



Processing Number _____

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

Application for Individual Physician Professional Liability Insurance

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 employer, if any, prior to submitting an application to ISMIE.

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: 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 questions unanswered. If additional space is required to answer any questions, use the “Remarks Addendum.”** Please print your answers, but do not write in shaded areas.

1. Physician Name:

 First Middle Last Title

Male Female

2A. Name of ISMIE Mutual – insured Physician, Corporation, or Clinic you are joining, if applicable. (Disregard if you are applying as an individual.)

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. (12:01 a.m. Standard Time): Retroactive date is required to secure prior acts coverage (nose coverage). Only applicable for Claims-Made Coverage, leave blank if applying for Occurrence Coverage.

 Month / Day / Year

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. *(include copy of license)*
 Medical License Number: _____
 State: _____

9 a. *(include copy of license)*
 Controlled Substance Number: _____
 State: _____

8 b. *(include copy of license)*
 Medical License Number: _____
 State: _____

9 b. *(include copy of license)*
 Controlled Substance Number: _____
 State: _____

8c. *(include copy of license)*
 Medical License Number: _____
 State: _____

9 c. *(include copy of license)*
 Controlled Substance Number: _____
 State: _____

10. DEA Number: _____

10a. NPI Number: _____

11 a. Mailing Address:

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

Address Line 1: _____

Address Line 2: _____

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

Fax: () - E-mail Address: _____

11 b. Billing Address: Same as 11a.

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

Address Line 1: _____

Address Line 2: _____

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

Fax: () - E-mail Address: _____

12. Previous Insurance Carriers - Last ten years: *

Carrier Name	Policy Period	Limits	Claims-Made	Occurrence
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

*It is necessary that you obtain a current Loss History from each carrier listed above for a ten year period in order to be considered for the maximum loss free discount credits. While we will accept five years of loss history to underwrite your application, we will not be able to consider full loss free discount credits without receiving your complete ten year loss experience.

13. Medical School:

Year Graduated: _____

Name _____

Degree: _____

City State Country

14A. Residency Information:
Name of Hospital/Facility:

14B.
Name of Hospital/Facility:

City State Country City State Country

Specialty: _____ Specialty: _____

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

Completed: Yes No

Completed: Yes No

15A. Additional Training
Name of Hospital/Facility:

15B.
Name of Hospital/Facility:

City State Country City State Country

Specialty: _____ Specialty: _____

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

Completed: Yes No

Completed: Yes No

16. Previous Professional Experience-Since Completion of Formal Training

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

1. Include any "moonlighting" activities during residency/fellowship, any military service or other public activity. Also include all locations where professional services were rendered including, but not limited to offices, hospitals, licensed surgicenters, office surgery facilities, emergi-centers, outpatient laboratories and x-ray facilities, etc. Use "Remarks Addendum" if additional space is required. Explain all gaps in professional activities.
2. Please attach a copy of your current Curriculum Vitae.

17. Physician Limits: (Please skip this section if you practice in a state with a Patient's Compensation Fund.)

The offering of the following policy limits by ISMIE Mutual should not be deemed to express or imply that any particular policy limit is or is not adequate for an insured. It is the sole responsibility of each insured to select an appropriate limit of coverage.

- \$500,000/\$1,500,000*
"each person"/ "aggregate"
- \$1,000,000/\$3,000,000
"each person"/ "aggregate"
- \$2,000,000/\$4,000,000
"each person"/ "aggregate"

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

Medical Specialty Information:

18a. Principal Medical Specialty in which you practice: _____

18b. % of practice time: _____

19a. Sub-Specialty in which you practice: _____

19b. % of practice time: _____

20a. Currently Held Board Certifications and Dates: _____

20b. Recertification Dates: _____

20c. Do you practice as a Hospitalist? Yes % of practice time _____ No

(Hospitalist is defined as a physician who is solely based in a hospital and whose primary responsibility is to coordinate the care for hospital inpatients, including the coordination of hospital staff, ordering tests and making treatment decisions in consultation with the patient's attending physician)

20d. Do you provide Concierge services? Yes % of practice time _____ No

(Concierge medicine, also known as direct primary care, involves charging patients a fee or retainer in exchange for medical care and treatment)

If "yes", please describe the services you provide, hours of availability, etc.

21. Types of Practice Relationships (check all that apply)

A. Individual []

B. Employed
Employer's Name _____ []

C. Independent Contractor **(Please attach copy of contract)**
Contractor Name: _____ []

D. Partner of a medical partnership.
Partnership Name: _____ []
"Please attach copy of partnership or business agreement"

E. Shareholder/member of a medical/ professional service corporation/limited liability company (LLC). []
Corporation Name: _____
"Please submit State issued Organizational Documents"

F. Sole Shareholder of a Medical / Professional Service Corporation []
Corporation Name: _____
"Please submit State issued Organizational Documents"

Does this entity operate under any other names (d.b.a. "doing business as")?

Yes No

If Yes, list all names: _____

Are separate limits desired for this entity? (Only separate limits available for states with a Patient Compensation Fund).

Yes No

Please Note: If separate limits are desired for your Sole Shareholder Corporation, please complete an Application for Partnership/ Corporation/ Clinic Option, which is available on our website- www.ismie.com.

Coverage for your sole shareholder corporation is available at no additional charge on a shared-limits basis subject to underwriting approval and receipt of State issued Organizational Documents. Coverage for a Sole Shareholder Corporation will not exist unless specifically added by endorsement. (Shared limits for your Corporation are not available in states with Patient Compensation Fund)

* Please attach a copy of the Independent Contractor Agreement

22. Please provide census information on physicians who are partners, shareholders, officers, directors, employees or independent contractors. If additional space is required to complete this question, use “Remarks Addendum” section.

Code :	01 - Partner	02 - Shareholder	03 - Officer	04 - Director	05 - Employee	06 - Independent Contractor *
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Code	Physician Name	Insurance Carrier	Specialty	Limits of Liability	Policy Number
1)					
2)					
3)					
4)					
5)					

23. Allied Health Personnel

Please provide census information on your employed Allied Health Personnel. Only separate limits are available in states with a Patient Compensation Fund.

Coverage for the following Allied Health Personnel are offered on either a Shared or Separate Limit basis for an additional charge. A separate Non-Physician application is required, and is available on our website- www.ismie.com.

A. Certified Registered Nurse Anesthetist	Total	_____	E. Physician Assistant	Total	_____
B. Certified Clinical Nurse Specialist	_____		F. Psychologist	_____	
C. Certified Nurse Practitioner	_____		G. Other (Specify Below)	_____	
D. Certified Nurse-Midwife	_____				

Coverage for the following Health Care Professionals is only offered on Separate Limit basis for an additional charge. A separate Individual Physician application is required for Chiropractors and Podiatrists, and a Non-Physician application is required for Dentists, Optometrists and Pharmacists. Applications are available on our website- www.ismie.com.

H. Chiropractor	Total	_____	K. Podiatrist	Total	_____
I. Dentist	_____		L. Pharmacist	_____	
J. Optometrist	_____				

Note: Coverage for all Health Care Professionals is limited to the scope of employment and services rendered on behalf of the ISMIE Mutual insured Physician or Corporation.

24. 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 copy this page for additional locations. 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

<p>A. Office Name: _____</p> <p>Facility Code: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____</p> <p>Is this your primary office location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Distance from Home: Miles _____ Minutes _____</p> <p>Do you own or operate a Pharmacy at this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance. _____</p>	<p>Is ISMIE Mutual Insurance desired for this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "No," describe activity not to be covered and state by whom insured: _____</p> <p>Average number of patients per week: _____</p> <p>*Average weekly practice time at this location: _____</p> <p>*Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.</p>
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<p>B. Office Name: _____</p> <p>Facility Code: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____</p> <p>Is this your primary office location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Distance from Home: Miles _____ Minutes _____</p> <p>Do you own or operate a Pharmacy at this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance. _____</p>	<p>Is ISMIE Mutual Insurance desired for this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "No," describe activity not to be covered and state by whom insured: _____</p> <p>Average number of patients per week: _____</p> <p>*Average weekly practice time at this location: _____</p> <p>*Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.</p>
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24. PRACTICE INFORMATION (cont'd)

<p>C. Office Name: _____</p> <p>Facility Code: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____</p> <p>Is this your primary office location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Distance from Home: Miles _____ Minutes _____</p> <p>Do you own or operate a Pharmacy at this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance. _____</p>	<p>Is ISMIE Mutual Insurance desired for this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "No," describe activity not to be covered and state by whom insured: _____</p> <p>Average number of patients per week: _____</p> <p>*Average weekly practice time at this location: _____</p> <p>*Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.</p>
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25. Do you have a written contract to provide healthcare services to any professional sports organizations? Yes No

If "yes", please provide names of Organization(s) _____
(please include copy of contract)

26.A Do you provide Telemedicine Services? Yes No

If "yes", please indicate where the films or other forms of electronic transmissions will be read, i.e. City / State. _____

If these transmissions will originate in another state, please provide a copy of your medical license for that state.

26.B Do you perform Robotic Surgery? Yes No

If "yes", if please complete the medical procedures questions on pages 9-14, including #34 if necessary.

26.C Do you provide Aesthetic or Spa type services? Yes No

If "yes", please complete the medical procedure questions on page 10 and provide narrative if necessary.

27. Have you ever voluntarily given up performing one or more procedures at any of your hospital affiliations? Yes No

If "yes", please describe the procedures changed in the Remarks Addendum section of the application.

28. 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.

<p>A. Hospital Name: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____ Fax: _____</p> <p>Category of privileges (active, consulting, etc.) _____</p> <p>Specialty department of: _____</p> <p>Do you teach at this hospital? Yes <input type="checkbox"/> Classroom <input type="checkbox"/> Clinical <input type="checkbox"/></p> <p>Do you staff the ER at this hospital other than to maintain hospital privileges? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", average number of hours weekly: _____</p> <p>Is this location a Nursing Home or Extended Care Facility? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Is ISMIE Mutual Insurance desired for this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "no," describe activity not to be covered and state by whom insured: _____</p> <p>Is this your primary hospital location?: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Average number of patients per week: _____</p> <p>*Average weekly practice time at this location: _____</p> <p><small>*Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.</small></p> <p>Distance from Home: Miles _____ Minutes _____</p>
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<p>B. Hospital Name: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____ Fax: _____</p> <p>Category of privileges (active, consulting, etc.) _____</p> <p>Specialty department of: _____</p> <p>Do you teach at this hospital? Yes <input type="checkbox"/> Classroom <input type="checkbox"/> Clinical <input type="checkbox"/></p> <p>Do you staff the ER at this hospital other than to maintain hospital privileges? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", average number of hours weekly: _____</p> <p>Is this location a Nursing Home or Extended Care Facility? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Is ISMIE Mutual Insurance desired for this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "no," describe activity not to be covered and state by whom insured: _____</p> <p>Is this your primary hospital location?: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Average number of patients per week: _____</p> <p>*Average weekly practice time at this location: _____</p> <p><small>*Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.</small></p> <p>Distance from Home: Miles _____ Minutes _____</p>
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29. Minor Risk Procedures (please answer all questions regardless of your medical specialty)

A. Minor Risk Procedures – Interventional Cardiology

Currently Performing:

*Denotes Specified Minor Risk Procedures for Cardiovascular Disease specialists

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Angiography |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Arteriography |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Arterial, Venous, Cardiac or other Diagnostic Catheterizations
This does not apply to Swan-Ganz, umbilical cord, urethral catheterization or arterial line in a peripheral vessel, which are covered under a specialty designation/risk notation of NMRP |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Defibrillation Insertion |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Electro-physiological studies and ablations |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Insertion of Balloon Expandable Stent |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Insertion of Cardiac Pacemaker whether temporary or permanent * |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Insertion of intra-aorta balloon pump |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Intracoronary Infusions |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Myocardial Biopsies |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Pericardiocentesis * |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Percutaneous Transluminal Therapeutic Angioplasty including placement of stents |

B. Minor Risk Procedures - Interventional Radiology

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Peripheral arterial angiography, angioplasty, atherectomy, thrombolysis, and stenting |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Deep organ biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Nephrostomy |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Percutaneous vertebroplasty/kyphoplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Percutaneous radiofrequency ablation of deep/superficial tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Extracranial embolization procedures(including fibroid embolization, hepatic chemoembolization) |

C. Minor Risk Procedures - Ophthalmic Surgery

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Either extraocular only or extraocular and intraocular (includes surgery for glaucoma, cataract, retinal detachment and strabismus surgery including YAG Laser Treatment for membrane opacity, Laser Trabeculoplasty and Laser Iridectomy, Incision and Curettage |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Astigmatic Keratotomy (AK), Automated Lamellar Keratoplasty (ALK), Conductive Keratoplasty (CK), Laser-Assisted in situ Keratomileusis (LASIK), Laser Thermal Keratoplasty (LTK), Photorefractive Keratotomy (PRK), Radial Keratotomy (RK) or Refractive Lens Exchange (RLE) Surgery |

29. Minor Risk Procedures (cont'd)

D. Minor Risk Procedures – Other

- 21. Assisting in the performance of surgery *
- 22. Interstitial Hyperthermia
- 23. Ultrasound Hyperthermia (Superficial only)
- 24. MRI Guided Focused Ultrasound for Treatment of Uterine Fibroids
- 25. Vascular access for Dialysis (Including Tunneled Catheter)

30. Cosmetic Procedures (please answer all questions regardless of your medical specialty)

Currently Performing:

Yes **No**

- 1. Neurotoxin Injections such as: Botox and Dysport
- 2. Short-term Filler Injections such as: Collagen fillers - Evolence, Zyderm and Zyplast and potentially reversible fillers such as: Hyaluronic Acid Fillers - Juvederm Ultra, Juvederm Ultra Plus, Belotero, Perlane, Restylane, Restylane Silk, Voluma, Captique, Hylaform and Elevesse.
- 3. Long term Filler Injections that are semi-permanent such as: Artefill, Radiesse and Sculptra
- 4. Endovenous Laser Vein Treatment (EVLT)
- 5. Laser Treatment of Leg Veins
- 6. Skin Treatment performed with Non-Ablative Laser Treatment or Non-Ablative Chemical Peels (epidermis is left intact without full destruction)
- 7. Skin Treatment performed with Ablative Laser Treatment or Ablative Chemical Peels (extends through the epidermis with epidermal destruction).
- 8. Laser Hair Removal
- 9. Non-Invasive Skin Tightening or Fat/Cellulite Reduction procedures (no intravenous sedation or incisions) performed with lasers, ultrasound, radiofrequency or freezing.
- 10. Injection Lipolysis (Lipodissolve, Mesotherapy or Kybella injection)
- 11. Tumescant Liposuction (local anesthesia only)
- 12. Liposuction/Suction Lipectomy (under general anesthesia or intravenous sedation)
- 13. Other cosmetic fillers including any products from off-shore or non-authorized distributors :
List: _____

30. Cosmetic Procedures (cont'd)

Yes **No**

14. Other procedures not listed above:

List:

15. **Plastic surgery** (such as breast augmentation, abdominoplasty, blepharoplasty, rhinoplasty, face lift, etc.)

All specialists other than residency trained Plastic Surgeons or Otorhinolaryngologists (ENT), please list all surgical procedures:

If you are an OB/GYNE specialist, a Gynecology Specialist or a Primary Care Physician providing obstetrical or gynecological care, please answer all of the following questions:

31. Obstetrical Procedures

A. Number of **total deliveries** you perform **annually**: _____

B. Of your total annual deliveries, please provide a breakdown of the following:

1. Normal Vaginal Deliveries _____

(Uncomplicated pregnancy, may include episiotomy and application of outlet/low forceps or vacuum cup)

2. VBACs _____

3. Mid-forceps Delivery, Mid Vacuum _____

4. Cesarean Section (primary, repeat) _____

5. Breech Delivery, Vaginal _____

6. External Version _____

7. Multiple Gestation, Vaginal Delivery _____

8. Version and Extraction, 2nd Twin _____

C. Performance of Home Deliveries: Yes No

D. Chorionic Villi Sampling: Yes No

32. Gynecological Procedures

A. Termination of Pregnancy: Yes No
If "Yes" First Trimester, # per year _____
Second Trimester, # per year _____

B. Minor Gynecological Procedures. Please indicate the number performed annually:

Amniocentesis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cervical Conization	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
D&C (Does not apply to termination of pregnancy)	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Endometrial Ablation	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
LEEP	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Essure Sterilization	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Co2 Laser of Cervix	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Marsupilation of Bartholeum Cyst	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Operative Hysteroscopy	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Other _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
(Residency trained OB/GYNE physicians are not required to report other procedures in this section)	TOTAL	_____
		(Annual)

C. Major Gynecological Surgeries. Please indicate the number performed annually:

Anterior/Posterior Repair	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Diagnostic Laparoscopy	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Fallopian Tube Recanalization	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Hysterectomy (with or without salpingo oophorectomy)	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Myomectomy	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Operative Laparoscopy (includes tubal sterilization)	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Ovarian Cystectomy		
Sacrocolpopexy/Sacrospinous		
Vaginal Vault Suspension	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Other _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
(Residency trained OB/GYNE physicians are not required to report other procedures in this section)	TOTAL	_____
		(Annual)

33. Major Risk Procedures (please answer all questions regardless of your medical specialty)

Currently Performing:

Yes	No	Annual # Procedures	Practice Time %	Surgical Procedures
<input type="checkbox"/>	<input type="checkbox"/>			1. Administration of General Anesthesia, including intubation and Regional Anesthesia
<input type="checkbox"/>	<input type="checkbox"/>			2. Therapeutic Anesthesia for pain management (spinal nerve blocks, pumps, stimulators, etc.)
<input type="checkbox"/>	<input type="checkbox"/>			3. Bariatric Surgery for the treatment of Obesity (including Gastric Stapling, Laparoscopic Adjustable Gastric Band - LAP Band), Gastric Bypass Sleeve Resection, Duodenal Switch Procedures) or other similar surgical procedures for the treatment of morbid obesity, obesity or weight reduction
<input type="checkbox"/>	<input type="checkbox"/>			4. Cardiac Surgery
<input type="checkbox"/>	<input type="checkbox"/>			5. Colon Surgery
<input type="checkbox"/>	<input type="checkbox"/>			6A. *General Surgery - No Bariatric Surgery
<input type="checkbox"/>	<input type="checkbox"/>			6B. *General Surgery - Including Bariatric Surgery (as defined above in number 3) *(General Surgery may include Extensor Tendon Repair)
<input type="checkbox"/>	<input type="checkbox"/>			7. Hand Surgery a. Hand and Wrist Surgery - _____ % of practice time b. Upper Extremity Surgery, including elbow and shoulder (other than shoulder replacement) - _____ % of practice time c. Shoulder Replacement Surgery Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			8. Otorhinolaryngology a. Elective Plastic Head and Neck Only - Yes <input type="checkbox"/> No <input type="checkbox"/> b. Elective Plastic Other Than Head & Neck- Yes <input type="checkbox"/> No <input type="checkbox"/> c. Traumatic/Pathologic- Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			9. Intracranial Balloon Embolization
<input type="checkbox"/>	<input type="checkbox"/>			10. Neurological Surgery with Intracranial Surgery (Including Leksell Gamma Radiosurgical Unit)
<input type="checkbox"/>	<input type="checkbox"/>			11. Neurological Surgery No Intracranial Surgery (If yes, please also answer #16)
<input type="checkbox"/>	<input type="checkbox"/>			12. Organ Transplantation (Other than Corneal Transplants)
<input type="checkbox"/>	<input type="checkbox"/>			13. Orthopaedic Procedures excluding spine care/surgery. Orthopaedics includes but is not limited to the following: - Open or closed reduction of fractures or dislocations (other than fingers, toes and shoulders) Arthroscopic procedures, joint reconstruction/arthroplasty, musculoskeletal surgical procedures including grafts, repairs, reconstruction or transfers of bone/cartilage/ligament/tendon -Arthrodesis -Epiphysiodesis - Osteotomy - Amputations (other than digital) - Any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to the fracture - Any fracture of the vertebrae that is dislocated and/or involves concomitant injury to the spinal cord or other adjacent or subjacent organs due to the fracture

35. Profile Questions.

Include details to each question in the space provided.

If additional space is needed, utilize 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 19 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

36. If your insurance request is accepted, as a service to its insureds 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

Name of Certificate Holder

Street Address

Street Address

City State Zip

City State Zip

Fax:

Fax:

If the above is a hospital, please check one:

Medical Director Administrator

Medical Staff Office Other _____

If the above is a hospital, please check one:

Medical Director Administrator

Medical Staff Office Other _____

Specific Policy Limits will be printed on Certificate.

Specific Policy Limits will be printed on Certificate.

Name of Certificate Holder

Name of Certificate Holder

Street Address

Street Address

City State Zip

City State Zip

Fax:

Fax:

If the above is a hospital, please check one:

Medical Director Administrator

Medical Staff Office Other _____

If the above is a hospital, please check one:

Medical Director Administrator

Medical Staff Office Other _____

Specific Policy Limits will be printed on Certificate.

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 NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DELAWARE APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A person who knowingly and with intent to defraud and insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTICE TO KENTUCKY APPLICANTS: 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 insurance act, which is a crime.

NOTICE TO LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEVADA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO AND RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, will be sanctioned for each violation with a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty may be increased to a maximum of five (5) years, if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE TO TEXAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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 insecure. 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

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 \$ _____ Closed-With no payment made _____
 Closed-With payment made. Indicate amount of settlement or award:
- Has carrier indicated desire to settle?
 Yes No
a. Your policy \$ _____
b. Total (if additional defendants involved) \$ _____

-----NEXT CLAIM-----

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 \$ _____ Closed-With no payment made _____
 Closed-With payment made. Indicate amount of settlement or award:
- Has carrier indicated desire to settle?
 Yes No
a. Your policy \$ _____
b. Total (if additional defendants involved) \$ _____

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**

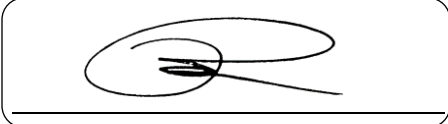
- A. *Regulatory References.* A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.
- B. *Amendment.* The parties shall take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity 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)

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