

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
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Organization Type (check all that apply)

<input type="checkbox"/> Individual	<input type="checkbox"/> Joint Venture	<input type="checkbox"/> For-Profit	<input type="checkbox"/> Taxable	<input type="checkbox"/> Other (describe) _____
<input type="checkbox"/> Corporation	<input type="checkbox"/> Governmental	<input type="checkbox"/> Charitable	<input type="checkbox"/> Non-Taxable	_____
<input type="checkbox"/> Partnership	<input type="checkbox"/> Not-For-Profit	<input type="checkbox"/> 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 _____

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 – OPERATIONS

Type of Hospital (Check all appropriate boxes)

- | | | |
|---|---|--|
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> General Hospital | <input type="checkbox"/> Research Hospital |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Governmental | <input type="checkbox"/> Rehabilitation Hospital |
| <input type="checkbox"/> Convalescent or Nursing Home | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Teaching Hospital * |

Other _____

* For Teaching Hospitals, please identify medical school affiliation(s). _____

Do you participate in any teaching programs? Yes No

If "Yes," please describe: _____

Is the program hospital sponsored? Yes No

If "No," please provide the name of the sponsoring institution: _____

PART III – ACCREDITATIONS, CERTIFICATIONS AND LICENSURE

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

- | | | |
|--|--|------------------------|
| <input type="checkbox"/> Medicaid Certified* | <input type="checkbox"/> Accredited by JCAHO | Other (describe) _____ |
| <input type="checkbox"/> Medicare Certified* | Date of Accreditation _____ | _____ |
| <input type="checkbox"/> Licensed/Approved by State Board of Health* | Duration of Accreditation _____ | _____ |
| *If Not, please explain in the Comment Section | Please attach copy of report | _____ |
| <input type="checkbox"/> NCQA | <input type="checkbox"/> Conditional Accreditation by JCAHO | _____ |
| <input type="checkbox"/> AABB | If conditional accreditation, please attach a copy of any Type 1 recommendations made at the last accreditation visit. | _____ |
| <input type="checkbox"/> CAP | | |
| <input type="checkbox"/> CARF | | |
| <input type="checkbox"/> CHAP | | |

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? Yes No
If "Yes," provide details in the Comment Section.

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):

- | | | | |
|--------------------------------|---------------------------------|---------------------------------|------------------------|
| <input type="checkbox"/> AHA # | <input type="checkbox"/> ADHA # | <input type="checkbox"/> HIDA # | Other (describe) _____ |
| <input type="checkbox"/> FAH # | <input type="checkbox"/> NAHC # | | _____ |

PART IV - RISK MANAGEMENT/QUALITY ASSURANCE

1.	Do you have a formal written Quality Assurance and Risk Management Program in place? If "Yes," please attach. <input type="checkbox"/> Yes <input type="checkbox"/> No
	If "No," please explain: _____ _____
2.	Is the overall responsibility for Risk Management activities assigned to one individual in your organization? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Are the results of patient/client surveys used to improve day-to-day operations? <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Is an "informed consent" document placed in the patient's medical record? <input type="checkbox"/> Yes <input type="checkbox"/> No

PART V - HIRING/SCREENING AND EMPLOYMENT PROCEDURES

1.	Are employees'/contractors' references contacted before being hired/placed? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you verify certification and/or professional licensure status of employees and independent contractors? <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	How are references checked? <input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Both
	If verbal only, please explain: _____
4.	Do you check references of previous employers? <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you check personal references? <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you screen prospective employees for criminal records? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If "No," please explain: _____ _____
7.	Do you screen employees to rule out drug, alcohol and sexual abuse? <input type="checkbox"/> Yes <input type="checkbox"/> 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.
	<ul style="list-style-type: none"> • Check of educational background, or residency program, when applicable. <input type="checkbox"/> Yes <input type="checkbox"/> No • Confirm hospital privileges for physicians, oral surgeons and dentists. <input type="checkbox"/> Yes <input type="checkbox"/> No <li style="padding-left: 20px;">How often do you update your list of specific privileges? _____ • Confirm that they have no pending license suspensions or revocations, or any pending disciplinary actions by other facilities. <input type="checkbox"/> Yes <input type="checkbox"/> No • Require information on any medical professional liability or work-related claim that has previously been made against any individual <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Is there such a requirement stated in the staff bylaws? <input type="checkbox"/> Yes <input type="checkbox"/> No

13.	What limits of liability are required? _____
14.	What evidence of compliance is required? _____
15.	For whom do you have written job descriptions? <input type="checkbox"/> Professionals <input type="checkbox"/> Paraprofessionals
16.	In the past 12 months, what percentage of your nursing staff was provided by a staffing agency? _____

PART VI – CONTRACTUAL AGREEMENTS

1.	<p>Do you enter into any contractual agreements (e.g., with hospitals, nursing homes or other health care facilities)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. If "Yes," please list and attach copies of all agreements: _____ _____ _____</p> <p>b. Do these agreements contain a hold harmless or indemnification clause favorable to the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>														
2.	<p>If the facility has any contracted professional services performed as shown below, please check and indicate the minimum professional liability limits required.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">Limit</td> <td style="width: 50%; text-align: center;">Limit</td> </tr> <tr> <td><input type="checkbox"/> Anesthesiology \$ _____</td> <td><input type="checkbox"/> Respiratory Therapy \$ _____</td> </tr> <tr> <td><input type="checkbox"/> Home Health Care _____</td> <td><input type="checkbox"/> Housekeeping _____</td> </tr> <tr> <td><input type="checkbox"/> Lab/Pathology _____</td> <td><input type="checkbox"/> Laundry _____</td> </tr> <tr> <td><input type="checkbox"/> Pharmacy _____</td> <td><input type="checkbox"/> Other professional services _____</td> </tr> <tr> <td><input type="checkbox"/> Physical/Occupational Therapy _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Radiology/Nuclear Medicine _____</td> <td></td> </tr> </table> <p style="text-align: center;"><i>Please submit a copy of each contract</i></p>	Limit	Limit	<input type="checkbox"/> Anesthesiology \$ _____	<input type="checkbox"/> Respiratory Therapy \$ _____	<input type="checkbox"/> Home Health Care _____	<input type="checkbox"/> Housekeeping _____	<input type="checkbox"/> Lab/Pathology _____	<input type="checkbox"/> Laundry _____	<input type="checkbox"/> Pharmacy _____	<input type="checkbox"/> Other professional services _____	<input type="checkbox"/> Physical/Occupational Therapy _____		<input type="checkbox"/> Radiology/Nuclear Medicine _____	
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<input type="checkbox"/> Physical/Occupational Therapy _____															
<input type="checkbox"/> Radiology/Nuclear Medicine _____															
3.	<p>Do you lease any equipment from others? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please list: _____ _____</p>														
4.	<p>Who services the equipment listed above? _____</p> <hr/> <p>Do you service any of the equipment yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How often is the equipment serviced? _____</p> <p>Do you indemnify (hold harmless) the owner for liability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," is it a mutual hold harmless agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "No," please explain for each on a separate sheet.</p>														
5.	<p>Are certificates of insurance obtained from all subcontractors? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Please provide a list of all subcontractors</i></p>														
6.	<p>Are there any other service contracts in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please describe services: _____ _____ _____</p> <p>Do you indemnify (hold harmless) the service provider? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If "Yes," please submit a copy of the contract.</i></p>														
7.	<p>Do you have any contract(s) to provide management services to other facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If "Yes," please provide name(s) and address(es) and a copy of each contract.</i></p>														
8.	<p>Does another facility or entity provide management services to you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If "Yes," please provide name(s) and address(es) and a copy of each contract.</i></p>														

9. Does your Pathology Department read specimens from other states? Yes No
 If "Yes," is this a contracted service you provide? Yes No
 If "Yes," for which states do you provide this service? _____

10. 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 VII – MEDICAL PROFESSIONAL SERVICES

1. Please indicate if you presently provide, plan to provide or presently operate any of the following:

Abortion Clinic	_____	Open Heart surgery	_____	Lifeline	_____
Ambulance Service	_____	Off-Premises Clinics	_____	Mobile Unit (blood-mobiles, mammography, CAT scan units, etc.)	_____
Base Hospital	_____	Dental Services	_____	Nursery	_____
Blood Bank	_____	Emergency Room	_____	Neonatal	_____
Burn Units	_____	Health Maintenance Organizations	_____	Hospice	_____
Cardiac Catheterization Ctrs	_____	Home Health Care	_____	Inhalation Therapy	_____
Coronary Care Unit	_____	Hospice	_____	Intensive Care Unit	_____
Day Care – Adult	_____	Off-Premises Food Services	_____	Organ Bank	_____
Day Care – Child	_____	Off-Premises Labs	_____	Organ Transplants	_____
Day Care - Respite	_____	Pharmacy	_____	Outpatient Surgicenters	_____
Dialysis	_____	Podiatry	_____	Transportation Services (other than ambulance)	_____
OB/Gyn	_____	Transportation Services (other than ambulance)	_____		
Other (explain):	_____				

2. Do you anticipate any facility expansions within the next year? Yes No
 Have you filed a certificate of need? Yes No
 If "Yes," please explain. _____

3. If you provide Home Health Care, what is the annual payroll of employees providing this care? _____

4. Do you provide any services that might be considered alternative medicine? (For example, homeopathy, acupuncture) Yes No
 If "Yes," please describe _____

5.	Please complete the occupancy chart below for the current and upcoming year. If this is a new account and prior acts coverage is requested, please also complete for the five previous years.									
<p><u>Visits:</u> 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.</p> <p><u>Beds:</u> Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.</p>										
a. OUTPATIENT VISITS					COMPLETE FIVE PRIOR YEARS IF PRIOR ACTS COVERAGE REQUESTED					
		Current Year Totals	Projections for upcoming year	1 Year ____	2 Year ____	3 Year ____	4 Year ____	5 Year ____		
1.	Alcohol/Drug Abuse Visits	_____	_____	_____	_____	_____	_____	_____		
2.	Emergency Room Visits	_____	_____	_____	_____	_____	_____	_____		
3.	Outpatient Surgery	_____	_____	_____	_____	_____	_____	_____		
4.	Physical Rehabilitation Therapy Visits	_____	_____	_____	_____	_____	_____	_____		
5.	Diagnostic Testing Referral Visits	_____	_____	_____	_____	_____	_____	_____		
6.	All Other (including Psychiatric, Radiology, Laboratory/Pathology, Cardiology, Hospice)	_____	_____	_____	_____	_____	_____	_____		
7.	Home Health Visits	_____	_____	_____	_____	_____	_____	_____		
8.	Clinic Visits	_____	_____	_____	_____	_____	_____	_____		
9.	Reference Laboratory Tests	_____	_____	_____	_____	_____	_____	_____		
b. HOSPITAL BEDS										
		# Licensed Beds	Average Occupied Beds	Average Occupied Beds	Average Occupied Beds	Average Occupied Beds	Average Occupied Beds	Average Occupied Beds	Average Occupied Beds	
1.	Acute Care	_____	_____	_____	_____	_____	_____	_____	_____	
2.	Chemical Dependency	_____	_____	_____	_____	_____	_____	_____	_____	
3.	Cribs and Bassinets	_____	_____	_____	_____	_____	_____	_____	_____	
4.	Extended Care	_____	_____	_____	_____	_____	_____	_____	_____	
5.	Hospice	_____	_____	_____	_____	_____	_____	_____	_____	
6.	Psychiatric	_____	_____	_____	_____	_____	_____	_____	_____	
7.	Rehabilitation	_____	_____	_____	_____	_____	_____	_____	_____	
8.	Swing Beds	_____	_____	_____	_____	_____	_____	_____	_____	
		Acute Care Utilization %: _____	_____	_____	_____	_____	_____	_____	_____	
		Extended Care Utilization %: _____	_____	_____	_____	_____	_____	_____	_____	
9.	Other _____	_____	_____	_____	_____	_____	_____	_____	_____	
c. INPATIENT SURGERIES										
d. DELIVERIES (excluding cesarean sections)										
e. CESAREAN SECTIONS										
f. VBACs										
g. BARIATRIC SURGERY (any type of procedure)										
h. OTHER (describe)										

PART VIII – EMPLOYED & CONTRACTED PHYSICIANS, SURGEONS AND PROFESSIONAL EMPLOYEES

1. Please provide total number in each category.

Position	Employed	Contracted	Position	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

	<p>h. Do CRNAs work under the medical direction of an anesthesiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please submit written guidelines for supervision</p>	
3.	RADIOLOGY SERVICES	
	<p>a. Radiology Department staffing is by: <input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contracted Physicians <input type="checkbox"/> Residents</p> <p>b. Are all physicians board certified eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please explain _____ _____</p> <p>c. If under contract, to whom is staffing contracted? _____</p> <p>d. Are contracted physicians required to carry professional liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what limits are required? _____ Do you obtain a certificate of insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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: _____ _____ _____</p>	
4.	OBSTETRICAL SERVICES	
	<p>a. Are you a regional referral center for newborns requiring intensive care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Number of labor rooms: _____ Number of delivery rooms: _____ Do you have a separate birthing center? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the delivery room suite separate from the surgical suite? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Can cesarean sections be performed within thirty (30) minutes at all times? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Is an anesthesiologist or CRNA available in-house twenty-four (24) hours per day for the obstetrical suite? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," what is the maximum time for arrival at the hospital? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Is an obstetrician available in-house twenty-four (24) hours per day for the obstetrical suite? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," what is the maximum time for arrival at the hospital? _____</p> <p>f. How many VBACs were performed at your facility during the last 12 months? _____ Do you follow ACOG guidelines for VBACs? <input type="checkbox"/> Yes <input type="checkbox"/> No Are VBACs performed in the delivery room or the operating room? _____ Is a surgical suite reserved for emergency use during a VBAC procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Pitocin used to induce labor for VBACs? <input type="checkbox"/> Yes <input type="checkbox"/> No Do nurse midwives and/or family practitioners perform VBACs? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," is an obstetrician immediately available? <input type="checkbox"/> Yes <input type="checkbox"/> No Is an anesthesiologist immediately available during all VBAC procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Do you perform underwater deliveries? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain: _____ _____</p> <p>h. If you have a neonatal intensive care unit (NICU), please provide: Total admissions in the past 12 months _____ Total transfers from other facilities in the past 12 months _____</p>	

	<p style="text-align: center;">Is there a full-time neonatologist on-site for 24 hours per day? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you do not have a neonatal intensive care unit, please provide the number of neonates transferred from this institution to other facilities in the past 12 months: _____</p>
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5.	EMERGENCY SERVICES
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	<p>a. Do you provide emergency room service? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please answer the following questions:</p> <p style="padding-left: 20px;">What level of service do you provide (based on the standards of JCAHO)?</p> <p style="padding-left: 40px;"><input type="checkbox"/> I (Tertiary) <input type="checkbox"/> II (Comprehensive) <input type="checkbox"/> III (Basic)</p> <p>b. What services do you provide?</p> <p style="padding-left: 40px;"><input type="checkbox"/> Standby Services <input type="checkbox"/> Basic Services</p> <p style="padding-left: 40px;"><input type="checkbox"/> Comprehensive Emergency Services <input type="checkbox"/> Trauma Center</p> <p>c. Emergency Department Staffing is by:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contracted Physicians <input type="checkbox"/> Residents</p> <p>d. Are all physicians board certified eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "No," please explain _____</p> <p>_____</p> <p>e. If under contract, to whom is staffing contracted? _____</p> <p>Are contracted physicians required to carry professional liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," what limits are required? _____</p> <p>Do you obtain a certificate of insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Special Services:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; padding-left: 20px;">Ambulance</td> <td style="padding-left: 20px;">Number of vehicles _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;">Number of runs per year _____</td> <td></td> </tr> <tr> <td style="padding-left: 20px;">Blood Banks</td> <td style="padding-left: 20px;">Number of Donors (pints) _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;">Number of pints purchased from others _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;">If you purchase blood products from others, please list sources:</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding-left: 20px;">Organ Tissue Bank</td> <td style="padding-left: 20px;">Number of Donors _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;">Number of organ/tissue donations per year _____</td> <td></td> </tr> <tr> <td style="padding-left: 20px;">Day Care</td> <td style="padding-left: 20px;">Number of children per day _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;">Number of days per week _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;">On hospital premises?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td></td> <td style="padding-left: 20px;">Open to the public?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Ambulance	Number of vehicles _____			Number of runs per year _____		Blood Banks	Number of Donors (pints) _____			Number of pints purchased from others _____			If you purchase blood products from others, please list sources:		Organ Tissue Bank	Number of Donors _____			Number of organ/tissue donations per year _____		Day Care	Number of children per day _____			Number of days per week _____			On hospital premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Open to the public?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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6.	STAFF PRIVILEGES
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	<p>a. Please indicate the number of physicians in the following categories:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">_____ Active</td> <td style="width: 33%;">_____ Consulting</td> <td style="width: 33%;">_____ Emeritus</td> </tr> <tr> <td>_____ Associate</td> <td>_____ Courtesy</td> <td>_____ Probationary</td> </tr> </table> <p>b. Are credentials for new staff members checked and approved prior to granting staff privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," by whom? _____</p> <p>c. How are the applicant's degree(s) and experience verified? _____</p> <p>_____</p> <p>d. Are privileges provisional for at least six (6) months for all new staff members? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	_____ Active	_____ Consulting	_____ Emeritus	_____ Associate	_____ Courtesy	_____ Probationary
_____ Active	_____ Consulting	_____ Emeritus					
_____ Associate	_____ Courtesy	_____ Probationary					

- e. Do you have any staff members who are not licensed or who have restricted licenses or privileges? If "Yes," please explain on a separate sheet Yes No
- f. Do department heads evaluate the work of their staff members? Yes No
- g. Is an ongoing medical audit maintained on all staff members' clinical work? Yes No
- h. Are all staff privileges reviewed each year? Yes No
- i. Do you require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? Yes No
- j. Are all members required to maintain professional liability insurance? Yes No
- Is this requirement stated in the staff bylaws? Yes No
- What limits are required? _____
- What evidence of compliance is required? _____
- _____
- Please include a copy of the medical staff bylaws for financial responsibility.
- k. Criteria for qualification of employed physicians and surgeons: _____
- _____
- l. How many employed physicians are board certified or board eligible? _____
- m. Has the license of any employed physician ever been restricted or suspended? Yes No
- If "Yes," provide name(s) and explanation: _____
- _____

PART IX - 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)
						<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	

2. Does your facility meet applicable NFPA building codes? Yes No
- If "No," provide comments in the Comment Section.

3. Do you anticipate any new construction during the next 12 months? Yes No
- If "Yes," purpose: _____
- Estimated cost \$ _____
- Estimated completion date: _____

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: | Areas protected by approved automatic sprinkler system: |
| <input type="checkbox"/> None | <input type="checkbox"/> None <input type="checkbox"/> Soiled Linen Chutes & Rooms |
| <input type="checkbox"/> Entire Facility | <input type="checkbox"/> Entire Facility <input type="checkbox"/> Trash Collection Area |
| <input type="checkbox"/> Common Areas | <input type="checkbox"/> Common Areas |
| <input type="checkbox"/> Hallways | <input type="checkbox"/> Hallways |
| <input type="checkbox"/> Patient or Resident Rooms | <input type="checkbox"/> Patient or Resident Rooms |
| <input type="checkbox"/> Other - Location: _____ | <input type="checkbox"/> Other - Location: _____ |

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)
					<input type="radio"/> Claims Made <input type="radio"/> Occurrence	
					<input type="radio"/> Claims Made <input type="radio"/> Occurrence	
					<input type="radio"/> Claims Made <input type="radio"/> 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 XI- LIMITS AND DEDUCTIBLES

1. PRIMARY 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:

<input type="checkbox"/> No deductible	<input type="checkbox"/> \$10,000/\$50,000	<input type="checkbox"/> \$25,000/\$125,000	<input type="checkbox"/> \$50,000/\$250,000
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> OTHER
<input type="checkbox"/> \$5,000/\$25,000	<input type="checkbox"/> \$25,000/\$100,000	<input type="checkbox"/> \$50,000/\$150,000	<input type="checkbox"/> \$ _____
<input type="checkbox"/> \$10,000			

NOTE: Deductibles apply separately to the professional and general liability coverages. Where two amounts are shown, the second amount limits the total deductible payments during each annual period.

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.

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

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.

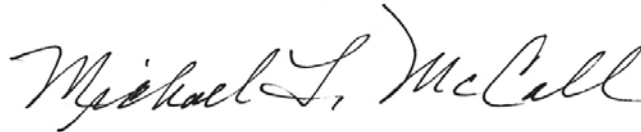
A. HIPAA Compliance: Business Associate has structured the Agreement so as to comply with the HIPAA Privacy Standards, and any ambiguity shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy Standards. Any provision of this Agreement found to be inconsistent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