THE DOCTORS COMPANY

CYBERGUARD PLUS APPLICATION

Higher Limits for Cyber and Regulatory Liability Coverage for Healthcare Professionals

AGENT INFORMATION

Agent name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Website: _____

J11169B 7/17

185 Greenwood Road Napa, CA 94558 (800) 421-2368 Fax: (707) 226-0107 E-mail: sales@thedoctors.com thedoctors.com

APPLICATION INSTRUCTIONS AND CHECKLIST

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process your application promptly and efficiently.

- Please complete this form electronically or print your responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply to you, please write "N/A."
- If you wish to explain any of your answers, please use the Remarks section. If you need additional space, please continue your answers on a separate page and attach it to the application.

If you need additional forms or have any questions about the application, please contact your broker/agent, or call The Doctors Company Member Services at (800) 421-2368. To complete an electronic version of this application, please visit www.thedoctors.com/cyberguardplus-apply.

The following items must be included with your application:

☐ Details regarding any claims or complaints or cease and desist demands alleging trademark, copyright, invasion of privacy, or defamation.

☐ Copies of written network and privacy policies.

☐ Training schedule for computer system issues and procedures.

☐ Documents pertaining to any Stark, EMTALA or HIPAA investigations, lawsuits, or proceedings involving you.

The following items must be included if you are seeking coverage for providers who bill their services through your tax identification number but are not covered under your professional liability policy:

☐ List of providers including name, designation, specialty, effective date, and current policy number if insured with The Doctors Company.

Please Note: Coverage can only be bound once your completed application has been approved and required premium paid.

PART I – APPLICATION INFORMATION

First name/Corporate name: _____ Middle initial: _____ Last name: _____

Professional liability policy number: _____ Professional liability policy period: _____

Requested Effective Date: _____

Address: _____

Name, title, telephone number, and e-mail address of Authorized Officer:

_____

_____

_____

PART II – COVERAGE SELECTION

Type of Coverage

☐ Combined CyberGuard and MediGuard Higher Limits

☐ CyberGuard Higher Limits Only

☐ MediGuard Higher Limits Only

To select additional limits of liability, please select either Option 1 or identify your choices within the Option 2 column.

LIMITS OF LIABILITY

COVERAGE	☐ OPTION 1*	☐ OPTION 2*** Limits of liability greater than $1 million only.
CyberGuard		
Information Security & Privacy Liability	$1,000,000	
Notification Services**	see chart below	
Privacy Breach Response Services	$1,000,000	
Regulatory Defense and Penalties	$1,000,000	
Website Media Content Liability	$1,000,000	
Cyber Extortion	$1,000,000	
First Party Data Protection	$1,000,000	
First Party Network Business Interruption	$1,000,000	
MediGuard	**$1,000,000**	

* Limits are excess of the underlying coverage provided.
** Notification services limit varies by group size.

GROUP SIZE	NOTIFICATION LIMIT
1	20,000 notifications
2 - 20	50,000 notifications
21 +	150,000 notifications

*** Limits of liability greater than $1 million will only be offered to groups with 20 or more doctors. The maximum limit of liability per any single coverage, and aggregate, is $5 million.

PART III – GENERAL QUESTIONS

1. Total net revenue for the most recent 12 months: _____

   Total net revenue for previous year: _____

   Total projected net revenue for next year: _____

   Net Medicare revenue for the most recent 12 months: _____

   Net Medicaid revenue for the most recent 12 months: _____

   Total number of Full Time Equivalent (FTE) doctors on your policy with The Doctors Company: _____
   (One full-time doctor counts as one FTE. One part-time doctor counts as 1/2 FTE.)

   Do you have any doctors not listed on your professional liability policy with The Doctors Company that bill their services through your Tax Identification Number? ☐ Yes ☐ No

   If yes, how many? _____

   Do you want to provide this coverage to these doctors? ☐ Yes ☐ No
   If yes, please provide a roster with the following information: name, designation, specialty, effective date, and their current policy number with The Doctors Company (if applicable).

2. Do you have a compliance program in place for both HIPAA and billing errors?

   ☐ Yes ☐ No

   If yes, when was it implemented? _____

3. Provide detail on any compliance software used:

   _____

   _____

4. Do you purchase any form of the following insurance other than what is included on your policy with The Doctors Company:

   Healthcare Regulatory Liability Insurance? ☐ Yes ☐ No

   Cyber Liability? ☐ Yes ☐ No

   Reputational Harm? ☐ Yes ☐ No

5. Are any changes in the nature or size of your business anticipated over the next year? ☐ Yes ☐ No
   Have there been any such changes in the past year? ☐ Yes ☐ No

   If yes to any of the above questions, please explain.

   _____

   _____

6. Please indicate what person/position (if any) is responsible for:

   Privacy Officer _____

   Billing Compliance _____

   Network Security _____

7. Do you have a written network security and privacy policy?

   ☐ Yes ☐ No *If yes, please provide copies.*

8. Do all employees with access to computer systems receive training in computer-system security issues and procedures?

   ☐ Yes ☐ No *If yes, please summarize the scope of such training and provide the schedule for conducting this training.*

   _____

   _____

9. Are you or any director, officer, employee, or other proposed insured aware of any actual or alleged fact, circumstance, issue, situation, error, omission, or event which:

   Might give rise to a claim against any proposed insured for invasion or interference with rights of privacy, disclosure, loss or misuse of personal information, or which might otherwise result in a claim against any proposed insured with regard to the insurance sought?

   ☐ Yes ☐ No

   Might give rise to an obligation to comply with a law requiring notification of an actual or suspected disclosure of personal information?

   ☐ Yes ☐ No

   Might give rise to a claim or privacy breach notification under the proposed insurance for knowledge or information of any fact, circumstance, situation, event, or transaction?

   ☐ Yes ☐ No

   If yes to any of the above questions, please provide details.

PART IV – MEDIGUARD QUESTIONS

(To be completed if MediGuard or combined CyberGuard/MediGuard coverage is desired.)

1. Do you handle all billings in-house?

   ☐ Yes ☐ No *If no, please list the amount done in-house and the amount done by third party billing service(s) and any ownership percentage in the third party billers used:*

2. Is the billing done exclusively by credentialed individuals?

   ☐ Yes ☐ No *If no, please provide details:*

3. Have you ever been subject to:

   A Stark investigation, lawsuit, or proceeding? ☐ Yes ☐ No

   An EMTALA investigation, lawsuit, or proceeding? ☐ Yes ☐ No

   A HIPAA investigation, lawsuit, or proceeding? ☐ Yes ☐ No

   If yes to any of the above, please provide relevant documents.

4. Have you ever been subject to a medical billings audit by any entity of or on behalf of the government or by a commercial payor?

   ☐ Yes ☐ No *If yes, please provide details:*

5. Has your license to practice or your DEA/narcotics license ever been denied, revoked, suspended, placed on probation, or limited in any way?

   ☐ Yes ☐ No *If yes, please provide details and include supporting documents.*

PART V – CYBERGUARD QUESTIONS

(To be completed if CyberGuard or combined CyberGuard/MediGuard coverage is desired.)

1. Do you have network security policies and procedures that include:

   Antivirus software and protection for all computers? ☐ Yes ☐ No

   Firewalls for all internet access points? ☐ Yes ☐ No

   A software-update process, including installation of security-related software patches, on a regular basis? ☐ Yes ☐ No

2. Do you encrypt data that contains Protected Health Information stored on laptop computers, smartphones and similar devices, and portable media such as thumb drives and backup tapes?

   ☐ Yes ☐ No *If no, why not?* _____

3. Do you have a website or produce any content for any other website?

   ☐ Yes ☐ No *If no, skip to question #7.* _____

4. Does the process for posting on the website include screening the content for the following:

   Disparagement issues? ☐ Yes ☐ No

   Copyright infringement? ☐ Yes ☐ No

   Trademark infringement? ☐ Yes ☐ No

   Invasion of privacy? ☐ Yes ☐ No

5. Do you have a written process to review all content prior to posting?

   ☐ Yes ☐ No *If no, please describe procedures to avoid posting improper or infringing content.*

   _____

   _____

   If yes, is the review performed by an attorney? ☐ Yes ☐ No

6. Please describe any website content you produce and the website URLs.

   _____

   _____

7. Within the last three (3) years, have you ever received any claims or complaints or cease and desist demands alleging trademark, copyright, invasion of privacy, or defamation with regard to any content published, displayed, or distributed by you or on your behalf?

   ☐ Yes ☐ No *If yes, please provide details regarding any such demands and attach any relevant documents.*

   _____

   _____

8. Within the last three (3) years, have you ever received any claims or complaints or cease and desist demands with respect to allegations of invasion of or injury to privacy, identity theft, theft of information, breach of information security, software copyright infringement or content infringement, or been required to provide notification to individuals due to an actual or suspected disclosure of personal information?

   ☐ Yes ☐ No *If yes, provide details of each such claim, allegation or incident, including costs, losses, or damages incurred or paid, and any amounts paid as a loss under any insurance policy.*

   _____

   _____

9. Have you been subject to any government action, investigation, or subpoena regarding any alleged violation of any privacy or information security related law or regulation?

☐ Yes ☐ No *If yes, please provide details of any such action, investigation, or subpoena.*

10. Have you ever experienced an extortion attempt or demand with respect to your computer systems?

☐ Yes ☐ No *If yes, please provide details.*

REMARKS SECTION

AGREEMENTS

AGREEMENT: I do hereby affirm the truth of all statements and answers, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for insurance. I have also made a reasonable inquiry, where appropriate, to ensure the responses herein are as complete and accurate as possible. I understand that any erroneous information or material misrepresentation may cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application and returned the original to the company with the required payment.

AGREEMENT: I understand that in order to underwrite the requested insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

AGREEMENT: I agree that this application shall be deemed appended to and a part of, any policy of insurance issued to me based on this application.

AGREEMENT: I further agree that my signature of this application shall be deemed to be a concurrent execution of the attached Subscriber Agreement and Power of Attorney.

SIGNATURE REQUIRED:

X _____ _____

Applicant Signature | Date

NOTICES

INSURANCE FRAUD WARNING

ALABAMA
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 restitution fines or confinement in prison, or any combination thereof.

ARKANSAS
Any person who knowingly presents a false or fraudulent claim for payment for 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.

COLORADO
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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

DISTRICT OF COLUMBIA
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.

FLORIDA
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.

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

KANSAS
Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

KENTUCKY
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.

LOUISIANA
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.

NOTICES (CONTINUED)

MAINE
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 denial of insurance benefits.

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

MINNESOTA
A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

MISSOURI
An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may subject to civil fines and criminal penalties.

NEW YORK
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 stated value of the claim for each such violation.

OHIO
Any person who, with intent to defraud or knowing that he 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.

OKLAHOMA
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. The absence of such a statement shall not constitute a defense in any prosecution.

OREGON
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.

PENNSYLVANIA
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.

RHODE ISLAND
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.

TENNESSEE
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

WASHINGTON
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA
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.

SUBSCRIBER AGREEMENT AND POWER OF ATTORNEY

For and in consideration of similar agreements executed or to be executed by other Subscribers and of the benefits of the exchange of such agreement, the Subscriber agrees to the below-stated terms and conditions.

1. The undersigned subscribes for membership in The Doctors Company and agrees with The Doctors Company and with other Subscribers, through their Attorney-in-Fact, The Doctors Management Company ("the Attorney"), to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in a form and containing terms and conditions as are approved by The Doctors Company Board of Governors.

2. Subscriber designates and appoints the Attorney to be his or her true and lawful agent and Attorney-in-Fact to act in his or her name, place, and stead and in the name of The Doctors Company, to exchange contracts of insurance and to do all things that the Subscribers might or could do severally or jointly with regard to the operation and management of The Doctors Company and the business of interinsurance. Subscriber adopts and approves the Management Agreement between The Doctors Company and the Attorney, as it may be amended from time to time, and of any successor Management Agreement as it also may be amended.

3. Subscriber delegates to the Board of Governors of The Doctors Company authority to negotiate all the terms and conditions of the Management Agreement between The Doctors Company and the Attorney on behalf of the Subscriber, including, but not limited to, the compensation to be paid to the Attorney by the Subscriber or The Doctors Company.

4. Subscriber further delegates to the Board of Governors of The Doctors Company all necessary and proper powers to conduct, manage, and control the affairs and business of The Doctors Company, subject to those retained by law or through the Rules and Regulations of The Doctors Company, or as they may be further amended at the Annual Meeting of Subscribers.

5. The Board of Governors is made up of public and professional members elected by a majority of Subscribers present or represented by proxy at the Annual Meeting of Subscribers. Governors generally serve four-year terms. Each year, Governors with expiring terms will stand for election.

6. Subscribership begins with the commencement of the policy period of the liability insurance policy issued by The Doctors Company and ends upon cancellation or other termination of that policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After termination of subscription, Subscriber shall have no further rights to participate in any distribution of savings to Subscribers or in any distribution of assets upon dissolution of The Doctors Company.

7. The Board of Governors may appoint any individual, partnership, or corporation to become successor to the Attorney with all of the powers and duties stated in this Agreement. All references to "Attorney" shall then be deemed to include such successor Attorney-in-Fact.

8. The principal offices of The Doctors Company and the Attorney shall be maintained at Napa, California, or at such other place approved by the Board of Governors.

9. The Agreement can be signed by each Subscriber separately with the same effect as if the signatures of all Subscribers were on one and the same instrument, and signature of the Application to which this Agreement is attached shall constitute signature of this Agreement. This Agreement shall continue in full force and effect until revoked by the written request of Subscriber who has signed this document. This Agreement shall be governed by and interpreted according to the laws of the State of California. All Subscriber Agreements shall be binding upon all Subscribers, and the provision of each shall not materially differ. Wherever the word "Subscriber" is used, it refers to all members of The Doctors Company, including the Subscriber who has signed this document.

PROXY

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company.

This proxy is solicited on behalf of the management of The Doctors Company and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

This proxy, unless revoked or replaced by substitution, shall remain in force for five years from the date stated below.

You may revoke this proxy by giving The Doctors Company written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.

The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.

SIGNATURE (OPTIONAL):

X _____ _____

Signature Date

Type or print name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

INSURANCE APPLICANT BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is entered into by and between The Doctors Company, including all of its subsidiaries, hereinafter referred to as "we," and "you" in conjunction with the policy of insurance we have entered into with you. This agreement supersedes and replaces any prior Business Associate Agreement ("BAA").

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as modified by the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and related rules and as may be modified subsequently (the "Privacy Regulations"). Under the Privacy Regulations, you are a "covered entity," and as required by 45 C.F.R. Section 164.502(e) and 45 C.F.R. Section 164.504(e), we acknowledge that we, in certain instances, may be your "business associate." We must use and disclose information that identifies an individual; relates to health, health treatment, or healthcare payment; and is maintained in any form (e.g., electronic, paper, oral) ("Protected Health Information" or "PHI") in our performance of services under this Policy, and we agree to abide by the assurances, terms, and conditions contained herein in the performance of our obligations.

This document sets forth the terms, conditions, and obligations pursuant to which Protected Health Information that is provided, created, or received by us from you or on your behalf, will be handled.

We agree as follows:

A. Permitted Uses and Disclosures of Protected Health Information.

Pursuant to this Agreement, we provide services ("Services") for your operations that may involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, quality assessment; quality improvement; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of healthcare 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, we may make any uses of Protected Health Information necessary to perform our obligations under this Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, we may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to our employees, subcontractors, and agents, in accordance with Section D(5) below; (ii) as directed by you in writing; or (iii) as otherwise permitted by the terms of this Agreement. Additionally, unless otherwise limited herein, we are permitted to make the following uses and disclosures:

B. Our Obligations and Activities.

We may use and disclose the Protected Health Information in our possession to third parties for the purpose of our proper management and administration, such as obtaining reinsurance, or to fulfill any of our present or future legal responsibilities, such as complying with insurance regulator requests, provided that (i) the disclosures are required by law; or (ii) we have received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 C.F.R. Section 164.504(e)(4) and where necessary received a BAA.

C. In addition to using the Protected Health Information to perform the services set forth above, we may:

(1) Aggregate the Protected Health Information in our possession with the Protected Health Information of other covered entities that we have in our possession through our capacity as a business associate to said other covered entities, provided that the purpose of such aggregation is to provide you with data analyses relating to your healthcare operations. Under no circumstances may we disclose Protected Health Information of one covered entity as defined by 45 C.F.R. Parts 160 and 164 to another covered entity absent your express written authorization; and

(2) De-identify any and all Protected Health Information provided that the de-identification conforms to the requirements of 45 C.F.R. Section 164.514(b), and further provided that you are sent the documentation required by 45 C.F.R. Section 164.15(b), which shall be in the form of a written assurance from us. Pursuant to 45 C.F.R. 164.502(d)(2), de-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement.

D. With regard to our use and/or disclosure of Protected Health Information, we agree to do the following:

(1) Use and/or disclose the Protected Health Information only as permitted or required by this Agreement or as otherwise required by law and then only to the minimum necessary extent to accomplish the intended purpose of the use;

(2) Report to your designated Privacy Officer, in writing, any use and/or disclosure of the Protected Health Information that is not permitted or required by this Agreement of which we become aware as soon as practical and within ten (10) business days of our discovery of such unauthorized use and/or disclosure. Where practical and possible, we will take steps to mitigate the harmful effect of any unpermitted disclosure of PHI;

(3) Use commercially reasonable efforts to maintain the security of the Protected Health Information and take appropriate physical, administrative, and technical safeguards to prevent unauthorized use and/or disclosure of such Protected Health Information;

(4) Require all of our subcontractors and agents that undertake to perform the services that we perform under this Agreement and that receive, use, or have access to Protected Health Information under this Agreement to agree, in writing, to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to us pursuant to this Agreement;

(5) Unless prohibited by attorney-client and other applicable legal privileges or unless it would violate our contractual and other legal obligation to you, make available all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to the Secretary of the United States Department of Health and Human Services for purposes of determining your compliance with the Privacy Regulations;

(6) Upon prior written request, make available during normal business hours at our offices all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to you within five (5) business days for purposes of enabling you to determine our compliance under the terms of this Agreement;

(7) We shall honor any request from you for information to assist in responding to an individual's request for an accounting of disclosures of Protected Health Information to us. However, should you be asked for an accounting of the disclosures of an individual's Protected Health Information in accordance with 45 C.F.R. Section 164.528, such accounting should not include any disclosures to us which are to carry out your healthcare operations. See 45 C.F.R. Section 164.528(a)(1)(i);

(8) Upon termination of this Policy, the protections of this Agreement will remain in force and we shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of our business or as required by law;

(9) In those instances when you would be required to honor an individual's request for access and/or amendment of Protected Health Information disclosed to us, we will assist you to comply with your duties under 45 C.F.R. Sections 154.524 and 164.526. However, usually you will not be required to honor such requests because Protected Health Information in our possession is not part of a designated record set as that term is defined by 45 C.F.R. 164.501; and/or because the information is exempt from access and amendment under 45 C.F.R. Sections 164.524(a) and 164.526(a)(2); and/or because access would violate your superseding contractual and other legal rights; and/or because any amendment could be tampering with evidence in a civil or administrative matter;

(10) You may terminate this Agreement by canceling this Policy if we violate a material term of this Agreement;

(11) You agree that we may modify this Agreement as required to comply with applicable laws or regulations.

In witness whereof, The Doctors Company has caused this Agreement to be signed by its Chairman at its Home Office.

Richard E. Anderson, MD
Chairman of the Board of Governors