TMLT
TEXAS MEDICAL LIABILITY TRUST
P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmlt.org

ENCLOSED ARE THE FORMS NECESSARY FOR INDIVIDUAL APPLICATION

Thank you for choosing to apply with TMLT. We know that you have choices when purchasing liability insurance to protect your reputation and your medical practice. We appreciate the opportunity to earn your business.

A few items that are especially helpful to know at the start of the application process:

Completing and submitting your application:

- You must be a member of the Texas Medical Association or have a membership application pending to obtain coverage through TMLT. To start this process, please visit the TMA web site **www.texmed.org** or call 1-800-880-1300.
- Remember to sign and date your application once it is complete.
- Please review the *Business Associate Agreement.*
- If you need coverage for a partnership or group, please complete an *Entity Application* at www.tmlt.org/policyholder/applications
- Please enclose any documentation requested in the application and include your current CV, Office Letterhead, or current declarations page.
- Please complete your Trust Rewards enrollment form. For information please visit www.tmlt.org/trustrewards

Our website has a wealth of information on products and services we offer, including Coverage types, Risk Management, Claims, and information about TMLT. Be sure and check out our FAQs**.**

We want to make your application experience as simple as possible. If you have any questions during the process, we will be happy to assist you. Call 1-800-580-8658 and ask for Sales and Business Development.

Payment Options

Consider which billing and payment options are right for you. Billing can be invoiced monthly or quarterly as a recurring automatic draft using your Visa, MasterCard, American Express credit cards or by bank draft. If no billing option is chosen, you will be invoiced quarterly. Please visit www.tmlt.org to select and set up your payment option or call Customer Service at 1-800-580-8658 ext. 5050 for assistance.

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INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE

PLEASE TYPE OR PRINT IN BLACK INK.
ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

POLICY NUMBER: _____
(For Trust Use Only)

I. GENERAL INFORMATION

A. _____ _____ _____ ☐ M.D. ☐ D.O.
First name | Middle name | Last name

_____ _____ _____ _____
Maiden / Other names | Date of birth | Texas medical license | Social security number

_____ _____ _____ _____
Office phone | Office fax | Home phone | Cell phone

_____ _____
Professional email address | Personal email address

_____ Preferred method of contact:
Professional website address ☐ Phone ☐ Fax ☐ Personal email ☐ Professional email

_____ _____ _____ _____
Home address | City | State | Zip

B. Please list all **Texas office locations** where you currently practice or intend to practice. Indicate the percentage of time spent at each location.

1. _____ 2. _____
Address | Address

_____ _____ _____ _____ _____ _____
City | State | Zip | City | State | Zip

_____ _____ _____ _____
County | % | County | %

C. Preferred **billing** address: ☐ home ☐ primary office ☐ other

_____ _____ _____ _____
Other billing address | City | State | Zip

Preferred **mailing** address: ☐ home ☐ primary office ☐ other

_____ _____ _____ _____
Other mailing address | City | State | Zip

D. Please list all Texas hospitals where you currently practice or intend to practice. *If "other" privileges, please provide details on page 8 Section VI.

_____ _____ Privileges : ☐ full ☐ courtesy ☐ other*
Hospital name | City

_____ _____ Privileges : ☐ full ☐ courtesy ☐ other*
Hospital name | City

E. Is any part of your practice outside of Texas? ☐ Yes ☐ No If yes, where/percentage? _____

F. Texas Medical Association membership is required. Are you currently a member or is membership pending? ☐ Yes ☐ No

II. PROFESSIONAL LIABILITY COVERAGE

A. Previous insurance history (Minimum of 3 years)

Insurance company	Coverage dates	Limits of liability each claim/All claims	☐ Claims-made ☐ Occurrence
Insurance company	Coverage dates	Limits of liability each claim/All claims	☐ Claims-made ☐ Occurrence
Insurance company	Coverage dates	Limits of liability each claim/All claims	☐ Claims-made ☐ Occurrence

B. **Requested coverage effective date 12:01 a.m.** _____ (Month) _____ (Day) _____ (Year)

C. **Professional Liability Coverage**: Please check type of coverage and the limits of liability requested.

Occurrence: (limits indicated are the only limits available and are for each claim/all claims)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $500,000/$1,000,000

OR

Claims-made: (limits indicated are for each claim/all claims)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $300,000/$900,000 ☐ $500,000/$1,000,000

☐ $500,000/$1,500,000 ☐ $750,000/$1,500,000 ☐ $1,000,000/$3,000,000

(Limits of liability in excess of $500,000 require special approval by our Underwriting Department.)

If your current insurance is written on an Occurrence policy, please skip to page 3 - Section IV.

D. **If your current insurance is written on a Claims-made policy, it is necessary to purchase a Reporting Endorsement (tail coverage) from your present insurer or Prior Acts (nose coverage) from TMLT to reduce the chances of having a gap in coverage. Any known incident or circumstance that might reasonably be expected to lead to a claim being made against you must be reported to your prior carrier.**

Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer for all of your previous exposures? ☐ Yes ☐ No

If yes, please skip to page 3 - Section IV.

Are you requesting Prior Acts (nose coverage) from TMLT? ☐ Yes ☐ No

III. PRIOR ACTS COVERAGE

The following questions apply to your past Claims-made coverage and must be answered for the entire time period following your retroactive date.

A. Has any portion of your practice been performed outside the state of Texas? ☐ Yes ☐ No

If yes, please list details and the percentage of practice below.

City/State	Dates	%	City/State	Dates	%

B. Has your Claims-made policy ever included coverage for any other individual or for an Entity other than a Solo PA? ☐ Yes ☐ No

If yes, please explain below and attach a copy of any endorsement providing coverage for other individuals (including locum tenens) or Entity. Each is subject to separate underwriting consideration.

C. Are you aware of any incidents or legal actions not reported to previous carriers which you have reason to believe may lead to a claim or suit against you? (i.e. subpoena, attorney request for patient records, etc.) ☐ Yes ☐ No

If yes, report these incidents to your current carrier.

D. Have you reported any incidents to another insurance carrier which have not yet resulted in a claim or suit? ☐ Yes ☐ No

If you answered yes to C or D above, please provide details below.

Patient name	Date of incident	Date incident report sent to insurance carrier (provide copies)

IV. UNDERWRITING AND RATING INFORMATION

A. Medical practice history / Education

Medical school | Degree/Specialty

City/State | Dates attended

Internship school/Hospital | Specialty

City/State | Dates attended

Residency school/Hospital | Specialty

City/State | Dates attended

Fellowship school/Hospital | Specialty

City/State | Dates attended

1. a. Did you complete residency training? ☐ Yes ☐ No

   b. Are you entering practice for the first time immediately following residency training, military service, or an academic position? ☐ Yes ☐ No

2. a. Are you currently American Board Certified? ☐ Yes ☐ No

   Specialty Board | Date(s) Certified

   b. Have you ever failed to pass a board exam or been denied certification? ☐ Yes ☐ No

   Specialty Board | Which portion?/Date(s)

3. Where have you practiced your profession since completion of your formal training, including military or any public service organization? PLEASE ACCOUNT FOR ALL TIMES SINCE COMPLETION OF MEDICAL SCHOOL WITH THE EXCEPTION OF YOUR RESIDENCY OR FELLOWSHIP TRAINING.

Name of practice	City/State	Country	Dates
Name of practice	City/State	Country	Dates
Name of practice	City/State	Country	Dates

4. Please provide an explanation for any gaps greater than six months in your work history.

Gap dates	Explanation
Gap dates	Explanation

B. Medical practice structure / Operations

1. Do you practice as a:

☐ Solo Incorporated (PA/ LLC) (This coverage is automatically provided under the individual policy with shared limits of liability.)

☐ Solo Unincorporated (Individual)

List any other name(s) under which you practice (i.e. DBA): _____

2. Do you practice with a group or clinic? ☐ Yes ☐ No

If yes, please provide the exact name: _____

Are you an ☐ Employee ☐ Independent contractor ☐ Shareholder / partner

Please list the names of all partners, members and shareholders: (if more than nine, please add to page 8 Section VI.)

1.	2.	3.
4.	5.	6.
7.	8.	9.

3. Do other licensed physicians work for you on an employment or contract basis? If yes, how many? _____ ☐ Yes ☐ No

4. Average number of patients seen per week: #_____

5. Average number of practice hours per week involved in direct patient care, including related administrative activities: #_____

6. Indicate the number of professional licensed personnel in each category employed or supervised by you.

CRNA/Anesthesia Assistant: _____ Physician Assistant: _____ RN/LVN: _____

Nurse Midwife: _____ Nurse Practitioner: _____ Medical Technician: _____

Please list the names of their current insurance provider: _____

*PLEASE NOTE, COVERAGE IS NOT PROVIDED FOR ANY OF THE ABOVE LICENSED PERSONNEL UNDER THE PHYSICIAN'S INDIVIDUAL POLICY. SEPARATE COVERAGE MAY BE OBTAINED THROUGH TEXAS MEDICAL INSURANCE COMPANY **(WWW.TMIC.BIZ).**

C. Medical practice description

1. What is your medical specialty? _____ Sub specialty? _____

2. Please check any of the following procedures you perform:

☐ Cardiac catheterization	☐ Interventional radiology	☐ Silicone breast implant
☐ Swan Ganz	☐ Open fracture reduction	☐ Autopsies
☐ Myringotomy	☐ Spinal surgery	☐ Adult circumcision
☐ Adenoidectomy	☐ Tubal ligation	☐ Vasectomy
☐ Tonsillectomy	☐ Abortion	
☐ ERCP	☐ D & C	

3. Do you perform minor surgery in an office setting including procedures performed under a local anesthetic? ☐ Yes ☐ No

4. Do you perform major surgery? ☐ Yes ☐ No
   If yes, # per year: _____ Cardiovascular:_____% Thoracic: _____% Vascular: _____%

5. Do you assist in major surgery on your own patients? ☐ Yes ☐ No
   If yes, # per year: _____

6. Do you assist in major surgery on patients other than your own? ☐ Yes ☐ No
   If yes, # per year: _____

7. Do you perform major surgery in a freestanding facility or your office? ☐ Yes ☐ No
   If yes, please provide details on page 8 Section VI.

8. Do you perform autopsies? ☐ Yes ☐ No
   If yes, percentage of practice: _____%

9. Do you perform bariatric surgery? (Limits are restricted to a maximum of $200,000/$600,000 or less) ☐ Yes ☐ No
   If yes, please request a **bariatric surgery questionnaire** for completion.

10. Do you perform pain management procedures in an office? ☐ Yes ☐ No
    If yes, please request a **pain management questionnaire** for completion.

11. Is laser equipment utilized in your practice? ☐ Yes ☐ No
    If yes, please provide details on page 8 Section VI.

12. Do you perform plastic surgery? ☐ Yes ☐ No

13. Does your practice include cosmetic/aesthetic procedures other than Botox or derma filler injections? ☐ Yes ☐ No
    If yes, please request a **cosmetic/aesthetic questionnaire** for completion.

14. Does your practice include telemedicine? ☐ Yes ☐ No
    If yes, please request a **telemedicine questionnaire** for completion.

15. Do you adhere to or follow written protocols that demonstrate a "good-faith effort" to prevent fraud and abuse of electronic patient health information (PHI)? ☐ Yes ☐ No

16. Do you access electronic patient data from a health information exchange? ☐ Yes ☐ No

17. Do you function as a hospitalist (i.e. hospital-based practice, admit and/or round on patients other than your own)? ☐ Yes ☐ No
    If yes, please provide details on page 8 Section VI.

18. Do you perform emergency medicine other than for maintaining privileges? ☐ Yes ☐ No
    Is insurance provided for this exposure? (If yes, please provide verification of insurance for each facility.) ☐ Yes ☐ No

19. Do you provide patient care in a nursing home or other residential care facility? ☐ Yes ☐ No
If yes, what percentage of these visits represent your total annual patient visits? _____%

20. Are you a medical director of a nursing home or other residential care facility? ☐ Yes ☐ No
If yes, how many? _____
Please provide verification of insurance for each facility.
Note: TMLT's policy provides coverage for direct patient care, but does not cover your administrative liability as a medical director.

21. Do you provide prenatal care? ☐ Yes ☐ No
If yes, does it include high-risk pregnancy? ☐ Yes ☐ No

22. Do you deliver infants? ☐ Yes ☐ No
Vaginal deliveries: #/year_____ VBAC: #/year _____ C-sections: #/year _____

23. Do you spend greater than 50% of your practice time supervising medical students, residents, or fellows? ☐ Yes ☐ No
Is insurance provided for this exposure? ☐ Yes ☐ No
If yes, please provide verification of insurance.

24. Which of the following methods of advertising do you use? Please provide samples or transcripts of all advertisements.
☐Yellow pages ☐Radio / Television ☐Newspaper / Print media
☐Internet / Email ☐Billboard ☐Other:_____

D. Additional Information

1. Have any of the following ever been under review or investigation, revoked, denied, suspended, voluntarily surrendered, or limited in any way:
a. Your medical license or permit to prescribe drugs? ☐ Yes ☐ No
b. Your privileges at any hospital, clinic, or other facility? ☐ Yes ☐ No
c. Your Medicare / Medicaid accreditation or certification? ☐ Yes ☐ No

2. Have you ever been:
a. Treated for alcohol or substance abuse? ☐ Yes ☐ No
b. Diagnosed with any mental illness? ☐ Yes ☐ No
c. Diagnosed with or had a chronic illness or physical impairment that affected your ability to practice medicine? ☐ Yes ☐ No

3. Have you ever been indicted, charged, or convicted of a crime other than a minor traffic violation? ☐ Yes ☐ No

4. Do you dispense or prescribe medications or use medical devices that have been disapproved by the FDA in the treatment or care of human beings? ☐ Yes ☐ No

5. Have any professional relations or fee complaints ever been made against you by a medical association, hospital or licensing authority? ☐ Yes ☐ No

6. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled, or non-renewed? ☐ Yes ☐ No

7. Are you aware that your present carrier plans to restrict, surcharge, cancel, or non-renew your coverage? ☐ Yes ☐ No

8. Have any lawsuits (other than medical and auto liability suits) been filed against you in the last 10 years? ☐ Yes ☐ No

9. How many professional liability claims have **ever** been brought against you? #_____
This includes notice of intent to sue and written demand from a patient or a lawsuit.
Complete the information for each claim or suit on page 8 Section VII.

V. AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any policy is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding. **I understand any policy issued by TMLT will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMLT any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: Texas Medical Board; any other licensing agency; Texas Medical Association; any other state medical association or organization; any county medical society; any specialty medical society or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability and/or Premises Liability Coverage. I further authorize TMLT and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

This application incorporates by reference the terms and conditions of TMLT's HIPAA-HITECH Business Associate Agreement (reviewable at www.tmlt.org/appdocs), copies of which will be provided to me upon request. By signing and accepting below, I consent to the terms and conditions of these documents and agreements.

By submission of this application, or by acceptance of coverage from TMLT, I hereby release TMLT and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

Physician's Signature	Printed Name	Date Signed

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

Coverage will not be considered until this application is completed, signed and dated.

Failure to provide complete information and/or attachments as requested will cause delay.

VI. ADDITIONAL DETAILS (Please use this area if additional space is needed for answers to any questions.)

PAGE NUMBER	QUESTION NUMBER	ANSWER AND/OR DETAILS

VII. CLAIM/SUIT INFORMATION

If additional space is required, please photocopy this form as needed. PLEASE TYPE OR PRINT IN BLACK INK. Note: Additional documentation may be requested by the Underwriting Department.

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

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BUSINESS ASSOCIATE AGREEMENT

Recitals

TMLT and the policyholder have an insurer/insured relationship by virtue of a professional liability policy issued by TMLT to the policyholder (hereinafter "Insurance Policy"). TMLT and the named policyholder are committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). Under the Privacy Regulations, the policyholder is a "covered entity," and, as defined by 45 CFR § 164.502(e) and 45 CFR § 164.504(e), TMLT is a business associate of the policyholder. TMLT must use and/or disclose Protected Health Information, as defined in 45 CFR § 164.501, in its performance of services under the Insurance Policy. TMLT agrees to abide by the assurances, terms, and conditions contained herein in the performance of its obligations. This Agreement sets forth the manner in which Protected Health Information, that is provided to, or received by, TMLT from the policyholder, or on behalf of the policyholder, will be handled. TMLT agrees as follows:

SECTION 1
Obligations and Activities of Business Associate

1.1 ***Not to Use or Disclose Protected Health Information Unless Permitted.*** TMLT may receive from policyholder health information protected under state or federal law, including Protected Health Information and/or electronic Protected Health Information (hereinafter both shall be referred to as Protected Health Information). TMLT agrees not to use, or further disclose, Protected Health Information other than as permitted or required by the Agreement or as required or allowed by law.

1.2 ***Use Safeguards.*** TMLT agrees to use reasonable safeguards to prevent use or disclosure of the Protected Health Information other than as allowed by this Agreement or as otherwise required or allowed by law. TMLT acknowledges that the HITECH Act requires TMLT to comply with the security provisions in 45 CFR § 164.308, 164.312 and 164.316 as well as all additional security provisions of the HITECH Act as if TMLT were a covered entity.

1.3 ***Report Inappropriate Disclosures of Protected Health Information.*** TMLT agrees to report to policyholder any use or disclosure of the Protected Health Information not permitted by this Agreement or by law of which it becomes aware. TMLT will comply with Section 13402 of the HITECH Act with respect to timeliness, method and content of the report.

1.4 ***Compliance of Agents.*** TMLT agrees to require any agents, including subcontractors, to agree to the same restrictions and conditions that apply to TMLT through this Agreement provided that such agents perform a service that TMLT agreed to perform for, or on behalf of, the policyholder under the Insurance Policy, and to whom TMLT provides Protected Health Information.

1.5 ***Access.*** To the extent that TMLT maintains an original Designated Record Set, as such term is defined in 45 CFR § 164.501, or a part thereof, TMLT agrees to provide access to the policyholder to Protected Health Information in the original Designated Record Set, during normal business hours, provided the policyholder delivers prior written notice to TMLT, at least five business days in advance, requesting such access but only to the extent required by 45 CFR § 164.524.

1.6 ***Amendments.*** To the extent TMLT maintains an original Designated Record Set, or a part thereof, TMLT agrees to make Protected Health Information available for amendment to the policyholder and to incorporate any amendment(s) to Protected Health Information in the original Designated Record Set that the policyholder directs, pursuant to 45 CFR § 164.526.

1.7 ***Disclosure of Practices, Books, and Records.*** Unless otherwise protected from discovery or disclosure by law or unless otherwise prohibited from discovery or disclosure by law, TMLT agrees to make internal practices, books, and records available to the policyholder or to the Secretary of the Department of Health and Human Services, hereinafter referred to as "Secretary," for purposes of the Secretary determining the policyholder's compliance with the Privacy Regulations but only to the extent such access is related to the use and disclosure of Protected Health Information received from the policyholder, or created or received by TMLT on behalf of the policyholder. TMLT shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after TMLT is in receipt of such request.

1.8 ***Accounting.*** Pursuant to 45 CFR § 164.528, as amended by Section 13405 (c) of the HITECH Act and any related regulations or guidelines, TMLT agrees to maintain sufficient documentation of disclosures of Protected Health Information and information related to such disclosures as would be required for the policyholder to respond to a request by an Individual for an accounting of

disclosures of Protected Health Information. The documentation of disclosures does not apply to disclosures necessary to carry out health care operations and Services, as defined in Section 2.1, and other functions necessary to perform these Services.

1.9 ***Release of Documentation of Disclosure.*** TMLT agrees to provide to the policyholder information collected in accordance with Section 1.8 of this Agreement, to permit the policyholder to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

SECTION 2
Permitted Uses and Disclosures by Business Associates

2.1 ***Use of Protected Health Information for Specified Purposes.*** Except as otherwise required by law, TMLT shall use PHI in compliance with 45 CFR § 164.504e. Under the Insurance Policy, TMLT provides the policyholder with insurance products and services (hereinafter "Services") that involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, the provision of professional liability insurance; receiving and evaluating incidents, claims, and lawsuits; quality assessment; quality improvement; loss prevention tools; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of health care practitioners and providers; credentialing, conducting or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances; placing stop-loss and excess of loss insurance, and other functions necessary to perform these Services. Except as otherwise specified herein, TMLT may make any uses of Protected Health Information necessary to perform its obligations under this Agreement and under the Insurance Policy, if such use of Protected Health Information would not violate the Privacy Regulations. Moreover, TMLT may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to its employees, subcontractors, and agents, in accordance with paragraphs Section 2.2 through 2.4 of this Section below; or (ii) as otherwise permitted by the terms of this Agreement. All other uses not authorized by this Agreement are prohibited.

2.2 ***Use of PHI for Business Associate Management and Administration.*** TMLT may use Protected Health Information for the proper management and administration of TMLT or to carry out the legal responsibilities of TMLT.

2.3 ***Disclosure Required by Law or With Reasonable Assurances.*** TMLT may disclose Protected Health Information for proper management and administration and to carry out its legal responsibilities, provided that disclosures are required by law, or provided that the TMLT obtains the following reasonable assurances from the person or entity to whom the Protected Health Information is disclosed: 1) the Protected Health Information will remain confidential; 2) the Protected Health Information will be used or further disclosed only as required by law or for the purposes for which it was disclosed; and, 3) the person or entity will notify TMLT of any instances of which the person or entity is aware in which the confidentiality of the information has been breached. In compliance with Section 13405(b) of the HITECH act, TMLT will only disclose the minimum necessary to accomplish the intended purpose of the disclosure and, if applicable, to the limited data set as defined in 45 CFR § 164.514(e)(2).

2.4 ***Data Aggregation Services.*** If necessary to provide services related to a policyholder's health care operations, TMLT may use Protected Health Information to provide data aggregation services to the policyholder as permitted by 45 CFR § 164.504(e)(2)(i)(B).

2.5 ***Disclosure to Report Violations of Law.*** TMLT may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

SECTION 3
Obligations of and Permissible Requests by Policyholder

3.1 ***Notification of Limitation(s).*** The policyholder shall notify TMLT of any limitation(s) in its notice of privacy practices of the policyholder in accordance with 45 CFR § 164.520, to the extent that such limitation may affect TMLT's use or disclosure of Protected Health Information.

3.2 ***Notification of Changes or Revocation.*** The policyholder shall notify TMLT 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 TMLT's use or disclosure of Protected Health Information.

3.3 ***Notification of Restriction.*** The policyholder shall notify TMLT of any restriction to the use or disclosure of Protected Health Information that the policyholder has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect TMLT's use or disclosure of Protected Health Information.

3.4 ***Permissible Requests.*** The policyholder shall not request TMLT to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Regulations if done by the policyholder. This provision does not apply to TMLT's use or disclosure of Protected Health Information for data aggregation or management and administrative activities as is otherwise permitted by this Agreement.

SECTION 4
Term and Termination of Agreement

4.1 ***Term.*** The Term of this Agreement shall be effective beginning April 14, 2003 and shall terminate when all of the Protected Health Information provided by the policyholder to TMLT, or created or received by TMLT on behalf of the policyholder, is destroyed. Protected Health Information is securely retained and/or destroyed as designated by TMLT policies for retention and destruction of Protected Health Information. Protections are extended to such information, in accordance with the termination provisions in this section. This agreement shall supersede any existing business associate agreements issued in accordance with the Privacy Regulations under the Health Insurance Portability and Accountability Act of 1996.

4.2 ***Termination for Cause.*** Upon the policyholder's knowledge of a material breach by TMLT of this Agreement, the policyholder shall either:

(1) Provide an opportunity for TMLT to cure the breach or end the violation within a reasonable period of time. If TMLT does not cure the breach or end the violation within the reasonable period of time specified by the policyholder, the policyholder shall terminate this Agreement and the underlying Insurance Policy;

(2) Immediately terminate this Agreement and the underlying Insurance Policy if TMLT has breached a material term of this Agreement and cure is not possible; or

(3) If neither termination nor cure is feasible, the policyholder shall report the violation to the Secretary.

4.3 ***Effect of Termination.***

(1) Due to the infeasibility of returning Protected Health Information to the policyholder, upon termination of this Agreement and/or the underlying Insurance Policy, for any reason, TMLT shall securely retain and/or destroy all Protected Health Information received from the policyholder, or created or received by TMLT on behalf of the policyholder in accordance with TMLT's policies for retention and destruction of Protected Health Information.

(2) TMLT shall limit further uses and disclosures to those purposes that make the return of the Protected Health Information infeasible. TMLT shall extend the protections of this Agreement to such Protected Health Information for so long as TMLT maintains such Protected Health Information.

SECTION 5
Miscellaneous Provisions

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

5.2 ***Amendment.*** TMLT and the policyholder agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the policyholder to comply with the requirements of the Privacy Regulations and HIPAA.

5.3 ***Survival.*** The respective rights and obligations of TMLT under Section 4.3 of this Agreement shall survive the termination of this Agreement.

5.4 ***Interpretation.*** Any ambiguity in this Agreement shall be resolved to permit TMLT to comply with the Privacy Regulations.

Debbie Giese
Senior Vice President
Underwriting Services