20. N. Michigan Ave., Suite 700
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. Certain electronic software including Docusign, AdobeSign, Citrix/ RightSignature, EasySign, Indio, DropBox Sign, Wunderite, and PandaDoc have been preapproved for use. Any software used must meet the requirements as outlined in the Electronic Signatures in Global and National Commerce Act (E-SIGN Act, 15 U.S.C. § 7001 et seq.)

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.

ISMIE Mutual Insurance Company
The Physician-First Service Insurer

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

CLEAR ALL FIELDS

Click here to SAVE

BA-3000-NV (05/25)

Processing Number: _____

Application for Partnership/Corporation -or- Clinic Option Professional Liability Insurance

Please choose your desired coverage option, either claims-made or occurrence.

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 question unanswered. If additional space is required to answer any question, use the "Remarks Addendum" section.**

INDICATE TYPE OF POLICY DESIRED:

A. ☐ PARTNERSHIP/CORPORATION POLICY Traditional entity coverage.

B. ☐ CLINIC OPTION POLICY A coverage alternative for corporations, partnerships or other legal entities with 2 or more physicians. The ISMIE Mutual Clinic Option covers each physician as an additional named insured (with separate limits) on a single policy form, eliminating the need for multiple bills and statements. Only the Clinic Option is available with unique shared aggregate limits of liability **(shared aggregate limits not available in states with a Patient Compensation Fund)**.

1A. Partnership/Corporation or Clinic Name:

1B. Indicate all states of practice where ISMIE Mutual coverage is desired:

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

____ / ____ / ____
Month Day Year

3. 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

4. Mailing Address:

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

Address Line 1: _____

Address Line 2: _____

City State Zip

Telephone: (_____) _____-_____ Email: _____

5. Billing Address:

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

Same as Mailing Address ☐

Address Line 1: _____

Address Line 2: _____

City State Zip

Telephone: (_____) _____-_____ Email: _____

Partnership/Corporation/Clinic General Information

6. Name of President/Partner: _____

7. Name of Business Manager/Administrator: _____

8. The legal entity applying for coverage is a:

☐ Partnership
(Submit a copy of the partnership agreement)

☐ Limited Liability Company
(Submit a copy of State Issued Organizational)

☐ Multi-Shareholder Corporation
(Submit a copy of State issued Organizational Documents)

☐ Sole Shareholder of Medical Corporation
(Submit a copy of State Issued Organizational Documents)

☐ Other (Describe)

_____

9. Federal Tax Identification: _____

9a. NPI Number: _____

10. Does the Partnership/ Corporation/ Clinic operate under any other names (d.b.a. "doing business as")?

YES☐ NO☐

If "Yes", please list all "doing business as" names of the Partnership/Corporation/ Clinic:

1.
2.
3.
4.

Professional Liability Insurance Information

It is necessary that you obtain a current Loss History for a ten-year period from each carrier listed below.

11. List all current and previous insurance carriers within the past 10 years.

Use "Remarks Addendum" if additional space is needed.

1. Previous Insurer: _____

From: _____ To: _____ Occurrence ☐ Claims-Made ☐
MM/DD/YYYY MM/DD/YYYY

2. Previous Insurer: _____

From: _____ To: _____ Occurrence ☐ Claims-Made ☐
MM/DD/YYYY MM/DD/YYYY

3. Previous Insurer: _____

From: _____ To: _____ Occurrence ☐ Claims-Made ☐
MM/DD/YYYY MM/DD/YYYY

4. Previous Insurer: _____

From: _____ To: _____ Occurrence ☐ Claims-Made ☐
MM/DD/YYYY MM/DD/YYYY

12. Please provide total Group premiums paid, by year, for the last ten years.

Year	Annual Premium
1. Current Year	**$**
2.	**$**
3.	**$**
4.	**$**
5.	**$**
6.	**$**
7.	**$**
8.	**$**
9.	**$**
10.	**$**

13. Have any malpractice claims or suits been brought against your entity within the past five (5) years?

Yes ☐ No ☐

If "Yes", please provide the following:

- Brief description of each claim (Use Claim Information Supplement included in application)
- Reserves on pending claims (both indemnity and expense)
- Payments on any closed claim/suit (both indemnity and expense)
- Complete copies of all office/hospital medical records and summons and complain may be requested.

Limits of Liability Requested

14. Limits of Liability (Please skip this section if your entity is domiciled 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.

Please select **one** of the following options available: A, B, C or D.

A. Limits of Liability: Corporation/ Partnership Only – Not applicable for Clinic Option

☐ Yes ☐ No

☐ $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

B. Limits of Liability: Clinic Option Only – Not applicable for Corporation/Partnership

☐ Yes ☐ No

☐ $1,000,000/$3,000,000 "each person"/ "aggregate" ☐ $2,000,000/$4,000,000 "each person"/ "aggregate"

C. Limits of Liability: Shared Aggregate Limit Clinic Option Only – Not applicable for Corporation/Partnership (Shared Clinic Aggregate Limits option only available in DC, Illinois, Georgia, Iowa, Missouri and Ohio)

☐Yes ☐No

		Aggregate Limit ***	
"Each Person" Limit	# of Exposures*	$1M	$2M
	2	5M	6M
☐$1 million each person/	3	8M	10M
	4	10M	12M
☐$2 million each person	5	15M	16M
	6	16M	18M
	7	18M	22M
	8	20M	24M
	9	22M	28M
	10-19	25M	30M
	20-39	40M	45M
	40-59	55M	60M
	60-79	70M	75M
	80-99**	85M	90M

* Includes legal entity and each physician affiliate.

** For each additional 20 physicians insured, increase the aggregate by $15M.

*** Increased aggregate limits may be purchased. For each additional limit, an additional premium of 1% of the aggregate physician and Allied Health Personnel premiums will be charged.

D. Shared Limits of Liability: Clinic Option Only – <u>Not applicable for Corporation/Partnership</u>

☐Yes ☐No

The shared limit option is only available in certain states for clinic option policyholders who **desire to insure their professional entity on a** shared limit basis under the clinic option policy, which means the entity shares in one limit of liability with one ISMIE insured employed physician when both are named as co-defendants in the same claim. Further details will be provided to applicants interested in this option.

<u>The Shared Limit Option must match the limits of the ISMIE insured physician affiliates, as listed below:</u>

☐$1 million each person

☐$2 million each person

15. Profile Questions

Please answer each question below and use the "Remarks Addendum" to provide a detailed narrative if you answer "Yes" to any of the questions.

YES	NO		
☐	☐	A.	Has the partnership/corporation/ clinic's professional liability insurance ever been canceled for non-payment of premium? If "yes," indicate date(s) of such cancellation **(Not Applicable in Missouri)**: _____
☐	☐	B.	Has the partnership/corporation/ clinic's professional liability insurance ever been declined, canceled, non-renewed or issued on special terms? (Including but not limited to: restrictive endorsements, surcharged premium, etc.) **(Not Applicable in Missouri)**
☐	☐	C.	Has the partnership/corporation/ clinic owned and operated, participated in or directed any entrepreneurial medical business? If "yes," indicate name(s), address(es) and type(s) of business(es): _____
☐	☐	D.	Does the partnership/corporation/clinic, through its additional named insured physicians, treat or intend to treat any patient by means of 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" to identify physician(s) in the clinic who participate in this activity and provide a full written narrative indicating treatment(s) and provide name(s) and address(es) of sponsoring institution(s) or entity(ies) if applicable.
☐	☐	E.	Does the partnership/corporation/ clinic contract to any governmental facility? If "Yes," please provide a copy of any contract you have executed.
☐	☐	F.	Does the partnership/corporation/clinic have any knowledge or information, or have any reason to have any knowledge or information, of an act, error, omission, fact or circumstance which might give rise to a claim which may fall within the scope of the proposed insurance?

16. Please provide a detailed narrative of your group's process for credentialing its physician affiliates:

Partnership/Corporation /Clinic Census

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

Codes: 01-Partner 02-Shareholder 03-Employee 04-Independent Contractor

Code	Physician Name	Insurance Carrier	Limits of Liability	Policy Number	Specialty
	1)				
	2)				
	3)				
	4)				
	5)				
	6)				
	7)				
	8)				
	9)				
	10)				
	11)				
	12)				
	13)				
	14)				
	15)				
	16)				
	17)				
	18)				
	19)				
	20)				
	21)				
	22)				
	23)				
	24)				
	25)				
	26)				

18. Allied Health Personnel

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

		Total			Total
A .	**Certified Registered Nurse Anesthetist**	____	**E.**	**Physician Assistant**	____
B.	**Certified Clinical Nurse Specialist**	____	**F.**	**Psychologist**	____
C.	**Certified Nurse Practitioner**	____	**G.**	**Other** (Specify in Remarks Addendum)	____
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.

		Total			Total
H.	**Chiropractor**	____	**K.**	**Podiatrist**	____
I.	**Dentist**	____	**L.**	**Pharmacist**	____
J.	**Optometrist**	____	**M.**	**Other** (Specify in Remarks Addendum)	____

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. *(Not applicable in the State of Kansas)*

19. Practice Location Information

List all current hospital, outpatient office practice locations and all or other facilities in this section. Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values. Include all locations whether or not ISMIE Mutual insurance is desired at that location. Please copy this page for additional locations, and/or list additional locations in the "Remarks Addendum" section.

1. Name of Location: _____

Is ISMIE coverage desired for this location? Yes ☐ No ☐ If "No", describe activity not to be covered and state by whom insured:
_____

Indicate type of location: Office ☐ Hospital ☐ Surgery Center ☐ Nursing Home ☐ Other ☐

If other, please indicate: _____

Address: _____
Street City State Zip

County: _____

If this your primary location? Yes ☐ No ☐ % of practice: _____

Average weekly practice time at this location: _____

2. Name of Location: _____

Is ISMIE coverage desired for this location? Yes ☐ No ☐ If "No", describe activity not to be covered and state by whom insured:
_____

Indicate type of location: Office ☐ Hospital ☐ Surgery Center ☐ Nursing Home ☐ Other ☐

If other, please indicate: _____

Address: _____
Street City State Zip

County: _____

If this your primary location? Yes ☐ No ☐ % of practice: _____

Average weekly practice time at this location: _____

3. Name of Location: _____

Is ISMIE coverage desired for this location? Yes ☐ No ☐ If "No", describe activity not to be covered and state by whom insured:
_____

Indicate type of location: Office ☐ Hospital ☐ Surgery Center ☐ Nursing Home ☐ Other ☐

If other, please indicate: _____

Address: _____
Street City State Zip

County: _____

If this your primary location? Yes ☐ No ☐ % of practice: _____

Average weekly practice time at this location: _____

4. Name of Location: _____

Is ISMIE coverage desired for this location? Yes ☐ No ☐ If "No", describe activity not to be covered and state by whom insured: _____

Indicate type of location: Office ☐ Hospital ☐ Surgery Center ☐ Nursing Home ☐ Other ☐

If other, please indicate: _____

Address: _____
Street City State Zip

County: _____

If this your primary location? Yes ☐ No ☐ % of practice: _____

Average weekly practice time at this location: _____

5. Name of Location: _____

Is ISMIE coverage desired for this location? Yes ☐ No ☐ If "No", describe activity not to be covered and state by whom insured: _____

Indicate type of location: Office ☐ Hospital ☐ Surgery Center ☐ Nursing Home ☐ Other ☐

If other, please indicate: _____

Address: _____
Street City State Zip

County: _____

If this your primary location? Yes ☐ No ☐ % of practice: _____

Average weekly practice time at this location: _____

6. Name of Location: _____

Is ISMIE coverage desired for this location? Yes ☐ No ☐ If "No", describe activity not to be covered and state by whom insured: _____

Indicate type of location: Office ☐ Hospital ☐ Surgery Center ☐ Nursing Home ☐ Other ☐

If other, please indicate: _____

Address: _____
Street City State Zip

County: _____

If this your primary location? Yes ☐ No ☐ % of practice: _____

Average weekly practice time at this location: _____

Practice Information

21. Does your group have a credentialing process for staff?

A. Physician staff? ❑ Yes ❑ No

B. Non-physician staff? ❑ Yes ❑ No

If "Yes", does your credentialing include the following:	Physicians	Non-physicians
A. Verification of Training?	❑ Yes ❑ No	❑ Yes ❑ No
B. Verification of Appropriate Licensure?	❑ Yes ❑ No	❑ Yes ❑ No
C. Confirmation of Board Certification?	❑ Yes ❑ No	❑ Yes ❑ No
D. Appropriate certification for non-physicians?	❑ Yes ❑ No	
E. Evaluation of clinical competence?	❑ Yes ❑ No	❑ Yes ❑ No
F. Evaluation of loss experience?	❑ Yes ❑ No	❑ Yes ❑ No
G. Review of any disciplinary action by a Hospital or Licensing Board?	❑ Yes ❑ No	❑ Yes ❑ No

22. Does your group maintain any kind of accreditation? ❑ Yes ❑ No

-If "Yes, please indicate accrediting organization(s), effective date and term:

_____

_____

23. Does your group maintain medical equipment which requires on-going maintenance? ❑ Yes ❑ No

-If "Yes, describe your maintenance process and procedures:

_____

_____

24. Does your group maintain written practice protocols such as:

A. Delegation of medical treatment to non-physician staff? ❑ Yes ❑ No

B. Office procedures for follow-up on Lab reports/X-rays? ❑ Yes ❑ No

C. Office procedures for missed appointments? ❑ Yes ❑ No

D. Office procedures for referrals? ❑ Yes ❑ No

E. Prescription refill authorization? ❑ Yes ❑ No

F. Medical record retention/HIPAA compliance? ❑ Yes ❑ No

G. Written procedures for resolution of patient complaints? ❑ Yes ❑ No

H. Patient satisfaction surveys? ❑ Yes ❑ No

I. Guidelines for access to care after hours, weekends, holidays? ❑ Yes ❑ No

(copies of practice protocols/documentation may be requested)

25. Does you group have an active Quality Service Committee and/or Medical Director responsible to review unexpected outcomes, monitor quality of care, etc.? ❑ Yes ❑ No

-If "Yes", copies of reports or minutes may be requested

-If "No", describe the process your group utilizes:

_____

_____

26. Does your group, on an annual or more frequent basis, monitor the ratio of Patient Volume to Physician Staff and Non-Physician Staff? ☐ Yes ☐ No

27. Do any of your physicians function as a Hospitalist or Laborist?
If "yes", list physician names below:

_____

_____

-If "No", does your group utilize the services of outside Hospitalists or Laborists? ☐ Yes ☐ No

28. Does your group or any of your physicians 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)

29. Does your group 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 physician's medical license for that state with their individual applications.

If your physicians do not maintain a license in that other state, please explain:

_____

_____

30. Does your group or any of your physicians provide Concierge services? ☐ Yes ☐ 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 provided, hours of availability, etc.

_____

_____

31. Does your group or any of your physicians provide Aesthetic or Spa type services? ☐ Yes ☐ No

32. Does your group employ a full-time Risk Manager? ☐ Yes ☐ No
-If "Yes", provide the individual's name, title and employment date, and provide written job description:
(Please note an application for Risk Manager Premium Discount must be submitted and approved by ISMIE to qualify for any discounts available)

_____

_____

33. Provide an overview of your group's practice by reimbursement type:

Payor	Percent of Practice Total
Medicare	_____
Medicaid	_____
Private Insurance Companies	_____
Private HMO (Managed Care)	_____
Self-Pay	_____

34. Does your group support participation in Continuing Medical Education (CME)? -If yes, complete A - D ☐ Yes ☐ No

A. Does your group provide physicians with time away from practice to ensure participation? ☐ Yes ☐ No

B. List the number of days per physician per year: _____;
Annual CME hours expected: _____

C. Does your group provide Allied Health Personnel (AHPs) with time away from practice to ensure participation? ☐ Yes ☐ No

D. List the number of days per AHP per year: _____;
Annual CME hours expected: _____

Certificate(s) of Insurance

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED.

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 hospital or other health care institution on your behalf, complete the following:

A. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

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

Specific Policy Limits will be printed on Certificate.

B. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

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

Specific Policy Limits will be printed on Certificate.

C. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

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

Specific Policy Limits will be printed on Certificate.

D. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

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

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

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.

Partnership/Corporation or Clinic Name (*please print*)	Signature of President/Partner or Authorized Person	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 presents a false or fraudulent claim for payment of a loss or benefit or who knowingly 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 an 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 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 fines or 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 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 as 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: 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.

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 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 the acceptance of this application and any future renewal, ISMIE Mutual or its duly authorized representatives may conduct an inquiry or investigation into my professional background, qualifications, and competence, as well as other relevant underwriting and claims matters necessary for this insurance. I expressly consent to such inquiries and authorize the release and exchange of information related to this investigation between ISMIE Mutual and any professional organizations in which I am or have been a member, my insurance agents, brokers, or consultants, any hospitals where I currently or previously held staff privileges, including those where an application for staff privileges was denied, any state licensing agency, any attending or treating physician, and any prior or current insurance carriers

I release and discharge all aforementioned entities, including ISMIE Mutual and its authorized review committees, from any legal liability for good faith communications, reports, disclosures, recommendations, or actions taken in connection with any inquiry or investigation conducted by ISMIE Mutual or its representatives. I further authorize ISMIE Mutual or its representatives to provide information regarding my professional liability history and issue Certificates of Insurance to hospitals, managed care entities, or other affiliated organizations. I also authorize ISMIE Mutual or its representatives to exchange information about my professional liability policy with my current and future employer. If my insurance premiums are paid by my employer and my employment relationship ends for any reason during the policy period, including policy cancellation, I agree that any remaining insurance premiums, including return premiums, shall be retained by the employer.

ISMIE Mutual may collect personal information from sources other than the applicant for processing this application. In certain circumstances, such information may be disclosed without prior authorization. I understand that I have the right, subject to legal limitations, to request access to personal information collected by ISMIE Mutual and to request corrections, amendments, or deletions of certain personal information, subject to regulatory guidelines.

Pursuant to the Uniform Electronic Transactions Act (Chapter 719 of the Nevada Revised Statutes) and the Electronic Signatures in Global and National Commerce Act (E-SIGN Act, 15 U.S.C. § 7001 et seq.), I acknowledge and agree that my electronic signature carries the same legal effect as a handwritten signature. I further consent to ISMIE Mutual and its affiliates and agents to share or distribute my personal information to send communications, notices, and policy-related information via mail, email, fax, or other electronic methods including promotional notices or solicitations related to the practice of medicine including but not limited to the availability of goods, services, membership, and opportunities. I understand that I may withdraw consent to electronic communications by notifying ISMIE Mutual in writing.

By signing below, I confirm that I have read, understand, and consent to the terms outlined in this Authorization, Consent, and Disclosure Statement.

Partnership/Corporation or Clinic Name (*please print*)	Signature of President/Partner or Authorized Person	Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor 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.

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

*This application must be signed by the applicant. If an insurance agent/producer/broker assisted with completion of the application, they are permitted to sign the application in addition to the applicant, but an application will not be accepted if not signed by the applicant.

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 when _____ / _____

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 $_____

☐ Closed-With no payment made
Date _____

☐ Closed-With payment made.

- Has carrier indicated desire to settle?

Indicate amount of settlement or award:

☐ Yes ☐ No

a. Your policy $ _____ Date _____

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 when _____ / _____

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 $ _____

☐ Closed-With no payment made
Date _____

☐ Closed-With payment made.

- Has carrier indicated desire to settle?

Indicate amount of settlement or award:

☐ Yes ☐ No

a. Your policy $ _____ Date _____

b. Total (if additional defendants involved) $_____

Remarks Addendum

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED, OR CONTINUE INFORMATION ON YOUR LETTERHEAD. PLEASE WRITE LEGIBLY

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
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: Nicole Scott

Title: HIPAA Privacy Officer

(2/23)