



**Clinic Purchasing Group**  
**APPLICATION**  
**For Clinics**

For Claims Made Professional Liability  
Insurance and Prior Acts Coverage

 **NORCAL**  
Mutual Insurance Company

# COVERAGE HIGHLIGHTS

Feature	Benefit
Physicians Administrative Defense Coverage	Provides defense cost and practice interruption expense coverage for administrative proceedings
Optional Health Care General Liability Insurance (additional charge applies)	Provides coverage for bodily injury, property damage, fire damage, personal injury, advertising injury and medical payments
Optional Non-Owned Auto and Hired Auto Liability Insurance for Qualified Clinic's/Organizations (additional charge applies)	Provides coverage for bodily injury, property damage and fire damage arising from the use of qualified autos in connection with the clinic's/organization's business
Administration of Your Employee Benefits Program Insurance	Provides coverage for benefit errors in the administration of the clinic's/organization's employee benefits program
Prior Acts/Retrospective Coverage (Over Current Retroactive Date)	Conveniently provides coverage from one insurer
Right to Consent to Settle	Places the Insured in control of whether to settle a claim
Federal Tort Claims Act Gap/Wrap-Around Coverage Credit	This credit is available to clinics funded through Section 330 of the Public Service Act and deemed a covered health center under the Federal Tort Claims Act (FTCA).

**The following benefits are provided in addition to the limits of liability of the policy:**

- Defense Costs
- Attendance at Trial: *\$500 maximum per half day per Insured*
- Pre-judgment and Post-judgment Interest on that part of any judgment we pay

**Additional Highlights**

Aggressive Claims Handling	Represents the Insured's interests and helps protect the Insured's reputation
On-Site Clinical and Administrative Assessment	Helps the clinic/organization to identify risks and evaluate and improve its practice systems
Award-winning CME Material	Assists the clinic/organization in enhancing patient safety and improving communication
Monthly <i>Claims Rx</i> Newsletter	Helps the clinic/organization stay on top of current administrative and clinical issues
Risk Management 24/7 Phone Consultations	Offers peace of mind and allows an Insured to call NORCAL 24/7 for Risk Management advice

The above information is intended only to highlight the NORCAL policy features and benefits. The conditions of coverage are specifically explained in the NORCAL policy. Please read the policy for complete coverage information.

If you have questions regarding this application or would like a copy of the NORCAL policy, please contact your broker or NORCAL's Policyholder Services Unit at (877) 443-7232.

## IMPORTANT INFORMATION

The coverage of any policy, if issued, is limited generally to liability only for those claims that are first made against an Insured and reported to NORCAL while the policy is in force. The coverage provided under the optional Health Care General Liability Insurance, if purchased, is limited to bodily injury, property damage, fire damage, personal injury or advertising injury that occurred during the policy period. The coverage provided under the optional Non-Owned Auto and Hired Auto Liability Insurance, if purchased, is limited to bodily injury, property damage or fire damage that occurred during the policy period.

The coverage of any policy, if issued, is limited to the liability of the Named Insured and any Insured. The Named Insured and all Insureds share a single limit of liability. Coverage for an Insured is provided only while he or she is acting within the course and scope of his or her duties for the Named Insured.

Please review the policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance advisor, agent or broker.

No coverage exists until written verification of coverage by NORCAL Mutual Insurance Company is issued in the clinic's/organization's name.

The application asks that you provide information regarding affiliations, practice associations, etc. This information is requested to provide us with an understanding of the clinic's/organization's practice but does not mean that a policy, if issued, would cover such entities and persons.

If the clinic/organization engages in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, the clinic/organization may be considered a *Covered Entity* under HIPAA and thus may be required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at [www.norcalmutual.com](http://www.norcalmutual.com).

## APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- If you wish to explain any of your answers, please use the Remarks section on page 17. If you need more space, please attach additional pages.
- If a table in the application does not have a sufficient number of rows to provide the requested information, please photocopy the applicable page.
- Please ensure that you sign and date the application on page 18.
- In addition to a completed application and the information requested within it, please provide the following items:
  - Completed health care provider applications for all individuals as specified in the Personnel section of this application.
  - A copy of the clinic's/organization's letterhead(s).
  - Loss runs for the previous ten years for the clinic/organization and each clinic/organization member. The loss runs must include paid and reserved amounts and be less than ninety (90) days old.
  - A copy of the declarations page and any endorsements from the clinic's/organization's most recent insurance policy, if applicable. If each physician was issued a declarations page, please provide each declarations page. If each physician was not issued a declarations page, please provide the endorsement to the policy that identifies all Insureds and their retroactive dates.
- Please make a copy of the completed application and supporting documentation for your records.

## SECTION I GENERAL INFORMATION

Clinic/Organization Name					Tax ID Number	
Primary Address	City	County	State	Zip Code	Telephone # (with area code)	Fax # (with area code)
Mailing Address (Location where all mailings except invoices will be sent)		City	State	Zip Code	Telephone # (with area code)	Fax # (with area code)
Billing Address (Location where invoices will be sent)		City	State	Zip Code	Telephone # (with area code)	Fax # (with area code)
Type of Clinic/Organization <input type="checkbox"/> American Indian/Native Indian Clinic <input type="checkbox"/> Community Clinic <input type="checkbox"/> Free Clinic <input type="checkbox"/> Migratory and Rural Health Clinic <input type="checkbox"/> Other (specify): _____						
Is the clinic/organization a non-profit/not-for-profit organization? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>NOTE:</b> Coverage under NORCAL's Clinic Purchasing Group policy is available only to non-profit/not-for-profit organizations. If you are not a non-profit/not-for-profit organization, do not complete the remainder of this application; please contact your broker.						

### Authorized Representative

The Authorized Representative is the person responsible for providing consent decisions on behalf of the Named Insured and the person who will act on behalf of the Named Insured or other Insureds for all other purposes relating to the policy. One person may be designated for both purposes or a separate person may be designated for each purpose.

Please provide the name and title of the person authorized to provide consent decisions on behalf of the Named Insured:

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

Please provide the name and title of the person authorized to act on behalf of the Named Insured and all other Insureds for all other (non-consent) purposes relating to the policy.

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

## SECTION II COVERAGE INFORMATION

**Requested Effective Date** (the date you wish coverage to begin)

\_\_\_\_\_ 12:01 a.m. Local Time  
Month Day Year

**NOTE:** NORCAL should receive the application at least thirty (30) days before the Requested Effective Date.

### Prior Acts Coverage

**NOTE:** If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims or administrative proceedings that 1) are first made against an Insured and reported to NORCAL after the policy effective date with NORCAL and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or expiration date of that policy.

The Retroactive Date is the earliest date on which a medical incident, benefit error or administrative proceeding may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current insurer, if applicable. This coverage does not apply to the optional Health Care General Liability Insurance or Non-Owned Auto and Hired Auto Liability Insurance. **NORCAL does not automatically provide Prior Acts Coverage.**

**Check one of the following:**

- The clinic/organization wishes to apply for Prior Acts Coverage.** Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Tail Coverage from your current insurer. Please identify the Requested Retroactive Date below and complete the Prior Acts Coverage section on page 16. The Retroactive Date must be the same as the Retroactive Date of your current policy.

\_\_\_\_\_ 12:01 a.m. Local Time  
Month Day Year

- The clinic/organization does not wish to apply for Prior Acts Coverage.** It is understood that if the clinic/organization does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the effective date of the NORCAL policy, if issued.

### Health Care General Liability Insurance – Occurrence

**NOTE:** Health Care General Liability Insurance is an optional, occurrence-based coverage. Additional premium will be charged if this coverage is approved. NORCAL does not automatically provide Health Care General Liability Insurance coverage. Please discuss with your broker before completing the following question.

Does the clinic/organization wish to apply for Health Care General Liability Insurance?  **Yes**  **No**

**If yes,** please contact your broker for an application in order to apply for such coverage.

### Non-Owned Auto and Hired Auto Liability Insurance – Occurrence

**NOTE:** This optional, occurrence-based coverage is available only to clinics/organizations that purchase NORCAL's Health Care General Liability Insurance coverage. Additional premium will be charged if this coverage is approved. NORCAL does not automatically provide Non-Owned Auto and Hired Auto Liability Insurance coverage. Please discuss with your broker before completing the following question.

Does the clinic/organization wish to apply for Non-Owned Auto and Hired Auto Liability Insurance?  **Yes**  **No**

**If yes,** please contact your broker for an application in order to apply for such coverage.

### Requested Limits of Liability

Please indicate the desired limits of liability (select one). The Named Insured and all other Insureds will share the same limits of liability.

- \$1,000,000/\$3,000,000  \$2,000,000/\$4,000,000  
 \$1,000,000/\$6,000,000  \$2,000,000/\$8,000,000  
 \$1,000,000/\$9,000,000

## Scope of Coverage

### Check one of the following:

- NORCAL coverage is being requested for the clinic's/organization's entire medical practice as described in this application.
- NORCAL coverage **is not** needed for part of the clinic's/organization's medical practice (for example, services rendered at certain locations).

If the clinic/organization does not need NORCAL coverage for a particular part of its practice, please:

- Provide a detailed description of that part of the clinic's/organization's practice, including the start date.
- Identify the name of the insurance company that is providing the clinic/organization with professional liability insurance coverage for that part of its practice, including the limits of liability of that insurance coverage.

## SECTION III PROFESSIONAL LIABILITY INSURANCE HISTORY

1. Has any professional liability insurance company **ever** canceled, nonrenewed or modified (for example, involuntarily reduced limits, restricted coverage or added a deductible and/or surcharge) the clinic's/organization's insurance, declined to offer the clinic/organization coverage or notified the clinic/organization of its intent to pursue such action?  **Yes**  **No**

**If yes**, please provide a detailed written narrative and copies of all pertinent documentation (for example, a copy of the nonrenewal or declination notice). At a minimum, the narrative must include the name of the insurance company, the date(s) of the action(s) and a detailed description of the reason(s) for the action(s).

2. Please complete the following regarding all professional liability insurance maintained by the clinic/organization during the past ten years, beginning with the most current:

Name of Insurer	Coverage Dates (Month/Day/Year)	Deductible or Self-insured Retention?	Policy Type	If Claims Made, Check One
	From:  To:	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  <b>If yes:</b> Type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage
	From:  To:	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  <b>If yes:</b> Type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage
	From:  To:	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  <b>If yes:</b> Type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage
	From:  To:	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  <b>If yes:</b> Type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage

3. If any one of the insurance coverages identified above was claims made coverage, and the clinic/organization did not obtain Tail Coverage or Prior Acts Coverage, please explain:

## SECTION IV LEGAL STRUCTURE

1. Please complete the following regarding the primary legal entity applying for coverage and provide a copy of the entity's partnership agreement, articles of incorporation, etc:

Name of Entity	Legal Structure	Name(s) of Owner(s) and the Percentage of Ownership Interest
	<input type="checkbox"/> 501(c)(3) Corporation <input type="checkbox"/> Other Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____	

2. Does the entity identified in question 1 own, operate or manage any other organization or entity?  Yes  No

**If yes**, please complete the following for each organization or entity and provide a copy of each entity's partnership agreement, articles of incorporation, etc:

Name of Entity	Legal Structure	Name(s) of Owner(s) and the Percentage of Ownership Interest	Is NORCAL Coverage Desired for the Organization/Entity?*
	<input type="checkbox"/> 501(c)(3) Corporation <input type="checkbox"/> Other Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> 501(c)(3) Corporation <input type="checkbox"/> Other Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If NORCAL coverage is not desired for the organization or entity, please explain in the Remarks section on page 17.

3. Does the clinic/organization desire coverage for any entity(ies) not already identified in question 1 or 2?  Yes  No

**If yes**, please identify each entity and its owner(s), provide a copy of each entity's partnership agreement, articles of incorporation, etc. and explain:

---



---



---

4. Is the clinic/organization owned, operated or managed by another organization or entity not already specified above?  Yes  No

**If yes**, please explain and provide the name(s) of the organization(s) or entity(ies):

---



---



---

5. Is the clinic/organization involved in any joint ventures or partnerships?  Yes  No

**If yes**, please explain:

---



---

6. If you answered yes to question 2, 3, 4 or 5, please provide a chart of the organizational structure on a separate sheet of paper.

7. Does the clinic/organization or any of its members use any fictitious name(s) or dba(s)?  Yes  No

**If yes**, please identify each fictitious name or dba and explain:

---



---

## SECTION V PRACTICE LOCATIONS

1. Please complete the following by identifying all locations *owned or operated* by the clinic/organization:

Location (name and address)	Percentage of Organization's Total Services	Type of Location and Percentage of Location's Services
	_____ %	<input type="checkbox"/> Primary Care Clinic _____ % <input type="checkbox"/> Extended Care Facility _____ % <input type="checkbox"/> Halfway House _____ % <input type="checkbox"/> Long Term Inpatient Mental Health _____ % <input type="checkbox"/> Nursing Home _____ % <input type="checkbox"/> Residential Treatment Center _____ % <input type="checkbox"/> Other (specify): _____ %
	_____ %	<input type="checkbox"/> Primary Care Clinic _____ % <input type="checkbox"/> Extended Care Facility _____ % <input type="checkbox"/> Halfway House _____ % <input type="checkbox"/> Long Term Inpatient Mental Health _____ % <input type="checkbox"/> Nursing Home _____ % <input type="checkbox"/> Residential Treatment Center _____ % <input type="checkbox"/> Other (specify): _____ %
	_____ %	<input type="checkbox"/> Primary Care Clinic _____ % <input type="checkbox"/> Extended Care Facility _____ % <input type="checkbox"/> Halfway House _____ % <input type="checkbox"/> Long Term Inpatient Mental Health _____ % <input type="checkbox"/> Nursing Home _____ % <input type="checkbox"/> Residential Treatment Center _____ % <input type="checkbox"/> Other (specify): _____ %
	_____ %	<input type="checkbox"/> Primary Care Clinic _____ % <input type="checkbox"/> Extended Care Facility _____ % <input type="checkbox"/> Halfway House _____ % <input type="checkbox"/> Long Term Inpatient Mental Health _____ % <input type="checkbox"/> Nursing Home _____ % <input type="checkbox"/> Residential Treatment Center _____ % <input type="checkbox"/> Other (specify): _____ %
	_____ %	<input type="checkbox"/> Primary Care Clinic _____ % <input type="checkbox"/> Extended Care Facility _____ % <input type="checkbox"/> Halfway House _____ % <input type="checkbox"/> Long Term Inpatient Mental Health _____ % <input type="checkbox"/> Nursing Home _____ % <input type="checkbox"/> Residential Treatment Center _____ % <input type="checkbox"/> Other (specify): _____ %

a. Please provide copies of the licenses for all locations identified above.

b. If any location is not licensed, please explain:

---



---



---

2. Please complete the following by identifying all other locations at which the clinic's/organization's personnel perform procedures/surgeries and/or provide services on behalf of your clinic/organization:

Location (name and address)	Type of Location	Reason Health Care Provider Provides Services on Behalf of the Clinic/Organization at This Location
	<input type="checkbox"/> Community Clinic <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Urgent Care Clinic <input type="checkbox"/> Other (specify): _____	
	<input type="checkbox"/> Community Clinic <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Urgent Care Clinic <input type="checkbox"/> Other (specify): _____	
	<input type="checkbox"/> Community Clinic <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Urgent Care Clinic <input type="checkbox"/> Other (specify): _____	

**NOTE:** Please complete the remaining questions in this section only if you identified locations for question 2.

- a. Please describe in detail how your clinic/organization receives payment from, and then submits payment on behalf of, each facility listed in question 2.

---



---



---

- b. How do the individuals who perform the procedures/surgeries and/or provide the services on behalf of your clinic/organization at these locations bill for them (check all that apply)?

Bill under your clinic's/organization's name

Bill under the individual's own name

Bill under the outside facility's name

Other (specify): \_\_\_\_\_

If you indicated anything other than billing under your clinic's/organization's name, please identify the individuals and explain:

---



---



---

## SECTION VI PERSONNEL

1. Please identify the following administrative personnel:

Title	Name	Number of Years with Clinic/Organization
Chief Executive Officer:		
President:		
Executive Director:		
Medical Director:		
Administrator:		
Other:		

2. Please attach a roster of all individuals who provide services on behalf of the clinic/organization. The roster must include the following items for each individual:

- Name and designation
- Type of provider (for example, physician, nurse practitioner or registered nurse)
- Whether the individual is a partner/shareholder, employee, independent contractor, leased worker or volunteer
- Date of employment, if an employee

3. Please submit completed applications for the following individuals if they are administering anesthesia (other than topical or by means of local infiltration) or performing deliveries, abortions and/or any procedure specified in Section VII of this application as an intermediate procedure or surgery, oral surgery or major surgery:

- Physicians, surgeons and dentists
- Certified registered nurse anesthetists
- Midwives
- Nurse practitioners
- Perfusionists
- Physician assistants
- Podiatrists

4. Are all personnel who provide professional health care services in or on behalf of the clinic/organization licensed and/or certified as required by state law for the services they provide?  **Yes**  **No**

If no, please explain:

---



---



---

## SECTION VII PROCEDURES, SERVICES AND OCCUPIED BEDS

1. Please complete the following table by providing the *estimated* number of procedures and surgeries to be performed or services to be provided on behalf of the clinic/organization for the current (and complete) calendar year, regardless of where they are performed or provided. If the clinic/organization has deemed status under the Federal Tort Claims Act (FTCA), please estimate the number of procedures or services that are not covered by the FTCA and those that are.

Procedure/Surgery/Service	Non-FTCA	FTCA
<b>Family Practice and General Visits (excluding general podiatric visits):</b>		
<b>General Podiatric Visits:</b>		
<b>Prenatal and Postnatal Visits:</b>		
<b>General Dental Visits (excluding oral surgery):</b>		
<b>Mental Health Counseling Visits:</b>		
<b>Deliveries (including cesarean delivery):</b>		
<b>Abortions:</b>		
<b>Emergency Medical Technician Runs/Calls:</b>		
<b>Oral Surgery:</b>	-----	-----
Cleft lip and palate surgery		
Dental implants		
Orthognathic surgery		
Temporomandibular joint surgery		
Wisdom tooth extraction		
Other oral surgery (specify procedures):		
_____		
_____		
_____		
_____		

Procedure/Surgery/Service	Non-FTCA	FTCA
<b>Minor Procedures and Surgeries:</b>	-----	-----
Biopsy of lesions on the skin and of the mucous membranes		
Biopsy excision of lymph nodes within the subcutaneous tissue		
NORPLANT insertion or removal		
Surgical treatment of cysts, abscesses and traumatic wounds		
<b>Intermediate Procedures and Surgeries:</b>	-----	-----
Carpal tunnel release		
Catheterization – right heart		
Circumcision		
Dilation and curettage of the uterus (other than for the termination of a pregnancy)		
Herniorrhaphy (inguinal or femoral only)		
Hemorrhoidectomy and other procedures limited to the anal ring		
Hysteroscopy		
Injection treatment of varicose veins		
Lithotripsy		
Myringotomy		
Orthopedic operations of the interphalangeal joints		
Tonsillectomy and adenoidectomy		
Transurethral procedures on the kidney, ureter, bladder or urethra		
Vasectomy and other procedures involving cutting of the scrotal sac		
Other intermediate procedures and surgeries (specify):		
_____		
_____		
_____		

Procedure/Surgery/Service	Non-FTCA	FTCA
<b>Major Surgery:</b>	-----	-----
Amputations		
Angiography		
Angioplasty		
Catheterization – left heart and noncoronary		
Fracture repair – plating, pinning or open reduction		
Mastectomy		
Reconstructive vascular surgery, thromboembolectomy and thrombectomy of the arteries and veins and arterial-venous fistula creation/revision		
Neurological surgery		
Ophthalmic surgery		
Operations within the middle inner ear		
Orthopedic surgery (other than orthopedic operations on the interphalangeal joints)		
Plastic (cosmetic or reconstructive) surgery		
Prostatectomy		
Submucous nasal resection and other sinus surgery		
Stenting – coronary and noncoronary		
Thyroidectomy		
Any surgical procedure on malignant lesions (other than for diagnostic purposes)		
Any cutting into or on the kidney, urethra or bladder		
Any surgical procedure involving cutting into or within the abdominal cavity, cranial cavity, orbital cavity, spine or facial sinuses (not already identified in the major surgery section)		
Other major surgery (specify): _____ _____ _____		

2. Please complete the following table by providing the *estimated* number of persons enrolled or the average number of occupied beds for the following services to be provided on behalf of the clinic/organization for the current (and complete) calendar year. If the clinic/organization has deemed status under the Federal Tort Claims Act (FTCA), please estimate numbers for those services that are not covered by the FTCA and those that are.

Service	Non-FTCA	FTCA
Adult Day Care Services (average number enrolled)		
Child Day Care Services (average number enrolled)		
Halfway House (average number of occupied beds)		
Long Term Inpatient Mental Health (average number of occupied beds)		
Nursing Home (average number of occupied beds)		
Residential Treatment Center (average number of occupied beds)		
Aerobics (square feet of dedicated space)		
Other services (specify): _____ _____		

## SECTION VIII GENERAL PRACTICE INFORMATION

1. Does the clinic/organization currently have deemed status under the Federal Tort Claims Act (FTCA)?  Yes  No

**If yes**, please complete the following:

- a. Please attach a copy of the clinic's/organization's most recent scoping document and deeming letter.
- b. When did the organization/clinic first obtain deemed status (month/year)? \_\_\_\_\_
- c. Have there been any changes in the clinic's/organization's deemed status since first becoming deemed?  Yes  No

**If yes**, please explain:

---

---

---

- d. Does the clinic/organization have deemed status for all of the services that it provides and for all of the procedures performed on its behalf?  Yes  No

**If no**, please explain and identify those services and/or procedures for which the clinic/organization does not have FTCA protection:

---

---

- e. Do all of the individuals who provide health care services on behalf of the clinic/organization have FTCA protection for those services?  Yes  No

**If no**, please explain and provide the names of the individuals who do not have FTCA protection:

---

---

- f. Are all of the locations owned or operated by the clinic/organization deemed as FTCA covered health centers?  Yes  No

**If no**, please explain and identify the locations that are not deemed as FTCA covered health centers:

---

---

---

2. Within the next 12 months, are there any planned material changes for the clinic/organization (for example, the addition of a new location, establishment of another entity or changes in the type of procedures performed and/or services provided)?  Yes  No

**If yes**, please explain:

---

---

3. Does the clinic/organization advertise in any way other than listing the name, address and telephone number in the telephone book?  Yes  No

**If yes**, please submit copies of all of the advertisements (excluding those that appear on the website, if applicable) and/or the scripts of ads in any voice, film or TV media.

4. Is there a website related to the clinic's/organization's medical practice?  Yes  No

**If yes**, please provide the website address(es):

---

---

5. Has the clinic/organization entered into any contracts to provide professional health care services (excluding those with managed care organizations)?  **Yes**  **No**

If **yes**, please explain and provide a copy of the contract(s):

---

---

## SECTION IX RISK MANAGEMENT

### Risk Management/Quality Improvement

1. Does the clinic/organization have a formal risk management program?  **Yes**  **No**
- a. If **yes**, who (name and title) is responsible for the risk management program and what other job responsibilities does this person have?

---

---

- b. If **no**, please explain why the clinic/organization does not have a formal risk management program:

---

---

---

2. Does the clinic/organization have a formal process to evaluate and address concerns of unexpected patient outcomes?  **Yes**  **No**

3. Does the clinic/organization have a formal process to evaluate patient complaints?  **Yes**  **No**

4. Does the clinic/organization conduct patient satisfaction surveys?  **Yes**  **No**

If **yes**, how often: \_\_\_\_\_

5. Does the clinic/organization have any current risk management or quality improvement initiatives in place?  **Yes**  **No**

If **yes**, please describe the initiatives:

---

---

---

### Credentialing

1. Does the clinic/organization have a formal process to credential its health care providers?  **Yes**  **No**

- a. If **yes**, please identify who performs the initial credentialing (for example, employee, hospital or outside company):

---

---

---

- b. If **no**, please explain the process for determining which health care providers the clinic/organization will hire or with whom it will contract:

---

---

---

2. Are all health care providers required to maintain and provide proof of hospital privileges for the procedures/surgeries they intend to perform on behalf of the clinic/organization?  **Yes**  **No**

**If no**, please explain and identify the credentialing process used to ensure that these individuals are qualified to perform the applicable procedures/surgeries:

---

---

---

3. Does the clinic/organization evaluate the following when credentialing its health care providers?

- Claim History  **Yes**  **No** **If yes**, source(s) used: \_\_\_\_\_
- Employment History  **Yes**  **No** **If yes**, source(s) used: \_\_\_\_\_
- Education History  **Yes**  **No** **If yes**, source(s) used: \_\_\_\_\_
- Felony/Misdemeanor History  **Yes**  **No** **If yes**, source(s) used: \_\_\_\_\_
- Medical/Dental/Nursing License  **Yes**  **No** **If yes**, source(s) used: \_\_\_\_\_
- DEA Registration  **Yes**  **No** **If yes**, source(s) used: \_\_\_\_\_
- Board Certification  **Yes**  **No** **If yes**, source(s) used: \_\_\_\_\_

If you answered no to any one of the above, please explain why this item(s) is not evaluated:

---

---

---

4. Does the clinic/organization require that all graduates of foreign medical schools be certified by the Education Council for Foreign Medical School Graduates?  **Yes**  **No**

**If no**, please explain:

---

---

---

5. Are credentials approved before privileges are granted to the health care providers?  **Yes**  **No**

**If no**, please explain:

---

---

---

6. Are the privileges granted to the health care providers always specified in writing?  **Yes**  **No**

**If no**, please explain:

---

---

---

7. How often are the clinic's/organization's health care providers recredentialed and what does the recredentialed process involve?

---

---

---

8. Does the clinic/organization use the same credentialing and re-credentialing procedures to credential and re-credential independent contractors and locum tenens health care providers as it does to credential and re-credential employed health care providers?  
 Yes  No

If no, please describe how and why the procedures are different:

---



---



---

## SECTION X SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (for example, medical board documents, or letters from a hospital, diversion program and/or treating physician).

1. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the clinic/organization or any of the clinic's/organization's licenses?  Yes  No
2. Have the clinic's/organization's clinical privileges, membership, contractual participation or employment by any medical organization (for example, hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO) or private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending?  Yes  No
3. Has the clinic/organization **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (for example, hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO) or private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?  Yes  No
4. Has any clinic/organization member **ever** been accused of sexual misconduct?  Yes  No
5. Do you know if any individual who works on the clinic's/organization's behalf has a prior history or propensity for sexual misconduct?  Yes  No

## SECTION XI CLAIMS HISTORY

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the clinic/organization entity(ies), or has a clinic/organization entity been notified of its involvement in a malpractice claim or suit, either directly or indirectly?  Yes  No
2. Is the clinic/organization aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against a clinic/organization entity, directly or indirectly, even if you believe the claim or suit would be without merit?  Yes  No

**If you answered yes to question 1 or 2, please complete the attached Claim Information Form and Claim Information Narrative Form for each applicable claim, suit, incident, conduct, etc.**

## SECTION XII PRIOR ACTS COVERAGE

**NOTE:** If the clinic/organization is not applying for Prior Acts Coverage, please skip this section.

Please ensure that your answers to the following questions reflect the clinic's/organization's practice as it was during the Prior Acts Period.

1. Since the Requested Retroactive Date:

- a. Has there been a change in the information provided in Section IV, Legal Structure (for example, entities dissolved or legal associations ended)?  **Yes**  **No**

**If yes,** please explain and identify the entities, associations, etc. and the corresponding dates:

---



---

- b. Has the clinic/organization owned or operated any location other than a location identified for question 1 in Section V, Practice Locations?  **Yes**  **No**

**If yes,** please complete the following regarding those locations:

Location (name and address)	Type of Location (for example, primary care clinic)	From (month/year)	To (month/year)

2. Since the Requested Retroactive Date, have there been any material changes in the clinic's/organization's practice other than as specified above?  **Yes**  **No**

**If yes,** please provide a detailed description of the change(s):

---



---



---



---

3. Other than any exposure that you might have identified under Scope of Coverage in Section II (Coverage Information), is there any aspect of the clinic's/organization's practice since the Requested Retroactive Date for which you do not need NORCAL Prior Acts Coverage?  **Yes**  **No**

**If yes,** please provide a detailed description of that practice, including the start and end dates. Please also identify the name of the insurance company that provided you with professional liability insurance coverage for that practice:

---



---



---



---



## REPRESENTATIONS, WARRANTIES, AUTHORIZATION TO RELEASE INFORMATION AND FRAUD STATEMENTS

**NOTE: "Warrant" in the following statement is not applicable to Arizona or New Mexico clinics/organizations. By statute, Arizona or New Mexico clinics/organizations are only required to represent the truth of their statements and information.**

I understand that this application and any supplemental information supplied by me or on my clinic's/organization's behalf are incorporated into and made a part of any policy of insurance that may be issued to my clinic/organization by NORCAL ("the Company").

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between the clinic/organization and NORCAL, the dispute will be submitted to binding arbitration.

I understand that this policy, if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that in the event this coverage is canceled, any unearned premiums will be refunded to the person or clinic/organization that paid NORCAL (that is, the payer).

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on the clinic's/organization's behalf, including changes in its partners or associates, medical licenses, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that is assumed under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by my clinic/organization or others trading under my clinic's/organization's name.

*I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and any past and present association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where any members presently hold, are applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my clinic's/organization's insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about my clinic/organization and its members that is done in good faith and without malice.*

**Notice to New Mexico Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

# CLAIM INFORMATION FORM

Name of Patient: \_\_\_\_\_ Gender:  Male  Female

Age of Patient (at time of treatment): \_\_\_\_\_

Name of Claimant (if different than patient): \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Allegation Against the Clinic/Organization: \_\_\_\_\_

Clinic/Organization Member Defendants: \_\_\_\_\_

Non Clinic/Organization Member Defendants: \_\_\_\_\_

Date Incident or Claim Was Reported to the Insurance Company: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Disposition or Current Status of the Incident, Claim or Suit Against the Clinic/Organization:

Open

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

Closed

Date Closed (Month/Day/Year): \_\_\_\_\_

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in the entity's favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): \_\_\_\_\_

Amount paid on the clinic's/organization's behalf: \_\_\_\_\_

Total verdict amount (if different than total loss payment amount): \_\_\_\_\_





THIS AGREEMENT and commitment is executed this 20th day of April 2005, by NORCAL Mutual Insurance Company, hereinafter referred to as “NORCAL.” This agreement supersedes inconsistent provisions of existing agreements between the parties.

NORCAL and the insured or applicant have an insurer/insured relationship by virtue of a professional liability policy requested from or issued by NORCAL. NORCAL and its insureds and applicants are committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Regulations”) and Security Regulations under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Under the Privacy Regulations, the NORCAL insured or applicant may be a “Covered Entity,” and, as defined by 45 C.F.R. §164.502(e) and 45 C.F.R. §164.504(e), NORCAL may be a “Business Associate” of the insured or applicant. This Agreement sets forth the manner in which NORCAL will handle “Protected Health Information” that is provided by or received from or on behalf of the insured or applicant. NORCAL agrees as follows:

## **SECTION 1**

### *Definitions*

**1.1 Business Associate:** “Business Associate” shall mean a “Business Associate” as defined in 45 C.F.R. §164.501. Unless otherwise specified, the term Business Associate in this Agreement shall refer to NORCAL.

**1.2 Covered Entity:** “Covered Entity” shall mean the insured or applicant.

**1.3 Designated Record Set:** “Designated Record Set” means “Designated Record Set” as defined in 45 C.F.R. §164.501.

**1.4 Electronic Protected Health Information:** “Electronic Protected Health Information” shall mean Protected Health Information that is transmitted or maintained in electronic format or by electronic media.

**1.5 Insurance Policy:** “Insurance Policy” shall mean the policy of professional liability insurance requested by an applicant or now in effect between NORCAL and the insured, and any subsequent or replacement policy between NORCAL and the insured.

**1.6 Privacy Rule:** “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts §160 and §164, subparts A and E, as amended from time to time.

**1.7 Protected Health Information (PHI):** “Protected Health Information” or “PHI” shall have the same meaning as the term “Protected Health Information” in 45 C.F.R.



§164.501, limited to the information received by NORCAL from, or on behalf of, Covered Entity.

**1.8 Secretary:** “Secretary” shall mean the Secretary of the Department of Health and Human Services of his/her designee.

**1.9 Security Incident:** “Security Incident” shall have the same meaning as the term “Security Incident” in 45 C.F.R. §164.304.

**1.10 Security Rule:** “Security Rule” shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. §160 and §164, subparts A and C.

## **SECTION 2**

### *Obligations and Activities of NORCAL*

In consideration of the Covered Entity’s continuing obligation to assist and cooperate with NORCAL’s efforts in providing services under the Insurance Policy, NORCAL hereby agrees to the following:

**2.1 Not to Use or Disclose PHI Unless Permitted.** NORCAL 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.

**2.2 Use Safeguards.** NORCAL agrees to use reasonable safeguards to prevent use or disclosure of Protected Health Information other than as allowed by this Agreement or as otherwise required or allowed by law. NORCAL will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic Protected Health Information NORCAL creates, receives, maintains or transmits on behalf of Covered Entity.

**2.3 Mitigation of Harmful Effects.** NORCAL agrees to mitigate, to the extent practicable, any harmful effect that is known to NORCAL of a use or disclosure of Protected Health Information by NORCAL in violation of the requirements of this Agreement.

**2.4 Report Inappropriate Disclosure of PHI.** NORCAL agrees to report to Covered Entity any use or disclosure of the Protected Health Information not permitted or required by this Agreement of which NORCAL becomes aware. NORCAL also agrees to report to Covered Entity any Security Incident related to Electronic Protected Health Information of which NORCAL becomes aware.

**2.5 Compliance of Agents.** NORCAL agrees to require any agents, including subcontractors, to agree to the same restrictions and conditions that apply to NORCAL through



this Agreement provided that such agents perform a service that NORCAL agreed to perform for, or on behalf of, the Covered Entity under the Insurance Policy and to whom NORCAL provides Protected Health Information. NORCAL also agrees to ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it.

**2.6 Access.** To the extent that NORCAL possesses a Designated Record Set, NORCAL agrees to provide access to the Protected Health Information in that Designated Record Set, during normal business hours, provided the Covered Entity delivers prior written notice to NORCAL, at least five business days in advance, requesting such access but only to the extent required by 45 C.F.R. §164.524.

**2.7 Amendments.** To the extent that NORCAL possesses a Designated Record Set, NORCAL agrees to incorporate any amendment(s) to Protected Health Information in that Designated Record Set that the Covered Entity directs, pursuant to 45 C.F.R. §164.526.

**2.8 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, NORCAL agrees to make internal practices, books, and records available to the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule. NORCAL 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 NORCAL's receipt of such request.

**2.9 Accounting.** NORCAL agrees to maintain sufficient documentation to allow it to provide to Covered Entity a list of any disclosures of Protected Health Information by NORCAL or its agents so as to allow the Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. §164.528.

### **SECTION 3**

#### *Permitted Uses and Disclosures by NORCAL*

**3.1 Use of PHI for Specified Purposes.** Under the Insurance Policy, NORCAL provides the Covered Entity 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 acceptance, declination, or acceptance with revisions 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 insurance or reinsurance, including but not limited to pro rata, stop-loss, and excess of loss insurance, and other functions necessary to perform these Services. NORCAL may make any uses of Protected Health Information necessary to perform its obligations under this Agreement and under the Insurance Policy. Moreover, NORCAL may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to its employees, subcontractors, and agents, in accordance with paragraphs Section 3.2 through 3.4 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.

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

**3.3 Disclosure Required by Law or With Reasonable Assurance.** NORCAL may disclose Protected Health Information for the proper management and administration of NORCAL and to carry out its legal responsibilities, provided that disclosures are required by law, or provided that NORCAL obtains the following reasonable assurances from the person or entity to whom the Protected Health Information is disclosed: 1) the PHI will remain confidential; 2) the PHI 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 NORCAL of any instances of which the person or entity is aware in which the confidentiality of the information has been breached.

**3.4 Data Aggregation Services.** NORCAL may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B).

**3.5 De-identified Information.** NORCAL may de-identify any and all Protected Health Information in accord with the requirements of applicable law as provided in 42 C.F.R. §164.514(b), and use or disclose all such de-identified information for its own managerial and administrative activities as it sees fit. NORCAL agrees to maintain such documentation regarding de-identified information as required by 42 C.F.R. §164.514(b). Covered Entity understands and acknowledges that de-identified information is not Protected Health Information under the terms of this Agreement.



## **SECTION 4**

### *Impermissible Requests by Covered Entity*

NORCAL shall not use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except that, despite this Section 4, NORCAL may use or disclose Protected Health Information for data aggregation or management and administrative activities of NORCAL as provided in sections 3.2, 3.3, and 3.4 above, or as otherwise permitted by this Agreement.

## **SECTION 5**

### *Term and Termination*

**5.1 Term.** This Agreement shall remain effective during the time that NORCAL provides the Covered Entity with Services, as defined in section 3.1 above, pursuant to the terms of the Insurance Policy, and shall terminate when all such Services under the Insurance Policy are terminated and all of the Protected Health Information created or received by NORCAL on behalf of Covered Entity is destroyed or returned to Covered Entity; provided, however, certain provisions and requirements of this Agreement shall survive such termination in accord with subsection 5.3, below.

**5.2 Termination by Covered Entity.** Upon Covered Entity's determination that NORCAL has breached a material term of this Agreement, Covered Entity shall immediately notify NORCAL and provide NORCAL a reasonable opportunity to cure the breach. Covered Entity may terminate this Agreement, and NORCAL agrees to such immediate termination, if NORCAL has breached a material term of this Agreement and cure is not possible. **Covered Entity and NORCAL hereby acknowledge and agree that the termination of this Agreement by Covered Entity shall have no effect on the terms and conditions of the Insurance Policy between them unless NORCAL determines, in its sole discretion, that the termination of this Agreement by Covered Entity constitutes a breach of Covered Entity's duty of cooperation under the Insurance Policy.**

**5.3 Effect of Termination.** Upon termination of NORCAL's provision of Services under the Insurance Policy, the protection of this Agreement will remain in force and NORCAL shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of its business or to carry out its legal responsibilities or as required by law. To the extent that it is feasible to do so, NORCAL agrees to return or destroy all PHI, pursuant to 45 C.F.R. §164(e)(2)(ii)(I), and to require any and all of its subcontractors or agents to return or destroy any PHI in their possession. However, NORCAL and Covered Entity hereby acknowledge and agree that, because of the nature of the Services provided by NORCAL and its business obligations, it is not feasible to return or destroy all



Protected Health Information immediately on the termination of this Agreement, or for some time thereafter. Therefore, NORCAL agrees to extend, and require its subcontractor and agents to extend, and all protections, limitations, and restrictions contained in this Agreement to such PHI as may be retained after the termination of this Agreement. **This section 5 shall survive the termination of this Agreement and NORCAL's provision of Services under the Insurance Policy.**

## **SECTION 6**

### *Miscellaneous Provisions*

**6.1 Regulatory References.** A reference in this Agreement to a section in the Privacy or Security Rule means the Section in effect or as amended, and for which compliance is required.

**6.2 Amendment.** NORCAL agrees to take such action as is necessary to amend this Agreement from time to time as is necessary, as determined by NORCAL, for compliance with the requirements of the Privacy Rule, the Security Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191 as determined by NORCAL.

A handwritten signature in black ink that reads "David R. Holley, MD." The signature is written in a cursive style.

David R. Holley, MD  
Secretary, Board of Directors

A handwritten signature in black ink that reads "James Sunseri". The signature is written in a cursive style.

James Sunseri  
President & Chief Executive Officer