Chicago, IL 60602
Toll-free: 800-782-4767
Telephone:312-782-2749
Email: underwriting@ismie.com
www.ismie.com

To submit your completed application to ISMIE, please follow these instructions.

1. Complete all sections of the application, sign and save the document, and return it via your preferred method as identified below.

2. If you prefer to sign the application with an electronic signature, please request approval for the use of the specific electronic signature software to be used to sign the documents. Docusign, AdobeSign, Citrix/RightSignature, EasySign, and Indio have been preapproved for use.

3. To submit your completed application please complete one of the following actions:

   A. **If you have an insurance producer, return your completed application to your Broker/Agent**: they will submit the application to ISMIE on your behalf.

   B. **Secure Online Portal**: Submit the application in ISMIE's website via the Secure File Upload option. This provides a secure method transmission.

   C. **Email**: Submit the completed application by email to underwriting@ismie.com
   Please Note:
   This application contains Protected Information and email is not secure unless encrypted with password protection. By submitting the application by email, you acknowledge that email is not a secure method of communication and could potentially be viewed by unauthorized persons who might intercept or read those emails. Secure Methods of submission are available on www.ismie.com

   D. **Mail**: Send it by mail to ATTN: Underwriting Division ISMIE Mutual Insurance Company 20 N. Michigan Avenue, Suite 700, Chicago, IL 60602.

   E. **Fax**: Submit completed application via fax to the ISMIE's fax number: (312) 782-2023

If you need help or have questions, please contact your broker/agent or contact ISMIE directly by email at underwriting@ismie.com or via phone at 1 -800-782-4767.

Personal information may be collected from persons other than the applicant in order to process this application. Such information may in certain circumstances be disclosed without any prior authorization. You have the right, subject to limited restrictions, to request the personal information that ISMIE has collected. You may also request that ISMIE correct, amend, or delete certain personal information collected subject to limitations.

ISMIE Mutual Insurance Company
The Physician-First Service Insurer

CLEAR ALL FIELDS

Click here to SAVE

BR-3900 (02/23

ATTN: UNDERWRITING DIVISION

Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
Telephone 312-782-2749
Toll Free 800-782-4767
Fax 312-782-2023
www.ismie.com

Processing Number _____

Application for Non-Physician Professional Liability Insurance

☐ **Separate Limits**

☐ **Shared Limits***

Please choose your desired coverage option either claims-made or occurrence. It is important for you to discuss which coverage type to apply for with your ISMIE insured employer prior to submitting an application to ISMIE. The type of coverage you can obtain will typically match your employer's coverage.

Claims-Made Coverage ☐

"A claims-made policy is limited to claims which are first made while the policy is in force and arise out of professional services provided on or after the retroactive date stated in the Declarations page, and as defined in the policy."

Occurrence Coverage ☐

"An occurrence policy is limited to claims that arise out of professional services rendered during the policy period stated in the Declarations Page and as defined in the policy."

Instructions: This application should be completed by Allied Health Personnel including: Certified Registered Nurse Anesthetists, Certified Clinical Nurse Specialists, Certified Nurse Practitioners, Certified Nurse-Midwifes, Physician Assistants and Psychologists, as well as Dentists, Optometrists and Pharmacists. An Individual Physician application is required for Chiropractors and Podiatrists. It is essential that all statements be completed and all questions answered. If the answer to any question is "**no**", be certain to check "**no"** on the Application. **Please do not leave any question unanswered. If additional space is required to answer any question, use the "Remarks Addendum" section. *Only separate limits are available in states with a Patient Compensation Fund.**

1. Applicant Name:

First Middle Last Title

☐ Male ☐ Female

2A. Name of ISMIE Mutual Insured Employer:

Name Policy Number

2B. Indicate all states of practice where ISMIE Mutual coverage is desired:

3. Desired effective date of coverage (12:01 a.m. Standard Time):

Month Day Year

4. Desired retroactive date for Claims-Made coverage (for prior acts coverage only - 12:01 a.m. Standard Time)
Retroactive date is required to secure prior acts coverage (nose coverage). ***Applicable to separate limits only*:**
***only applicable for Claims-Made Coverage, leave blank if applying for Occurrence Coverage**

Month Day Year

Non-Physician General Information

5. Date of Birth: _____ 6. Social Security Number:_____

7. Home Address: _____

_____

City: State: Zip Code:

Telephone: ( ) - Fax: ( ) - E-Mail Address:

8 a. Professional Designation (i.e. Nurse Practitioner, Certified Nurse Midwife, etc.):_____

Please provide a copy of your current job description; and provide a copy of your collaborative agreement(s) (if applicable).

8 b. License Number:_____

(include copy of license) State:_____

8 c. Professional Certification(s):_____

8 d. NPI Number: _____

9 a. Mailing Address:

Note: This address is where all of your insurance documents and correspondence will be sent.

Address Line l:

Address Line 2:

City: State: Zip Code: Telephone: ( ) -

Fax: ( ) - E-mail Address:

9 b. Billing Address: Same as 9a. ☐

Note: This address is where all of your insurance premium invoices and notices will be sent.

Address Line l:

Address Line 2:

City: State: Zip Code: Telephone: ( ) -

Fax: ( ) - E-mail Address:

10. Previous Insurance Carriers - Last five (5) years:*

Carrier Name	Policy Period	Limits	Claims-Made	Occurrence
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

*It is necessary that you obtain a current Loss History from each carrier listed above.

11. Training Completed:_____ Year Graduated:_____
Name of Facility/Institution

_____ Degree:_____
City State Country

12. A. Additional Training
Name of Hospital/Facility:

_____

_____
City State Country

Type of Training:_____

From: _____ _____ To:
mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

B. Additional Training
Name of Hospital/Facility:

_____

_____
City State Country

Type of Training:_____

From: _____ _____ To:
mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

13. Previous Professional Experience since Completion of Formal Training

City, State, Country	From Month /Year	To Month/Year	Practice Activity/ Employer	Carrier

14. Policy Limits

☐ $500,000/$1,500,000* ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000
(will be separate from your employer's, but must be equivalent to your employer's)

*NOTE: These limits are only available in Illinois for claims-made coverage

☐ Shared Limits (will be shared with your employer)

Please skip this section if you practice in a state with a Patient's Compensation Fund

15. Practice Information

List all current Office/Outpatient Practice Locations in this section. Include all locations whether or not ISMIE Mutual insurance is desired at that location. Please indicate additional locations on the "Remarks Addendum" section. Please include facility code(s) to identify all that are applicable.

Facility Codes (Please indicate all that apply)

01- Physician Office
02- Hospital
03- Extended Hour Walk-In Clinic
04- Surgicenter
05- Day Spa / Medi-Spa
06- Nursing Home/Extended Care Facility
07-HMO, IPA, PPO
08-Urgent Care Center
09-Clinic with overnight stays
10-Industrial Clinic
11- Government Location
12-Weight Reduction Clinic
13-Pharmacy
14-Abortion Clinic
15-Drug Control Clinic
16-Commercial Laboratory
17-Other

A. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

B. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

16. **Do you maintain hospital privileges at one or more facilities? Yes ☐ No ☐**
If yes, please complete section A and B (please copy this page for additional hospital locations)
If you do not maintain hospital privileges, please explain in the "Remarks Addendum" section.

A. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____ **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes ☐ Classroom ☐ Clinical ☐**

Do you provide services in the ER at this hospital?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: Yes ☐ No ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, etc.**

Distance from Home: **Miles** _____ **Minutes** _____

B. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____ **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes ☐ Classroom ☐ Clinical ☐**

Do you provide services in the ER at this hospital?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: Yes ☐ No ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, etc.**

Distance from Home: **Miles** _____ **Minutes** _____

17. Describe practice activities, including any procedures performed:

18. Profile Questions (Include details to each question in the "Remarks Addendum.")

YES	NO		
☐	☐	a.	Has your professional liability insurance ever been canceled for non-payment, declined, non-renewed, or issued on terms (including, but not restricted to: restrictive endorsements, surcharged premium, other underwriting action etc.)? **(Not Applicable in Missouri)**
☐	☐	b.	Have you treated any patients by means of any therapeutics which could be considered unconventional, experimental, investigational or clinical research that is not within the scope of research protocols approved by the Food and Drug Administration (FDA) or an institutional review board (IRB) (also known as an independent ethics committee (IEC), an ethical review board (ERB) or a research ethics board (REB))? If "Yes", utilize the "Remarks Addendum" on page 11 to provide a full written narrative indicating treatment(s), and provide name(s) and address(es) of sponsoring institution(s) or entity(ies) if applicable.
☐	☐	c.	Have any of your hospital privileges ever been denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or have you ever been subjected to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry?
☐	☐	d.	Have you ever been subjected to probation, suspension, reprimand, censure, sanction or other disciplinary action as a result of any governmental agency, medical or professional society disciplinary or administrative proceedings?
☐	☐	e.	Has membership in any medical society or professional organization ever been denied, suspended, revoked, voluntarily surrendered or accepted on a restricted basis?
☐	☐	f.	Have you ever been convicted of an act committed in violation of any law, statute or ordinance, including a conviction for driving while intoxicated (DUI), excluding other traffic offenses?
☐	☐	g.	Has your license to practice medicine or prescribe controlled substance ever been suspended, revoked, voluntarily surrendered, reprimanded, fined or subjected to probationary terms? If "Yes", indicate which:
☐	☐	h.	Have you ever incurred, become aware of having, or had an allegation made against you of having any illness or physical disability that impairs or potentially could impair your ability to practice medicine or your specialty including but not limited to: alcoholism, substance abuse, mental illness, degenerative diseases of the central nervous system, organic brain disease, convulsive disorders, multiple sclerosis, rheumatoid arthritis, infectious disease, etc.?
☐	☐	i.	Has any malpractice claim or suit been brought against you within the past five (5) years? If "Yes", please complete the Claim Information Supplement for each claim/suit brought against you in the past and submit complete copies of all office/hospital records, summons and complaint, etc.

Certificate(s) of Insurance

19. If your insurance request is accepted, as a service to its members, ISMIE Mutual can provide evidence of your coverage on an automated basis to a hospital, employer, etc. by issuing a Certificate of Insurance. If you wish to have a Certificate of Insurance issued to a **third party**, please complete the following:

Name of Certificate Holder

Street Address

City **State** **Zip**

Please check one:

- ☐ **Medical Director**
- ☐ **Medical Staff Office**
- ☐ **Administrator**
- ☐ **Other** _____

Specific Policy Limits will be printed on Certificate.

Name of Certificate Holder

Street Address

City **State** **Zip**

Please check one:

- ☐ **Medical Director**
- ☐ **Medical Staff Office**
- ☐ **Administrator**
- ☐ **Other** _____

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

ELECTRONIC SIGNATURES ARE PERMISSIBLE PURSUANT TO THE ELECTRONIC COMMERCE SECURITY ACT (5 ILCS 175)

PROXY

By applying for and receiving coverage from ISMIE Mutual Insurance Company, the policyholder/member agrees to grant, assign, and give a proxy to the Board of Directors of ISMIE Mutual Insurance Company or their designee, for purpose of casting a vote at any and all meetings or in any and all instances in which a vote of the policyholders/members is required. It is understood that in the absence of any further action by the policyholder/member, this proxy shall remain valid and binding for the length of time which the policyholder/member shall continue to be a policyholder/member of ISMIE Mutual Insurance Company. It is further understood that on any given issue as to which policyholders/members shall have a right to vote the policyholder/member may, by indicating in writing his, her, or its desire, revoke this proxy for purposes of the issue or matter then pending a vote. In the instance in which the policyholder/member revokes this proxy, he, she, or it may then vote in person or by written proxy at any meeting called for the casting of said vote. At the conclusion of said vote, this proxy, given to the ISMIE Mutual Board of Directors or its designee, shall return to full force and effect and shall continue in full force and effect unless and until the policyholder/member elects to revoke this proxy for purposes of a future issue which may arise.

Applicant's Name (please print)	Applicant's Signature	Date

REPRESENTATION

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of ISMIE Mutual in considering this application have been omitted. *I agree that this shall be the basis of the policy of insurance requested and that I will notify ISMIE Mutual of any changes contained herein.*

FRAUD NOTICE (applicable in Kentucky only)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

HIPAA DISCLOSURE

ISMIE Mutual Insurance Company and its affiliates shall act as business associates of applicant(s) with respect to the receipt, use and disclosure of protected health information. The Business Associate Agreement is hereby incorporated by reference.

AUTHORIZATION

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, ISMIE Mutual or its duly authorized representative may conduct an inquiry or investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant for this insurance. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, my/their insurance agents or consultants, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physician, any prior insurance carriers and ISMIE Mutual, or its duly authorized representative. I hereby release and discharge the aforementioned providers of information, ISMIE Mutual, its duly authorized review committee from any and all legal liability which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by ISMIE Mutual or its duly authorized representative**.** I authorize ISMIE Mutual or its duly authorized representative to provide information regarding my professional liability history and to issue Certificates of Insurance to those hospitals, managed care entities or other organizations to which I am affiliated or have applied. I consent and agree to the exchange of information regarding my professional liability policy between my present/future employer and ISMIE Mutual or its duly authorized representative. In the event that my insurance premiums are paid by my present/future employer and the practice relationship between myself and my employer is severed at any time during the policy period for any reason, including but not limited to cancellation of my policy, it is agreed that any and all remaining insurance premiums, including any return premium due, as of the severance date of the practice relationship, shall be the property of the employer. Communication regulations require that certain entities, including ISMIE Mutual and its affiliates, obtain written consent to share or distribute policyholder information via regular mail, e-mail, and facsimile. By signing this consent and authorization, you are agreeing to receive promotional notices or solicitation of the availability of goods, services, membership, and opportunities related to the practice of medicine from ISMIE Mutual and its affiliates.

Applicant's Name (*please print*)	Applicant's Signature	Date
Employer's Name (*please print*)	Employer's Signature	Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor to offer insurance to the applicant. A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original. PLEASE NOTE: Email transmission of a completed application or other document is unsecure. ISMIE Mutual is not responsible for any disclosure while the information is in transit. Email submissions may be made to underwriting@ismie.com

Insurance Agent/Producer/Broker (*please print*)	Signature	Date

SAVE APPLICATION

Claim Information Supplement (please print).

In addition to completing this form, please provide a typed, detailed narrative for each open claim, or any claim that has closed with an indemnity payment. Please photocopy this form for additional claims.

1. Patient/Claimant

_____
Name **Age** **Sex**

2. Date(s) of treatment and/or surgery which led to the allegations against you: _____

3. Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state** _____ _____
Month **Year**

4. Name of insurance carrier defending you: _____

5. Policy Number: _____

6. Names of other doctors and hospitals, if any, involved in claim or suit: _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $**_____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made. Indicate amount of settlement or award:**

a. Your policy $ _____ **Date**

b. Total (if additional defendants involved) $ _____

---

1. Patient/Claimant

_____
Name **Age** **Sex**

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state** _____ _____
Month **Year**

4. Name of insurance carrier defending you: _____

5. Policy Number:_____

6. Names of other doctors and hospitals, if any, involved in claim or suit: _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $**_____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made. Indicate amount of settlement or award:**

a. Your policy $ _____ **Date**

b. Total (if additional defendants involved) $ _____

Remarks Addendum (please print)

Question Number	Remarks

ISMIE MUTUAL INSURANCE COMPANY
BUSINESS ASSOCIATE AGREEMENT (POLICYHOLDER)
REVISED 2023

This Business Associate Agreement ("**Agreement**") is between ISMIE Mutual Insurance Company, and all affiliates and subsidiaries (collectively, "**ISMIE**"), 20 North Michigan Avenue, Suite 700, Chicago, IL 60602, and Covered Entity (as defined below). This Agreement is to memorialize the relationship between ISMIE and Covered Entity and the terms that govern the use and disclosure of Protected Health Information to ISMIE from Covered Entity consistent with HIPAA (as defined below).

I. DEFINITIONS

A. *Breach Notification Rule*. "**Breach Notification Rule**" shall mean the Notification in the Case of Breach of Unsecured Protected Health Information at 45 CFR Part 160 and Part 164, Subpart D.

B. *Business Associate*. "**Business Associate**" shall mean ISMIE Mutual Insurance Company, and all affiliates and subsidiaries.

C. *Covered Entity*. "**Covered Entity**" shall mean, with respect to Business Associate: (a) prior insureds, (b) insureds, (c) all persons or entities applying for insurance coverage, (d) all insureds by reporting endorsement. In this Agreement, "Covered Entity" shall mean the entity set forth on the attached application for insurance.

D. *Electronic Protected Health Information*. "**Electronic Protected Health Information**" shall have the meaning found in the Security Rule. [45 CFR § 160.103.]

E. *HIPAA*. "**HIPAA**" shall mean the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-91), as amended by the HITECH Act, and the implementing regulations promulgated thereunder, including, without limitation, the Privacy Rule, the Security Rule, and the Breach Notification Rule.

F. *HITECH Act*. "**HITECH Act**" shall mean the Health Information Technology for Economic and Clinical Health Act (Division A, Title XIII of the American Recovery and Reinvestment Act of 2009, P.L. 111-5).

G. *Individual*. "**Individual**" shall mean a person who is the subject of Protected Health Information and includes a personal representative who under law has authority to make health decisions for another person. [45 CFR § 164.502(g)].

H. *Privacy Rule*. "**Privacy Rule**" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

I. *Protected Health Information*. "**Protected Health Information**" shall mean individually identifiable health information that is transmitted or maintained in any form or medium, limited to the information created or received by Business Associate from or on behalf of Covered Entity. [45 CFR § 160.103].

J. *Required By Law*. "**Required By Law**" shall mean a mandate contained in law that compels use or disclosure of Protected Health Information and that is enforceable in a court of law including but not limited to subpoenas. [45 CFR § 164.103].

K. *Security Incident*. "**Security Incident**" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.

L. *Security Rule*. "**Security Rule**" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

M. *Secretary*. "**Secretary**" shall mean the Secretary of the Department of Health and Human Services or his designee.

N. *Unsecured Protected Health Information*. "**Unsecured Protected Health Information**" shall have the same meaning as "unsecured protected health information" in 45 CFR § 164.402.

O. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules (which include the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164) regardless of whether the terms are capitalized: Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Minimum Necessary, Notice of Privacy Practices, Subcontractor and Use.

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

A. Business Associate shall not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law, such as mandated reports to the Illinois Department of Insurance, Illinois Department of Financial and Professional Regulation or National Practitioner Data Bank.

B. Business Associate shall use appropriate safeguards and comply with subpart C of Part 164 of the Security Rule, where applicable, with respect to Electronic Protected Health Information, to prevent unauthorized use or disclosure of Protected Health Information other than as provided for by this Agreement.

C. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement of which Business Associate becomes aware.

D. Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information not provided for by this Agreement of which it becomes aware. In addition, Business Associate shall notify Covered Entity without unreasonable delay, but in no event later than 45 days, following the discovery of a breach of Unsecured Protected Health Information and in accordance with the breach notification requirements set forth in 45 CFR § 164.410. "**Breach**" shall have the same meaning as the term "breach" in 45 CFR § 164.402.

E. Business Associate shall ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Business Associate agree to restrictions and conditions no less stringent than those that apply to Business Associate with respect to such information.

F. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary, upon 10 business days written notice during regular business hours of 10am - 3 pm or as otherwise designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

G. To the extent Business Associate maintains a designated record set, within 20 days of a written notice, Business Associate shall make available to Covered Entity Protected Health Information about the Individual in accordance with the requirements of 45 CFR § 164.524.

H. To the extent Business Associate maintains a designated record set, Business Associate shall make available for amendment and incorporate any amendments to Protected Health Information that the Covered Entity directs or agrees to, within 45 days of receiving a written notice from Covered Entity. [45 CFR § 164.526].

I. Business Associate shall document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information. Business Associate shall provide to Covered Entity within 45 days after receipt of a written request for an accounting of disclosures, such information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information. [45 CFR § 164.528].

J. Business Associate shall report to Covered Entity any Security Incident involving Electronic Protected Health Information of which it becomes aware. [45 CFR § 164.314]. The parties acknowledge and agree that this Section II.J. constitutes notice by Business Associate to Covered Entity of the ongoing existence and occurrence or attempts of Unsuccessful Security Incidents for which no additional notice to Covered Entity is required. "**Unsuccessful Security Incidents**" means, without limitation pings and other broadcast attacks on Business Associate's firewalls, port scans, unsuccessful log on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in any unauthorized access, use, or disclosure of Protected Health Information.

K. To the extent Business Associate is to carry out an obligation of Covered Entity under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligation.

III. **PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE.**

A. Except as otherwise limited in this Agreement or required by applicable law, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity in order for Business Associate to carry out its obligations under an ISMIE Insurance policy of insurance with Covered Entity and this Agreement, including but not limited to the following purposes:

1. Underwriting professional liability insurance.
2. Managing professional liability claims.
3. Providing risk management services.
4. Investigating any reported incidents.
5. Professional liability research and study.
6. Providing professional liability insurance services.

B. Business Associate may not use or disclose Protected Health Information in a manner that would violate the Privacy Rule if done by Covered Entity, except that:

1. Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate;

2. Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person promptly notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached. [45 CFR § 164.504(e)(4)(ii)(B)]; and

3. Business Associate may use Protected Health Information to provide data aggregation services related to the health care operations of Covered Entity. [45 CFR § 164.504(e)(2)(i)(B)].

C. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities [45 CFR § 164.502(j)(1)].

IV. **OBLIGATIONS OF COVERED ENTITY – PROVISIONS FOR COVERED ENTITY TO INFORM BUSINESS ASSOCIATE OF RESTRICTIONS**

A. Covered Entity shall promptly notify Business Associate in writing and in advance of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information. [45 CFR § 164.522].

B. Covered Entity shall promptly notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

C. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

D. Covered Entity shall only disclose to Business Associate the minimum amount of Protected Health Information necessary to accomplish the purpose of the disclosure to Business Associate in accordance with 45 CFR § 164.514(d) and HITECH Act § 13405(b) and any regulations or guidance issued by the Secretary regarding minimum necessary requirements.

V. PERMISSIBLE REQUESTS BY COVERED ENTITY

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity. The Business Associate may use or disclose Protected Health Information for data aggregation or management and administrative activities of Business Associate.

VI. TERM AND TERMINATION

A. *Term*. The term ("**Term**") of this Agreement shall be effective when Covered Entity submits to Business Associate an application for insurance, and Business Associate accepts and approves such application, and for the period the Covered Entity is insured by Business Associate, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity is returned to Covered Entity or destroyed, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

B. *Termination for Cause*. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall:

1. Provide written notice of 45 days for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within such 45 day period; or

2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

C. *Effect of Termination*.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information, except as required by law.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon notice that the return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes stated for so long as Business Associate maintains such Protected Health Information, except as required by law.

3. *Automatic Termination*. Subject to the terms set forth in this Section VI, this Agreement shall automatically terminate if Covered Entity is no longer a member of ISMIE in good standing.

VII. **MISCELLANEOUS**

A. *Regulatory References*. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.

B. *Amendment*. The parties shall take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA.

C. *Survival*. The respective rights and obligations of Business Associate under Section VI (C) of this Agreement shall survive the termination of this Agreement.

D. *Interpretation*. This Business Associate Agreement shall be interpreted in the following manner:

1. Any ambiguity shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Rules.

2. Any inconsistency between the Agreement's provisions and the HIPAA Rules, including all amendments, as interpreted by the DHHS, a court, or another regulatory agency with authority over the Parties.

3. Any provision of this Agreement that differs from those required by the HIPAA Rules, but is nonetheless permitted by the HIPAA Rules, shall be adhered to as stated in this Agreement.

E. *Notice*. Any notice required to be given to Covered Entity shall be made in writing to the address set forth on Covered Entity's application for insurance, or the last known address of Covered Entity. Any notice required to be given to Business Associate shall be made in writing to the addresses set forth below:

ISMIE Mutual Insurance Company
[20 North Michigan Avenue, 7th Floor]
[Chicago, IL 60602]
ATTN: [HIPAA Privacy Officer]
[Robert John Kane]

ISMIE Mutual Insurance Company
[20 North Michigan Avenue, 7th Floor]
[Chicago, IL 60602]
ATTN: [HIPAA Security Officer]
[Nicole Scott]

F. *Changes in Law*. This Agreement shall automatically incorporate any new or revised provisions in HIPAA which are required to be incorporated into this Agreement, including changes to terms used herein which are defined in HIPAA.

G. *Governing Law.* Except to the extent preempted by federal law, this Agreement shall be governed by and construed in accordance with the laws of the state of Illinois.

H. *Entire Agreement.* This Business Associate Agreement constitutes the entire agreement between the parties related to the subject matter of this Agreement, except to the extent that the Underlying Agreement imposes more stringent requirements related to the use and protection of Protected Health Information upon Business Associate Subcontractor. This Agreement supersedes all prior negotiations, discussions, representations, or proposals, whether oral or written. This Agreement may not be modified unless done so in writing and signed by a duly authorized representative of both Parties. If any provision of this Agreement, or part thereof, is found to be invalid, the remaining provisions shall remain in effect.

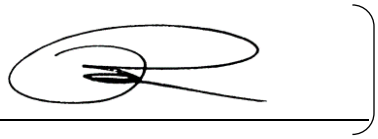
I. *Assignment.* This Agreement will be binding on the successors and assigns of the Covered Entity, ISMIE and the Business Associate Subcontractor.

J. *Counterparts.* This Agreement may be executed in two or more counterparts, each of which shall be deemed an original.

IN WITNESS WHEREOF, the parties have executed this Agreement.

BUSINESS ASSOCIATE

ISMIE MUTUAL INSURANCE COMPANY

Signature: 

Name: [Robert John Kane]

Title: HIPAA Privacy Officer

(2/23)