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.

AA-1000-OK (05/25)

CLEAR ALL FIELDS

Click here to SAVE

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

Processing Number: _____

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.

Please provide a copy of your current Curriculum Vitae (required)

Application Information

1. Full Name:

_____

Last *First* *M.I.* *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 physician)

_____

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 Personal Information

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

7. Home Address Line 1: _____

Address Line 2: _____

City State Zip

Telephone: (_____)_____-_____ Email: _____

8a. 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: _____

8b. 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: _____

Licensure

(Please include copies of all licenses)

9a. Medical License Number: _____ 10a. Controlled Substance Number: _____
Number State Number State

9b. Medical License Number: _____ 10b. Controlled Substance Number: _____
Number State Number State

9c. Medical License Number: _____ 10c. Controlled Substance Number: _____
Number State Number State

11. DEA Number: _____ 12. NPI Number: _____

Medical Education

13. Medical School: _____ Year Graduated: _____

Location: _____ Degree: _____
City State Country

Residency Information:

14a. Name of Hospital/Facility: _____

Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

Completed? Yes ☐ No ☐

14b. Name of Hospital/Facility: _____

Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

Completed? Yes ☐ No ☐

Additional Training:

15a. Name of Hospital/Facility: _____

Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

Completed? Yes ☐ No ☐

15b. Name of Hospital/Facility: _____
Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

Completed? Yes ☐ No ☐

16. Are you entering private practice for the first time? Yes ☐ No ☐

Board Certification Information

17. American Board Certified? Yes ☐ No ☐ Date most recently certified: _____
MM/DD/YYYY

Specialty Board: _____

18. If not American Board Certified, are you board eligible? Yes ☐ No ☐
If yes, when do you plan to take your boards? _____

19. If not American Board Certified, have you ever taken a specialty board examination and failed to pass?
Yes ☐ No ☐ If yes, how many times? _____

If yes, please explain: _____

Medical Specialty Information:

20a. Principal Medical Specialty in which you practice: _____
% of practice time _____%

20b. Sub-specialty in which you practice: _____
% of practice time _____%

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

Previous Practice Activity

21. Do you have any previous practice activities since completion of formal training?

If yes, list all activities within the past 10 years. 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, surgery centers, office surgery facilities, outpatient laboratories and x-ray facilities, etc. Use "Remarks Addendum" if additional space is required. Explain all gaps in professional activities.

1. Name of Practice: _____

Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

2. Name of Practice: _____

Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

3. Name of Practice: _____

Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

4. Name of Practice: _____

Address: _____
Street City State Zip

From: _____ To: _____ Specialty: _____
MM/DD/YYYY MM/DD/YYYY

Professional Liability Insurance Information

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

22. List all 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

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

☐ A. Individual

☐ B. Employed
Employers Name: _____

☐ C. Independent Contractor – *Please attach copy of contract*
Contractor Name: _____

☐ D. Partner of a medical partnership – *please attach copy of partnership or business agreement*
Partnership Name: _____

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

☐ F. Sole Shareholder of a Medical/Professional Service Corporation – *Please submit State issued Organizational Documents*
Corporation Name: _____

Does this entity operate under any other names (d.b.a. "doing business as")? Yes ☐ No ☐

If yes, list all names: _____

Note: 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's Compensation Fund)

Are separate policy limits desired for this entity? Yes ☐ No ☐
If "yes" a separate Application for Partnership/ Corporation/ Clinic is required and is available on our website- www.ismie.com.

Limits of Liability Requested

24. Physician Policy Limits of Liability: (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 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.

❑ $100,000/$300,000 "each person"/ "aggregate"	❑ $125,000/$1,000,000 "each person"/ "aggregate"	❑ $200,000/$600,000 "each person"/ "aggregate"
❑ $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"

`

Professional Practice Relationships

25. Please provide census information for all 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)				

Allied Health Personnel

26. 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 is 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. Corporation.

		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.

Questions About Your Practice

27. Do you have a written contract to provide healthcare services to any professional sports organization?
Yes ☐ No ☐

If yes, please provide names of Organization(s): _____

28a. 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.

28b. Do you provide Aesthetic or Spa type services? Yes ☐ No ☐

If "yes", please complete the cosmetic procedure questions and provide narrative if necessary.

29. Do you maintain hospital privileges at one or more facilities? Yes ☐ No ☐

If "yes," please indicate in the practice location section below.
If you do not maintain hospital privileges, please explain:

_____

_____

30. Do you practice part-time (defined as total practice time less than 21 hours per week including completion of medical records, consultations, in-house on call time, etc.) with significantly reduced patient encounters for your specialty? Yes ☐ No ☐

If yes, additional information will be required for consideration for part-time rating.

Profile Questions

31. 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 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)**

Yes ☐ No ☐ 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.

Yes ☐ No ☐ 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?

Yes ☐ No ☐ 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?

Yes ☐ No ☐ E. Has membership in any medical society or professional organization ever been denied, suspended, revoked, voluntarily surrendered or accepted on a restricted basis?

Yes ☐ No ☐ 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?

Yes ☐ No ☐ G. Has your license to practice or prescribe controlled substance ever been suspended, revoked, voluntarily surrendered, reprimanded, fined or subjected to probationary terms? If "Yes", indicate which:

_____

Yes ☐ No ☐ 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 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.?

Yes ☐ No ☐ 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.

Yes ☐ No ☐ J. Do you 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?

Practice Location Information:

32. List all hospital, outpatient office practice locations, and all or other facilities in this section. Please list primary location first. Combined percentage of practice time 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 insurance carrier: _____

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: _____

2. Name of Location: _____

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

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: _____

3. Name of Location: _____

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

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: _____

4. Name of Location: _____

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

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: _____

5. Name of Location: _____

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

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: _____

6. Name of Location: _____

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

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: _____

Medical Procedures

33. 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 ☐ 1. Angiography
Yes ☐ No ☐ 2. Arteriography
Yes ☐ No ☐ 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.)
Yes ☐ No ☐ 4. Defibrillation Insertion
Yes ☐ No ☐ 5. Electro-physiological studies and ablations
Yes ☐ No ☐ 6. Insertion of Balloon Expandable Stent
Yes ☐ No ☐ 7. Insertion of Cardiac Pacemaker whether temporary or permanent *
Yes ☐ No ☐ 8. Insertion of intra-aorta balloon pump
Yes ☐ No ☐ 9. Intracoronary Infusions
Yes ☐ No ☐ 10. Myocardial Biopsies
Yes ☐ No ☐ 11. Pericardiocentesis *
Yes ☐ No ☐ 12. Percutaneous Transluminal Therapeutic Angioplasty including placement of stents
Yes ☐ No ☐ 13. Left Atrial Appendage Occlusion Procedure
Yes ☐ No ☐ 14. Structural Cardiac Transcatheter Interventions
Yes ☐ No ☐ 15. Percutaneous Mechanical Circulatory Support

B. Minor Risk Procedures – Interventional Radiology

Yes ☐ No ☐ 1. Diagnostic angiography and treatment of arterial and venous vasculature including angioplasty, thrombolysis/thrombectomy, stent placement, atherectomy and embolization
Yes ☐ No ☐ 2. Deep organ biopsy including liver and kidney
Yes ☐ No ☐ 3. Percutaneous genitourinary interventions
Yes ☐ No ☐ 4. Percutaneous vertebroplasty/kyphoplasty
Yes ☐ No ☐ 5. Percutaneous radiofrequency ablation of deep/superficial tumors
Yes ☐ No ☐ 6. Extracranial embolization procedures (including fibroid embolization, hepatic chemoembolization)
Yes ☐ No ☐ 7. Hepatobiliary procedures
Yes ☐ No ☐ 8. Gastrostomy tube placement/revision

C. Minor Risk Procedures – Ophthalmic Surgery

Yes ☐ No ☐ 1. 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
Yes ☐ No ☐ 2. 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

D. Minor Risk Procedures – Other

Yes ☐ No ☐ 1. Assisting in the performance of surgery *
Yes ☐ No ☐ 2. Interstitial Hyperthermia
Yes ☐ No ☐ 3. Ultrasound Hyperthermia (Superficial only)
Yes ☐ No ☐ 4. MRI Guided Focused Ultrasound for Treatment of Uterine Fibroids
Yes ☐ No ☐ 5. Vascular access for Dialysis (Including Tunneled Catheter)

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

Currently Performing:

Yes ☐ No ☐ 1. Neurotoxin Injections such as: Botox and Dysport
Yes ☐ No ☐ 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.
Yes ☐ No ☐ 3. Long term Filler Injections that are semi-permanent such as: Artefill, Radiesse and Sculptra
Yes ☐ No ☐ 4. Endovenous Laser Vein Treatment (EVLT)
Yes ☐ No ☐ 5. Laser Treatment of Leg Veins
Yes ☐ No ☐ 6. Skin Treatment performed with Non-Ablative Laser Treatment or Non-Ablative Chemical Peels (epidermis is left intact without full destruction)
Yes ☐ No ☐ 7. Skin Treatment performed with Ablative Laser Treatment or Ablative Chemical Peels (extends through the epidermis with epidermal destruction).
Yes ☐ No ☐ 8. Laser Hair Removal
Yes ☐ No ☐ 9. Non-Invasive Skin Tightening or Fat/Cellulite Reduction procedures (no intravenous sedation or incisions) performed with lasers, ultrasound, radiofrequency or freezing.
Yes ☐ No ☐ 10. Injection Lipolysis (Lipodissolve, Mesotherapy or Kybella injection)
Yes ☐ No ☐ 11. Tumescent Liposuction (local anesthesia only)
Yes ☐ No ☐ 12. Liposuction/Suction Lipectomy (under general anesthesia or intravenous sedation)
Yes ☐ No ☐ 13. Other cosmetic fillers including any products from off-shore or non-authorized distributors
Yes ☐ No ☐ 14. Other procedures not listed above: _____
_____
Yes ☐ No ☐ 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:

34. Obstetrical Procedures

A. Number of total deliveries you perform annually: _____

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

	Total		Total
1. Normal Vaginal Deliveries: (Uncomplicated pregnancy, may include episiotomy and application of outlet/low forceps or vacuum cup)	_____	5. Breech Delivery, Vaginal:	_____
2. VBACs:	_____	6. External Version:	_____
3. Mid-forceps Delivery, Mid Vacuum:	_____	7. Multiple Gestation, Vaginal Delivery:	_____
4. Cesarean Section (primary, repeat):	_____	8. Version and Extraction, 2nd Twin:	_____

C. Performance of Home Deliveries Yes ☐ No ☐

D. Chorionic Villi Sampling Yes ☐ No ☐

35. Gynecological Procedures

A. Termination of Pregnancy: Yes ☐ No ☐ If yes, please indicate how many per year below:

First Trimester: _____ Second Trimester: _____

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

	Total		Total
Amniocentesis:	_____	LEEP:	_____
Cervical Conization:	_____	Essure Sterilization:	_____
D&C (Does not apply to termination of pregnancy):	_____	Marsupialization of Bartholin Cyst:	_____
Endometrial Ablation:	_____	Co2 Laser of Cervix:	_____
Operative Hysteroscopy:	_____	Other:	_____
Invitro Fertilization:	_____	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:

	Total		Total
Anterior/Posterior Repair:	_____	Vaginal Vault Suspension:	_____
Diagnostic Laparoscopy:	_____	Sacrocolpopexy/Sacrospinous:	_____
Urethral Suspension Procedure:	_____	Other:	_____
Operative Laparoscopy:	_____	(Residency trained OB/GYNE physicians are not required to report other procedures in this section)	
a. Hysterectomies			
b. Myomectomies			
c. Oophorectomies			
d. Ovarian Cystectomies			
e. Tubal Ligations/salpingectomies			
		TOTAL (Annual):	_____

36. Major Risk Procedures Please answer all questions regardless of your medical specialty:

Currently Performing:

Annual # Procedures	Practice Time%		Surgical Procedures
_____	_____	Yes☐ No☐	1. Administration of General Anesthesia, including intubation and Regional Anesthesia
_____	_____	Yes☐ No☐	2. Therapeutic Anesthesia for pain management (spinal nerve blocks, pumps, stimulators, etc.)
_____	_____	Yes☐ No☐	3. Advanced Pain Interventions (such as Minuteman procedure, MILD, Vertiflex), Discography, Percutaneous discectomy, Vertebroplasty, Kyphoplasty, Chemo neurolysis, Neuroblation
_____	_____	Yes☐ No☐	4. 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
_____	_____	Yes☐ No☐	5. Cardiac Surgery
_____	_____	Yes☐ No☐	6. Colon Surgery
_____	_____	Yes☐ No☐	7a. *General Surgery – No Bariatric Surgery *(General Surgery may include Extensor Tendon Repair)
_____	_____	Yes☐ No☐	7b. *General Surgery – Including Bariatric Surgery (as defined above in number 4)
_____	_____	Yes☐ No☐	8. 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 ☐ No☐
_____	_____	Yes☐ No☐	9. Otorhinolaryngology a. Elective Plastic Head and Neck Only - Yes ☐ No☐ b. Elective Plastic Other than Head and Neck - Yes ☐ No☐ c. Traumatic/Pathologic - Yes ☐ No☐
_____	_____	Yes☐ No☐	10. Intracranial Balloon Embolization
_____	_____	Yes☐ No☐	11. Neurological Surgery **with Intracranial Surgery** (Including Leksell Gamma Radiosurgical Unit)
_____	_____	Yes☐ No☐	12. Neurological Surgery **No Intracranial Surgery** (If yes, please also answer #17)
_____	_____	Yes☐ No☐	13. Organ Transplantation (Other than Corneal Transplants)

Currently Performing:

Annual # Procedures	Practice Time%		Surgical Procedures
_____	_____	Yes☐ No☐	14. 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 - Orthopaedic Surgery including obtaining an Iliac Crest Bone Graft and open procedures on the coccyx but excluding open procedures on the rest of the spine
_____	_____	Yes☐ No☐	15. Plastic Surgery (other than minor skin grafts)
_____	_____	Yes☐ No☐	16. Proctologic Surgery (This does not apply to Proctoscopy with or without biopsy)
_____	_____	Yes☐ No☐	17. Spinal Surgery (All open procedures on the spine excluding the coccyx and obtaining An Iliac crest bone graft)
_____	_____	Yes☐ No☐	18. Liposuction/suction lipectomy (under general anesthesia or intravenous sedation)
_____	_____	Yes☐ No☐	19. Tumescent Liposuction (local anesthesia only)
_____	_____	Yes☐ No☐	20. Temporomandibular Joint Surgery (Including total replacement, Arthroscopy, Alloplastic Implants or Meniscal Repair Via Plication)
_____	_____	Yes☐ No☐	21. Thoracic Surgery
_____	_____	Yes☐ No☐	22. Urological Surgery (Including Vasectomy, Adult Circumcision and Therapeutic Cystoscopy ☐ Check here if you insert penile protheses
_____	_____	Yes☐ No☐	23. Varicose Vein Surgery (This does not apply to injection sclerotherapy)
_____	_____	Yes☐ No☐	24. Vascular Surgery (Includes peripheral other than Varicose Veins)
_____	_____	Yes☐ No☐	25. Other Procedures. Do you perform other procedures which are not indicated? If yes, please list all other procedures below: _____ _____ _____

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.

Applicant Name (*please print*)	Applicant 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 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 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 (815 ILCS 333) 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.

Applicant Name (*please print*)	Applicant Signature	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 _____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

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

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 _____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

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

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

AA-1000-OK (05/25)

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)