construction during the next 12 months? If "Yes," purpose: ____________________ Estimated cost $ ____________________ Estimated completion date: ____________________	☐ Yes ☐ No
4.	Smoke detectors and automatic sprinkler system: If you answered "No" to any question regarding "Complete Sprinkler System" (Question 1, above), please complete below. Please attach a separate page for multiple locations. Location of smoke detectors: ☐ None ☐ Entire Facility ☐ Common Areas ☐ Hallways ☐ Patient or Resident Rooms ☐ Other - Location: ____________________ Areas protected by approved automatic sprinkler system: ☐ None ☐ Entire Facility ☐ Common Areas ☐ Hallways ☐ Patient or Resident Rooms ☐ Other - Location: ____________________ ☐ Soiled Linen Chutes & Rooms ☐ Trash Collection Area	
5.	When was this building's electric, heating and plumbing systems last inspected or updated? Please attach a separate page for multiple buildings.	

	Electric	Heating	Plumbing
Qualified Inspection			
Replaced or Updated			

When was this building last inspected by the:
Local fire authorities* ____________________ (Month/Year) State Department of Health* ____________________ (Month/Year)

*Please submit a copy of the most recent reports of inspection.

6.	Are there at least two exits, located remotely from each other, on each floor and fire section?	☐ Yes ☐ No
7.	Do you have an auxiliary electrical supply system? If "No," describe the type and location of any other electrical supply system in this building ____________________ ____________________ ____________________	☐ Yes ☐ No
8.	Was this building originally designed and constructed for the type of occupancy that currently exists? If "No," what was the original building occupancy? ____________________	☐ Yes ☐ No
9.	Are handrails provided in hallways and bathrooms?	☐ Yes ☐ No
10.	Are bathtubs/showers equipped with nonslip surfaces?	☐ Yes ☐ No
11.	Are all skilled and intermediate care patient beds equipped with siderails?	☐ Yes ☐ No
12.	Total square feet of patient/visitor pay parking areas: ____________ sq. ft.	
13.	Is there a heliport on premises?	☐ Yes ☐ No

PART XI – INSURANCE/CLAIMS HISTORY

1. LIABILITY COVERAGE, e.g., Professional Liability, Directors & Officers, Errors and Omissions, Stop Loss or Provider Excess, Fiduciary, Crime, Employment Practices Liability (complete with current through last five years.):

Type of coverage	Insurance Carrier	Limits of Liability	Deductible	Effective Dates	Annual Premium	Claims Made or Occurrence (check one)	Retroactive Date (Claims Made Only)
						☐ Claims Made ☐ Occurrence	
						☐ Claims Made ☐ Occurrence	
						☐ Claims Made ☐ Occurrence	
						☐ Claims Made ☐ Occurrence	
						☐ Claims Made ☐ Occurrence	
						☐ Claims Made ☐ Occurrence	
						☐ Claims Made ☐ Occurrence	
						☐ Claims Made ☐ Occurrence	

2. GENERAL LIABILITY COVERAGE, current through last five years:

Insurance Carrier	Limits of Liability	Deductible	Effective Dates	Annual Premium	Claims Made or Occurrence (check one)	Retroactive Date (Claims Made Only)
					☐ Claims Made ☐ Occurrence	
					☐ Claims Made ☐ Occurrence	
					☐ Claims Made ☐ Occurrence	

3. Please provide details of self-insurance and reinsurance currently in force (If none, so state.):___________________

____

____

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

5. Have you ever been notified of your involvement in a malpractice claim, suit, or "incident," either directly or indirectly? ☐ Yes ☐ No

6. Please provide information regarding each professional or general liability claim or suit during the last five years. Include any claims that you are aware of that might be made against you or activities that might give rise to a claim or suit in the future. (Include any non-billing or non-record transfer related requests for medical records.)

   a. If a current valued loss experience summary is available from present or previous carriers, please attach a copy.

   b. If a summary is not available, attach a separate page showing the following for each claim:

   - Name of the insurance company
   - Date of the event and date the claim was reported to the insurance company
   - Description (cause) of the loss or claim
   - Location of loss
   - Current status (e.g., closed with payment, closed with no payment, pending, dismissed)

   Paid amount for closed claims or current reserve amount, if known, for open claims

7. Has any insurance company or Lloyd's syndicate declined, canceled, or refused to renew any of your liability insurance? If "Yes," please explain in the attached Comments Section. ☐ Yes ☐ No

PART XII - LIMITS AND DEDUCTIBLES

1. LIABILITY LIMITS:
   Limits Requested (Professional and general liability limits must be the same.)
   - ☐ $1,000,000 Each Person (Each Event)/$3,000,000 Annual Total
   - ☐ $________________________Each Person (Each Event)/$ ____________________Annual Total

2. DEDUCTIBLES:

☐ No deductible	☐ $5,000	☐ $20,000	☐ OTHER:
☐ $1,000	☐ $10,000	☐ $25,000	$ ____________________
☐ $2,500	☐ $15,000		

   NOTE: Deductibles apply separately to the professional and general liability coverages.

   Do you want the deductible to apply to both indemnity and expense? ☐ Yes ☐ No

3. EXCESS LIABILITY LIMIT: Medical Mutual also provides limits above $1,000,000. If excess coverage is desired, please complete an ACORD Excess Liability Application.
   Auto: MINIMUM REQUIRED LIMIT: $1,000,000 combined single limit.
   Employers Liability: MINIMUM REQUIRED LIMIT: $500,000/$500,000/$500,000.

PART XIII – ATTACHMENT CHECKLIST

Please submit the following attachments with your application:

- ☐ Claims History, either currently valued loss experience or narrative
- ☐ Contractual Agreements (excluding agreements with landlords)
- ☐ Hold Harmless Agreements, as requested
- ☐ JCAHO Report, if available
- ☐ Latest Audited Financial Statement
- ☐ List of Subcontractors
- ☐ Most Recent Fire Inspection Report
- ☐ Most Recent State Board of Health Inspection Report
- ☐ Organizational Chart
- ☐ Patient/Client Satisfaction Surveys, if used
- ☐ Risk Management and Quality Assurance Written Plan
- ☐ Listing of Names & Specialties with Applications, as requested
- ☐ Service Contracts, as requested

PART XIV- COMMENT SECTION (Use additional sheets if necessary)

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.

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 ______________

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)

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, 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.

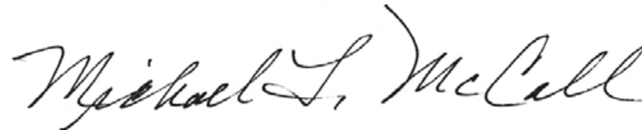
A. **<u>HIPAA Compliance</u>:** Business Associate has structured the Agreement so as to comply with the HIPAA Privacy Standards, and any ambiguity shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy Standards. Any provision of this Agreement found to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