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

Policy Number _____

Application for
Part-Time Rating
Professional Liability Insurance

Physician Name:

_____

First Middle Last Title

Information and Instructions (Please read carefully):

This application is to be utilized by existing ISMIE claims-made or occurrence insured policyholders only. Part-time rating is available to physicians who can demonstrate that their ISMIE Insured practice activities average 21 hours per week or less (24 hours per week for Emergency Medicine) and their average weekly patient volume is significantly reduced and correlates to the reduced average weekly practice time for a minimum of six months. Practice activities which will count toward your total practice time include, but are not limited to:

- Clinical patient care in all ISMIE insured office, hospital and ambulatory surgery center practice locations and all administrative duties directly associated with patient care.
- Consultations and professional services rendered while on call.
- Any provision of healthcare services for which ISMIE insurance is desired.

It is essential that all statements be completed, all questions answered, and any additional information requested is provided. 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.**

You will need to submit the following additional information:

1) **Copies of appointment books for each office location for the most recent six month period, and;**
2) **A Physician Activity Study (PAS) for each hospital location. (A form is attached for your convenience. If additional forms are needed please photocopy).**

NOTE: If you are a hospital based Emergency Medicine physician, an Anesthesiologist, Radiologist, Hospitalist or Pathologist, please provide a letter from your employer or Department Chairman which confirms your average weekly practice time. For all other specialties – please provide a Physician Activity Study (PAS) for each hospital location.

1. GENERAL INFORMATION

A. When did you begin to practice on a part-time basis?

B. Please describe, in detail, your part-time practice activities:

C. Please provide a narrative which explains how your practice has changed including the basis for your reduction to part-time; such as: a non-ISMIE insured activity, administrative duties, etc.

2. OFFICE/OUTPATIENT PRACTICE INFORMATION

(Do not include hospital practice locations here unless you maintain a clinical practice in the hospital or are a hospital based Emergency Medicine Physician, an Anesthesiologist, Radiologist, Hospitalist or Pathologist).

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

Facility Codes (Please Indicate All that Apply)

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

A. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

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

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

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

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

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

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

_____

_____

Average number of patients per week: _____

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

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

_____.

Please indicate the days and times of practice in a typical week:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
from:	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.
to:	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.

Remarks, if any _____

_____

2. OFFICE/OUTPATIENT PRACTICE INFORMATION (cont'd)

B. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

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

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

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

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

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

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

_____

_____

Average number of patients per week: _____

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

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

Please indicate the days and times of practice in a typical week:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
from:	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.
to:	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.

Remarks, if any _____

_____

3. Do you have a written contract to provide healthcare services to any professional sports organizations?

Yes ☐ **No** ☐

If "Yes", please provide names of Organization(s) _____

(please include copy of contract)

4. 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.

5. HOSPITAL PRACTICE LOCATIONS

A. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

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

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

Specialty department of: _____

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

Do you staff the ER at this hospital other than to maintain hospital privileges?

Yes ☐ **No** ☐

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

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ **No** ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

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

_____

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

Average number of patients per week: _____

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

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

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

Please indicate the days and times of practice in a typical week:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
from:	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.
to:	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.	a.m. / p.m.

Remarks, if any _____

_____

5. HOSPITAL PRACTICE LOCATIONS (cont'd)

B. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

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

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

Specialty department of: _____

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

Do you staff the ER at this hospital other than to maintain hospital privileges?

Yes ☐ **No** ☐

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

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ **No** ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

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

_____

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

Average number of patients per week: _____

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

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

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

Please indicate the days and times of practice in a typical week:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
from:	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.
to:	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.

Remarks, if any _____

_____

6. Do you practice as a Hospitalist? **Yes** ☐ **No** ☐

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

7. Do you provide Concierge practice services? **Yes** ☐ **% of practice time** _____ **No** ☐

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

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

_____

_____

8.A Do you perform Robotic Surgery? **Yes** ☐ **No** ☐
If "yes", if please complete the medical procedures questions on pages 8-13, including #16 if necessary.

8.B Do you provided Aesthetic or Spa type services **Yes** ☐ **No** ☐
If "yes", please complete the medical procedure questions on page 9 and provide narrative if necessary.

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

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

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

Policy Number

☐ **A**. Individual

☐ **B**. Employed
Employer's Name_____

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

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

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

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

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

Yes ☐ No ☐

If Yes, list all names: _____
_____

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

Yes ☐ No ☐

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

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

11. 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
☐	☐	2.	Arteriography
☐	☐	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
☐	☐	4.	Defibrillation Insertion
☐	☐	5.	Electro-physiological studies and ablations
☐	☐	6.	Insertion of Balloon Expandable Stent
☐	☐	7.	Insertion of Cardiac Pacemaker whether temporary or permanent *
☐	☐	8.	Insertion of intra-aorta balloon pump
☐	☐	9.	Intracoronary Infusions
☐	☐	10.	Myocardial Biopsies
☐	☐	11.	Pericardiocentesis *
☐	☐	12.	Percutaneous Transluminal Therapeutic Angioplasty including placement of stents

B. Minor Risk Procedures - Interventional Radiology

☐	☐	13.	Peripheral arterial angiography, angioplasty, atherectomy, thrombolysis, and stenting
☐	☐	14.	Deep organ biopsy
☐	☐	15.	Nephrostomy
☐	☐	16.	Percutaneous vertebroplasty/kyphoplasty
☐	☐	17.	Percutaneous radiofrequency ablation of deep/superficial tumors
☐	☐	18.	Extracranial embolization procedures(including fibroid embolization, hepatic chemoembolization)

C. Minor Risk Procedures - Ophthalmic Surgery

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

11. Minor Risk Procedures (cont'd)

D. Minor Risk Procedures – Other

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

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

Currently Performing:

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

List: _____

_____

_____

12. Cosmetic Procedures (cont'd)

Yes	No		
☐	☐	14.	Other procedures not listed above: List: _____ _____ _____
☐	☐	15.	**Plastic surgery** (such as breast augmentation, abdominoplasty, blepharoplasty, rhinoplasty, face lift, etc.) All specialists other than residency trained Plastic Surgeons or Otorhinolaryngologists (ENT), please list all surgical procedures: _____ _____ _____

13. Obstetrical Procedures

a. Number of **total deliveries** you perform **annually**: _____
b. Of your total annual deliveries, please provide a breakdown of the following:

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

c. Performance of Home Deliveries: Yes ☐ No ☐
d. Chorionic Villi Sampling: Yes ☐ No ☐

14. Gynecological Procedures

A. Termination of Pregnancy: Yes ☐ No ☐

If "Yes" First Trimester, # **per year** _____

Second Trimester, # **per year** _____

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

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

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

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

15. Major Risk Procedures (answer all questions)

Currently Performing:

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

15. Major Risk Procedures (con't)

Yes	No	Annual # Procedures	Practice Time %	Surgical Procedures
				- 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
☐	☐			14. Plastic Surgery (other than minor skin grafts)
☐	☐			15. Proctologic Surgery (This does not apply to Proctoscopy with or without biopsy)
☐	☐			16. Spinal Surgery (All open procedures on the spine excluding the coccyx and obtaining An Iliac crest bone graft)
☐	☐			17. Liposuction/suction lipectomy (under general anesthesia or intravenous sedation)
☐	☐			18. Tumescent Liposuction (local anesthesia only)
☐	☐			19. Temporomandibular Joint Surgery (Including total replacement, Arthroscopy, Alloplastic Implants or Meniscal Repair Via Plication)
☐	☐			20. Thoracic Surgery
☐	☐			21. Urological Surgery (Including Vasectomy, Adult Circumcision and Therapeutic Cystoscopy
				_____ **Check here, if you insert penile prostheses**
☐	☐			22. Varicose Vein Surgery(This does not apply to injection sclerotherapy)
☐	☐			23. Vascular Surgery (Includes peripheral other than Varicose Veins)

16. Other Procedures.

Do you perform other procedures which are not indicated? Yes ☐ No ☐
If Yes, please list all other procedures below.

Applicant's Representation, Authorization and Release

(Please read carefully)

REPRESENTATION

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

FRAUD NOTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

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

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

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

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

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

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

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

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

HIPAA DISCLOSURE

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

AUTHORIZATION

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

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

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

A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original.

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

Remarks Addendum (please print)

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

Question Number	Remarks

Date:_____

To:_____
(Insert Name of Hospital)

ATTENTION: MEDICAL RECORDS DEPARTMENT

I am required by my professional liability insurance company, ISMIE Mutual, to furnish a copy of my Professional Activities Study (PAS) or Physician Index from your institution outlining Hospital activities for the most recent 12 month period available. I understand this report will contain the following statistical information pertaining to my hospital practice for the period specified:

a) *Principal Non-Surgical*
- Report Number of Patients -- as attending physician, admitting physician and or consultant.

b) *Principal Surgical*
- Report of all surgical procedures, including OB deliveries, performed as attending physician, primary surgeon, other surgeon or consultant.
- Number of patients/procedures -- as attending physician, primary surgeon, other surgeon or consultant.

c) *Consultations*
- Number of patients

Please provide me with the requested information within 5 days.

Thank you for your assistance.

Physician's Name_____
(Please print or type)

Physician's Signature_____

NOTE: This form is intended to serve as an advisory instruction to the Hospital Medical Records Department in order to obtain the specified information.

PP-1215
Edition (11/17)

ISMIE MUTUAL INSURANCE COMPANY
BUSINESS ASSOCIATE AGREEMENT (B)
REVISED 2017

This Business Associate Agreement ("Agreement") is between ISMIE Mutual Insurance Company, and all affiliates and subsidiaries ("ISMIE"), 20 North Michigan Avenue, Suite 700, Chicago, IL 60602, and the "Covered Entity" (as such term is defined below) set forth on the attached application for insurance. 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 and the HITECH Act (as defined below) and the regulations promulgated thereunder.

I. DEFINITIONS

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

B. Covered Entity. "Covered Entity" shall mean, with respect to ISMIE: (a) prior insureds, (b) insureds, (c) all persons or entities applying for insurance coverage, (d) all insureds by reporting endorsement.

C. Electronic Protected Health Information. "Electronic protected health information" shall have the meaning found in the Security Rule. [45 CFR § 160.103.]

D. HIPAA. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-91).

E. 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).

F. 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)].

G. 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].

H. 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.].

I. 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].

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

K. 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.

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

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

N. 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): 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 agrees to not use or disclose Protected Health Information other than as permitted or required by the 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 agrees to use appropriate safeguards to prevent unauthorized use or disclosure of the Protected Health Information other than as provided for by this Agreement and to comply with subpart C of Part 164 of the Security Rule, where applicable, with respect to electronic Protected Health Information.

C. Business Associate agrees to 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 of which Business Associate becomes aware in violation of the requirements of this Agreement.

D. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured Protected Health Information as required by 45 CFR § 164.410.

E. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information by entering into a written agreement with any agent or subcontractor that complies with 45 CFR 164.504(e)(2).

F. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, 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 Covered Entity, or to the Secretary, upon 10 business days written notice during regular business hours of 10am - 3 pm or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

G. Business Associate agrees to provide an Individual, within 30 days of a written notice, access to inspect Protected Health Information about the Individual maintained in a designated record set in Business Associate's possession, or provide to an Individual, or their designee, an electronic copy of the Individual's Protected Health Information, in order to meet the requirements under 45 CFR § 164.524.

H. Business Associate agrees to make any amendment(s) to Protected Health Information in a designated record set in its possession that the Covered Entity directs or agrees to, within 60 days of receiving a written notice from Covered Entity or an Individual. [45 CFR § 164.526].

I. Business Associate agrees to 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 agrees to provide to Covered Entity or an Individual, upon 10 business days of 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 and HITECH Act § 13405(c)].

J. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule, and to require its workforce to comply with subpart C of Part 164. Business Associate will reasonably and appropriately protect against reasonably anticipated threats or hazards to the security or integrity of such information. Business Associate acknowledges that the safeguards include those specified in 45 CFR § 164.308 (Administrative Safeguards), 164.310 (Physical Safeguards), 164.312 (Technical Safeguards), and 164.316 (Policies and Procedures and Documentation Requirements). Business Associate will also reasonably and appropriately protect against any reasonably anticipated uses or disclosures that are not permitted or required under the Privacy Rule.

K. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information, agrees in writing to implement reasonable and appropriate safeguards to protect it.

L. Business Associate agrees to report to Covered Entity any Security Incident involving electronic Protected Health Information of which it becomes aware. [45 CFR § 164.314].

M. Business Associate shall not use or disclose Protected Health Information for marketing communications (as "marketing" is defined in 45 CFR 164.501).

N. Business Associate agrees to the prohibition on the sale of Protected Health Information without authorizations unless an exception under § 13405(d) of the HITECH Act applies.

O. Business Associate shall only disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the disclosure under HITECH Act § 13405(b) and any regulations or guidance issued by the Secretary regarding minimum necessary requirements.

P. Business Associate will comply with an Individual's request for restrictions on the use or disclosure of Protected Health Information to health plans for payment or health care operations purposes when the health care provider has been paid out of pocket in full consistent with HITECH Act § 13405(a) and Business Associate has been notified of the request for restriction by the health care provider, Covered Entity or the Individual, and the disclosure is not required by law.

Q. Business Associate will comply with, to the extent required, the requirements relating to the provision of access to certain Protected Health Information in electronic format under the HITECH Act § 13405(e).

R. 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 – GENERAL USE AND DISCLOSURE PROVISIONS

A. Except as otherwise limited in this Agreement or required by applicable law, Business Associate may use or disclose Protected Health Information on behalf of, or to provide services to, Covered Entity, in order for Business Associate to carry out its obligations under this Agreement, including but not limited to the following purposes, if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity:

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.

B. 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 is obligations under this Agreement or as specified in a currently issued ISMIE Insurance policy, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

IV. SPECIFIC USE AND DISCLOSURE PROVISIONS

A. Except as otherwise limited in this Agreement, 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.

B. Except as otherwise limited in this Agreement, 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)].

C. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity. [45 CFR § 164.504(e)(2)(i)(B)].

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

E. Business Associate shall disclose Protected Health Information when required by the Secretary to investigate or determine Business Associate's compliance with subpart C of Part 160 of the Security Rule.

F. Business Associate shall disclose Protected Health Information to Covered Entity, an Individual, or the Individual's designee as necessary to satisfy the Covered Entity's obligations with respect to an Individual's request for an electronic copy of Protected Health Information.

V. 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].

A. 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.

B. 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.

B. 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.

VI. 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.

VII. TERM AND TERMINATION

A. Term. The 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 ISMIE, 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 for purposes as delineated in III A herein, 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;

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

3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

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.

D. Automatic Termination. Subject to the terms set forth in this Section 7, this Agreement shall automatically terminate if Covered Entity is no longer a member of ISMIE in good standing.

VIII. 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 agree to 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 or the HITECH Act or any applicable regulations with regard to such laws.

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

D. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the parties to comply with HIPAA or the HITECH Act, or any other applicable regulations with regard to such laws.

E. Notice. Any notice required to be given to either party shall be made in writing to the address set forth on Covered Entity's application for insurance, or the last known address of the receiving party.

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

ISMIE Mutual Insurance Company
20 North Michigan Avenue, 7th Floor
Chicago, IL 60602
ATTN: HIPAA Assistant Security Officer
Stephen Maes

IX. RED FLAG POLICY

ISMIE has adopted an Identity Theft Policy to assist in identifying, detecting, and mitigating risks of identity theft affecting insureds of ISMIE. This policy is intended to comply with the requirements of the Federal Trade Commission's Identity Theft Rules (the "Red Flag Rules") (16 CFR § 681) which is a result of the Fair and Accurate Credit Transactions Act of 2003.

X. HHS BREACH NOTIFICATION

Subject to the law enforcement delay exception contained in 45 CFR § 164.412, Business Associate agrees to 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. Business Associate will reimburse Covered Entity for the direct costs of complying with the federal breach notification requirements resulting from a breach caused by Business Associate but in no event shall Business Associate be liable to Covered Entity or any third party for any indirect or consequential damages associated or related to any Breach.

ISMIE Mutual Insurance Company

HIPAA Privacy and Security Officer
Robert John Kane

(2/05, A 4/09, A 10/09, A 12/10, 3/13, A/17)