APPLICATION KIT

www.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:

- 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.
  I am a member ☐
  I have applied ☐
- Please review the *Business Associate Agreement*. ☐
- If you need coverage for an entity other than a solo professional association or solo PLLC, please complete an *Entity Application* at www.tmlt.org/policyholder/applications
  Note: Entity coverage is no available unless all partners, shareholders and employed physicians are insured by the company.
- Coverage is not typically available if you have an uninsured period (gap). Please contact us to discuss further.

When submitting your application, please enclose:

- Any documentation requested in the application
- Your current CV
- A copy of your current declarations page
- Current loss run(s) for a five-year period

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 (TMLT) and ask for Underwriting or visit our website at https://www.tmlt.org/resources/frequently-asked-questions

Payment Options

Which billing and payment option is right for you?

☐ Monthly – The first installment is 20%, with the balance due in remaining nine payments.
☐ Quarterly – with installments of 35%, 25%, 25%, and 15%.
☐ Payment in full

There are no finance charges or transaction fees associated with TMLT payment plans. You can set up recurring automatic payments once your policy is issued by contacting Customer Service at 1-800-580-8658 (TMLT) ext. 5050 for assistance.

If no billing option is chosen, you will be invoiced quarterly.

Billing email address: _____

INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE

ALL QUESTIONS MUST BE ANSWERED in DETAIL. IF A QUESTION DOES NOT APPLY, PLEASE RESPOND N/A.

I. GENERAL INFORMATION

First name: _____ Middle name: _____ Last name: _____

☐ M.D ☐ D.O. ☐ Male ☐ Female Opt out of paperless documents ☐

Maiden / Other names: _____ Date of birth: _____

Texas medical license: _____Professional website address: _____

HOME:

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Personal email address: _____

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

1. Primary Location Name:_____

Address:_____

City: _____ State: _____ Zip: _____

County: _____ %: _____ Professional email address: _____

Office phone: _____ Office fax: _____

2. Location Name: _____

Address:_____

City: _____ State: _____ Zip: _____

County: _____ %: _____ Professional email address: _____

Office phone: _____ Office fax: _____

Preferred **mailing** address for policy documents: ☐ professional email ☐ home ☐ primary office ☐ other

Other mailing address:_____

City: _____ State: _____ Zip: _____

Preferred **billing** address for invoices: ☐ billing email ☐ home ☐ primary office ☐ other

Other billing address: _____

City: _____ State: _____ Zip: _____

HOSPITAL PRIVILEGES:

Do you have hospital privileges in the counties in which you practice? ☐ Yes ☐ No

If not, what are you protocols for admitting patients? _____

II. PROFESSIONAL LIABILITY COVERAGE

A. CURRENT INSURANCE

Any known incident or circumstance that might reasonably be expected to lead to a claim being made against you must be reported to your current carrier.

Insurance company: _____

Coverage dates: _____

Limits of liability each claim/All claims: _____ ☐ Claims-made ☐ Occurrence

Retroactive date shown on your claims-made policy: _____

Will you continue this coverage if a TMLT policy is issued? ☐ Yes ☐ No

If no, and your current insurance is written on a claims-made policy, have you purchased or are you planning to purchase a reporting endorsement (tail coverage) from your current insurer for all of your previous exposures? ☐ Yes ☐ No

B. REQUESTED COVERAGE

Effective date 12:01 a.m. Month: _____ Day: _____ Year: _____

Please select one type of coverage and one limit of liability

☐ CLAIMS-MADE COVERAGE WITHOUT PRIOR ACTS
☐ CLAIMS-MADE COVERAGE WITH PRIOR ACTS
☐ OCCURRENCE COVERAGE

Note: If your current coverage is written on a claims-made basis and you are not buying tail from your current insurer, you will have an uninsured exposure for any future claims arising out of services rendered while the current policy was in effect.

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $300,000/$900,000
☐ $500,000/$1,000,000 ☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

Medefense: ($50,000 per claim standard to every policy)

☐ $100,000 per claim ($250/yr.) ☐ $200,000per claim ($350/yr.) ☐ $500,000 per claim ($550/yr.)

The higher limits above are available for an additional charge and are subject to underwriting approval. *Please note, at no time may Medefense limits be greater than the lowest primary medical malpractice liability limits.*

III. PRIOR ACTS COVERAGE – *COMPLETE SECTION BELOW ONLY IF REQUESTING PRIOR ACTS COVERAGE*

The questions below 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 of your requested county/state of practice? ☐ Yes ☐ No

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

City/County/State: _____ Dates: _____ %: _____

City/County/State: _____ Dates: _____ %: _____

B. Was your practice different in any way from your current practice and/or did you perform any procedures different from your current practice? ☐ Yes ☐ No

If yes, please explain _____

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

If yes, please explain below and attach a copy of any endorsement providing coverage for other individuals/entities.

_____

D. 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? If yes, please note these incidents will **not** be covered by TMLT. ☐ Yes ☐ No

E. 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 D or E above, please provide details below and include copies.

Patient Name	Date of Incident	Date incident report sent	Insurance Carrier
_____	_____	_____	_____
_____	_____	_____	_____

IV. UNDERWRITING AND RATING INFORMATION

A. EDUCATION/MEDICAL PRACTICE HISTORY *PLEASE ATTACH CV*

Medical school: _____

Degree/Specialty: _____

City/State/Country: _____ Dates attended: _____

Internship school/Hospital: _____

Degree/Specialty: _____

City/State/Country: _____ Dates attended: _____

Residency school/Hospital: _____

Degree/Specialty: _____

City/State/Country: _____ Dates attended: _____

Completed? ☐ Yes ☐ No

Fellowship school/Hospital: _____

Degree/Specialty: _____

City/State/Country: _____ Dates attended: _____

Completed? ☐ Yes ☐ No

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

Please explain any gaps in education or practice history greater than six months below:

_____

B. PRACTICE ORGANIZATION INFORMATION

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

Solo PA/PLLC Name: _____

Do you employ other licensed physicians? ☐ Yes ☐ No

If yes, please provide names _____

☐ Group or clinic

Are you a(n): ☐ Employee ☐ Independent contractor ☐ Shareholder/partner

Group name/dba as stated in articles of incorporation _____

Do you provide service outside of this group for which your need coverage? ☐ Yes ☐ No

If yes, please provide details _____

List other entities with which you are affiliated: _____

Are any of the entities a:

☐ Medical Surgery Center ☐ Med Spa ☐ Pain Management Clinic

☐ Other Please explain: _____

Are the entities used: ☐ For your patients only ☐ By other physicians no affiliated with your practice

If you desire coverage for these entities (if other than a Solo PA/PLLC), please go to https://www.tmlt.org/join/apply and submit an entity application for consideration.

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

C. MEDICAL PRACTICE DESCRIPTION

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

2. Are you ABMS board certified? ☐ Yes ☐ No In which specialty(ies) _____

   Date certification expires: _____ If No, please explain: _____

3. Have you ever failed to pass a board exam or been denied certification? ☐ Yes ☐ No
   If yes, please explain:_____

4. Does your practice have appropriate equipment for your specialty/procedures performed to handle an emergency? ☐ Yes ☐ No
   If no, please explain: _____

5. Including administrative activities, do you practice an average per week:

   ☐ less than 15 hours ☐ 15-30 hours ☐ More than 30 hours

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

   I DO NOT PERFORM ANY OF THE BELOW PROCEDURES (Please check box) ☐

☐ Minor Surgery	☐ Major Surgery	☐ Cardiac Catheterization
☐ Biopsies _____	☐ Cardiovascular Surgery	☐ Stem Cell Research
☐ Assist in Major Surgery	☐ Vascular Surgery	☐ Urgent Care/Extended Hours
☐ Own Patients	☐ Thoracic Surgery	☐ Adult Circumcision
☐ Other than your own Patients	☐ Spinal Surgery	☐ Interventional Radiology
☐ D & C	☐ Plastic Surgery	
☐ Abortion	☐ Breast Augmentation	
☐ Reproductive Endocrinology	☐ Assist in C-Sections	

If any question is marked "YES," please provide details or complete questionnaire as indicated.

7. Do you perform any procedures outside of your residency, fellowship or specialty training? ☐ Yes ☐ No

8. Does your practice provide office-based anesthesia? ☐ Yes ☐ No

9. Do you perform major surgery in your office? ☐ Yes ☐ No

10. Do you perform bariatric surgery? *(Limits are automatically restricted to $200,000/$600,000 or less)* ☐ Yes ☐ No
    If yes, please complete a bariatric surgery questionnaire.

11. Do you perform pain management procedures in an office setting? ○ Yes ○ No
    If yes, please complete a pain management questionnaire.

12. Do you perform infusion therapy in your office? ○ Yes ○ No
    If yes, please complete the infusion therapy questionnaire.

13. Does your practice include cosmetic/aesthetic procedures? ○ Yes ○ No
    If yes, please complete a cosmetic/aesthetic questionnaire.

14. Does your practice include telemedicine? ○ Yes ○ No
    If yes, please complete a telemedicine questionnaire.

15. Do you provide prenatal care and/or deliver infants? ○ Yes ○ No
    If yes, please complete a prenatal questionnaire.

16. Do you function as a hospitalist *(Only admit and round on hospital patients with no office-based practice)*? ○ Yes ○ No

17. Do you perform emergency medicine other than for maintaining privileges? ○ Yes ○ No

18. Do you perform volunteer work? ○ Yes ○ No

19. Do you spend greater than 50% of your practice time supervising medical students, residents, or fellows? ○ Yes ○ No

    Note: Coverage will not be provided for this exposure under your policy. Please provide a certificate of insurance showing you are covered.

20. Do you provide patient care in a nursing home or other residential care facility? ○ Yes ○ No

    If yes, what percentage of these visits represents your total annual patient visits? _____%

21. Do you provide patient care at a correctional facility? ○ Yes ○ No

22. Are you a physician for any high school, college, university, semi-professional or professional sports team? ○ Yes ○ No

23. Do you or your employees provide home health, concierge or mobile health care services? ○ Yes ○ No

24. Are you involved in any FDA-approved studies? What phase? _____ ○ Yes ○ No

25. Do you participate in any non-FDA approved studies? ○ Yes ○ No

26. Do you dispense or prescribe non-FDA approved medications or medical devices? ○ Yes ○ No

27. Do you dispense or prescribe medications for off-label use? ○ Yes ○ No

D. ADDITIONAL DISCLOSURE QUESTIONS *(If any question is marked 'YES' please provide details)*

1. Are you now, or have you ever been under any investigation/review/audit? ☐ Yes ☐ No

2. Have any charges and/or fines ever been brought against you due to Medicare/Medicaid investigations? ☐ Yes ☐ No

3. Have any of the following ever been under review or investigation, revoked, denied, suspended, voluntarily surrendered, or restricted in any way:

   Your Medicare / Medicaid accreditation or certification? ☐ Yes ☐ No
   Your medical license or permit (in any state) to prescribe drugs? ☐ Yes ☐ No
   Your privileges at any hospital, clinic, or other facility? ☐ Yes ☐ No

4. Have any professional relations complaints or fee complaints ever been made against you by a medical association, hospital or licensing authority, including medical board etc? Please include any board orders. ☐ Yes ☐ No

5. Have you ever resigned from a hospital, clinic, or other facility due to a potential or ongoing investigation? ☐ Yes ☐ No

6. Have you ever appeared before any state regulatory or review committee for alleged misconduct or malpractice? ☐ Yes ☐ No

7. Have you ever been:

   a. Treated for alcohol or substance abuse? ☐ Yes ☐ No

   b. Diagnosed with or had a chronic illness, mental illness or physical impairment? ☐ Yes ☐ No

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

9. Have you ever been accused of sexual misconduct of any kind in your professional capacity? ☐ Yes ☐ No

10. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled, or non-renewed, or is your present carrier planning to take similar action? ☐ Yes ☐ No

E. INCIDENT/CLAIM HISTORY *(If questions 1-4 are marked 'YES' please provide details)*

1. Are you aware of any incidents and/or records requests involving your professional services that have not been reported to your current carrier? ☐ Yes ☐ No

2. Have any lawsuits (other than medical malpractice) been filed against you in the last 10 years? ☐ Yes ☐ No

3. Has a claim involving cyber liability ever been brought against you or your group? ☐ Yes ☐ No

4. Has a claim involving employment practices liability ever been brought against you or your group? ☐ Yes ☐ No

5. 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.)

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 https://www.tmlt.org/join/apply), 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_____(M/D/Y)

Location: _____ City: _____ State: _____

Hospital: _____

Insurance company defending your claim: _____ Date reported: _____ (M/D/Y)

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: _____ (M/D/Y) Total amount paid to claimant for all defendants: $ _____

Patient's name: _____ Age: _____ Sex: _____

Date of incident_____(M/D/Y)

Location: _____ City: _____ State: _____

Hospital: _____

Insurance company defending your claim: _____ Date reported: _____ (M/D/Y)

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: _____ (M/D/Y) Total amount paid to claimant for all defendants: $ _____

BUSINESS ASSOCIATE AGREEMENT

BETWEEN TMLT AND POLICYHOLDERS

Recitals

Texas Medical Liability Trust ("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 and Security of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the revisions of 2013 made by the Omnibus Rule and all applicable state laws. Under the Privacy and Security 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.

Definitions

Catch-all definitions: The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

1. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean TMLT.

2. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean the policyholder.

3. HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

4. Sensitive Personal Information (SPI). Texas Business and Commerce, Chapter 521, Unauthorized use of Identifying Information defines SPI more broadly than HIPAA Protected Health Information; an Individual's first name or first initial and last name in combination with any one or more of the following items, if the name and the items are not encrypted:

    - social security number;
    - driver's license number or government-issued identification number; or,
    - account number or credit or debit card number in combination with any required security code, access code, or password that would permit access to an Individual's financial account; or, information that identifies an Individual and relates to:
    - the physical or mental health or condition of the Individual;

- the provision of health care to the Individual; or,
- payment for the provision of health care to the Individual.

SECTION 1
Obligations and Activities of Business Associate

TMLT agrees to:

1.1 **Not 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 Appropriate Safeguards.** TMLT agrees to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Protected Health Information, to prevent use or Disclosure of Protected Health Information other than provided for by the Agreement or as otherwise required or allowed by law. TMLT acknowledges that the HITECH Act and the HIPAA Omnibus Rule 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 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. TMLT agrees to notify the Covered Entity within 5 business days of TMLT's knowledge of any use or Disclosure of the Protected Health Information not permitted by this Agreement or by law.

1.4 **Compliance of Agents.** TMLT agrees, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), to require any Subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of the Business Associate to agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

1.5 **Access.** TMLT agrees to make available Protected Health Information in a Designated Record Set to "Covered Entity", as necessary to satisfy Covered Entity's obligations under 45 CFR 164.524. 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. Any requests for amendment to the original Designated Record Set should be made through the Covered Entity and their existing policy and procedure or the amendment process.

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.

1.9 **Release of Documentation of Disclosure.** TMLT agrees to provide to the policyholder, or others as Required by Law, 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 Protected Health Information 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: to its employees, Subcontractors, and agents, in accordance with paragraphs 2.2 through 2.4 of this Section below; or (2) as otherwise permitted by the terms of this Agreement. All other uses not authorized by this Agreement are prohibited. TMLT may use or disclose Protected Health Information that has been fully de-identified as Required by Law.

2.2 **Use of Protected Health Information 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 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 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 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 September 23, 2013 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 HIPAA.

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; or
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;

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 HIPAA Rules and any other applicable law.

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 interpreted to permit compliance with the HIPAA Rules

Debbie Giese
Vice President Underwriting Texas Medical Liability Trust