11 Executive Park Drive, Clifton Park, NY 12065
518-371-5522 - 800-695-8224
Fax: 518-371-6131

Advisors Insurance Brokers

BROKER PROFILE

NY/National – Long-Term Care Brokers, Ltd.

Thank You, for your interest in our General Agency.
We protect our Agents Personal and Business Information and Never Share Information with anyone other than our Insurance Carriers.

Please Complete the below information and FAX this form back to
518-688-8139 Attn: Rich Altier our Licensing and Contracting Director 518-688-8129 or 1-800-695-8224

Bob Vandy
CLU, ChFC, LUTCF, CLTC – President Advisors Insurance Brokers
A New York Long Term Care Brokers, LTD Company
Direct Dial: 518.688.8105 Toll Free: 800.695.8224 x105 Fax: 518.371.6131 Executive Park Dr. Clifton Park, NY 12065

Date →	
Name →	
Agency Name →	
Assistant Name →	
Mailing Address →	
Work Phone # →	
Cell Number →	
Fax Number →	
Best Way to Contact you →	
SS # →	
DOB →	
EMAIL: →	
Commissions are Paid to? →	
Have you written a new Client Application? Please Provide Clients Name, Resident State, Company, Product and Application Date →	
List Insurance Carriers you are currently Appointed or have been Appointed, and have you submitted new business with any of these carriers in the last 6-months And what States were you appointed in →	
SPECIAL INSTRUCTIONS →	

Our Policy is Taking Care of You

Long-Term Care | Life | Disability | Annuities | Medicare | Benefits

Please Scan & Email or Fax to Rich Altier, Licensing Coordinator. RAltier@AdvisorsIB.com 518.371.6131

ADVISORS INSURANCE BROKERS

NY Long Term Care Brokers

CONTRACTING FORMS

This Form is Fillable... Open the PDF Type into each Section Print, Sign and Fax All to 518-688-8139 Attn-Rich.
These Forms are also available on our WebSite www.nyltcb.com

SECTION-1 (This Section is for your **Clients.** Complete only if you've sent in or about to send in a New Business Application. **Leave Blank if no New Business is being submitted**)

Client Names: ______________________ **Client Home State:** __________

Company& Product Sold: ______________________ **Application Date:** __________

SECTION-2 **(This Section is for you the Writing Agent/Producer)**

Name: ______________________ **SSN#** __________

Date of Birth: __________ **Martial Status:** ____ **Gender** ____ **Email:** __________

Home Address: ______________________

Mailing Address: ______________________

Work Phone: __________ **Fax Phone:** __________ **Cell Phone:** __________

Your Home State Insurance License Number: __________ **Home Phone:** __________

Anti Money Laundering (AML) Training Date: __________ **Provider:** __________

If you are a Registered FINRA representative Broker Dealer Name __________

How your Commissions are paid: ☐ **Pay ME Individually:** ☐ **Pay My Corporation/Agency**

All Commissions Should be paid to: ______________________

SECTION-3 **This Section is for your Agency and/or Corporation if you are a Sub-Agent, Corporate Officer or Managing Member Please Complete the Below Information**

EIN (Tax ID#): __________ **Business Name:** __________

Business Mailing Address: ______________________

Business Phone: __________ **Business Fax:** __________ **WebSite:** __________

Principal-Sub-Agent-Signing Officer/Managing Member Name: __________

Principal: SS#: __________ **Principal Title:** __________

Please complete all Pages, Sign in two Places, and Fax all to 518-688-8139. Remember to include copies of your Insurance Licenses, E&O Coverage Certificate, AML and Long Term Care CE Certificates of Training. Thank You.

Legal Questions for Contracting and Appointment Requests

Please answer the following questions. If you answer YES to any question, be sure to provide a full, detailed explanation including specfic dates.

Name: _______________________________________

1	Have you ever been charged or convicted of or plead guilty or no contest to any Felony, Misdemeanor, federal/state insurance and/or securities or investments regulations or statutes? Have you ever been on probation?	◯ Yes ◯ No
1A	Have you ever been convicted of or plead guilty or no contest to any Felony?	◯ Yes ◯ No
1B	Have you ever been convicted of or plead guilty or no contest to any Misdemeanor?	◯ Yes ◯ No
1C	Have you ever been convicted of or plead guilty or no contest to a violation of federal or state securities or investment related regulations?	◯ Yes ◯ No
1D	Have you ever been convicted of or plead guilty or no contest to a violation of state insurance departement rulgulation or statute?	◯ Yes ◯ No
1E	Has any foreign government, court, regulatory agency, or exchange ever entered an order against you related to investments or fraud?	◯ Yes ◯ No
1F	Have you ever been charged with a Felony?	◯ Yes ◯ No
1G	Have you ever been charged with a Misdemeanor?	◯ Yes ◯ No
1H	Have you ever been on probation?	◯ Yes ◯ No
2	Have you ever been or are you currently being investigated, have any pending indictment, lawsuits, or have you ever been in a lawsuit with an insurance company?	◯ Yes ◯ No
2A	Are you currently under investigation by any legal or regulatory authority?	◯ Yes ◯ No
2B	Have you been under investigation by any insurance company?	◯ Yes ◯ No
2C	Have you ever been or are you currently involved in any pending indictments, lawsuits, civil judgments or other legal proceedings (civil or criminal)(you may omit family court).	◯ Yes ◯ No
2D	Have you ever been named as a defendant or codefendant in a lawsuit, or have you ever sued or been sued by an insurance company?	◯ Yes ◯ No
3	Have you ever been alleged to have engaged in any fraud?	◯ Yes ◯ No
4	Have you ever been found to have engaged in any fraud?	◯ Yes ◯ No
5	Has any insurance or financial services company or broker-dealer terminated your contract or appointment or permitted you to resign for reason other than lack of sales?	◯ Yes ◯ No
5A	Were you fired because you were accused of violating insurance or investment related statures, regulations, rules or industry standards of conduct?	◯ Yes ◯ No
5B	Were you fired because you were accused of fraud or the wrongful taking of poperty?	◯ Yes ◯ No
5C	Failure to supervise in connection with insurance or investment related statues, regulations, rules or industry standards of conduct?	◯ Yes ◯ No
6	Have you ever had an appointment with any insurance company denied or terminated for cause?	◯ Yes ◯ No
7	Does any insurer, insured, or other person claim any commission chargeback or other indebtedness from you as a result of any insurance transactions or business?	◯ Yes ◯ No

8	Has any lawsuit or claim ever been made against you, your surety company, or errors and omissions insurer arising out of your sales or practices, or, have you been refused surety bonding or E&O coverage?	Yes No
8A	Has a bonding or surety company ever denied, paid on or revoked a bond for you?	Yes No
8B	Has any Errors & Omissions (E&O) carrier ever denied, paid claims on or cancelled your coverage?	Yes No
9	Have you ever had an insurance or securities license denied, suspended, cancelled or revoked?	Yes No
10	Has any state or federal regulatory body found you to have been a cause of an investment – or insurance – related business having its authorization to do business denied, suspended, revoked, or restricted?	Yes No
11	Has any state or federal regulatory agency revoked or suspended your license as an attorney, accountant, or federal contractor?	Yes No
12	Has any state or federal regulatory agency found you to have made a false statement or omission or been dishonest, unfair, or unethical?	Yes No
13	Have you had any interruptions in licensing?	Yes No
14	Has any state, federal or self-regulatory agency filed a complaint against you, fined, sanctioned, censured, penalized or otherwise disciplined you for a violation of their regulations or state or federal statutes?	Yes No
14A	Has any regulatory body ever sanctioned, censured, penalized or otherwise disciplined you?	Yes No
14B	Has any state, federal, or self-regulatory agency filed a complaint against you, fined or sanctioned you?	Yes No
14C	Have you ever been the subject of a consumer initiated complaint?	Yes No
15	Have you personally or any insurance or securities brokerage firm with whom you have been associated filed a bankruptcy petition or declared bankruptcy?	Yes No
15A	Have you personally filed a bankruptcy petition or declared bankrtuptcy?	Yes No
15B	Has any insurance or securities brokerage firm with whom you have been associated filed a bankrtupcy petition or been declared bankrupt either during your association or within five years after termination of such association?	Yes No
15C	Is the bankruptcy pending?	Yes No
16	Are there any unsatisfied judgments, garnishments or liens against you?	Yes No
17	Are you connected in any way with a bank, savings & loan association, or other lending or financial institution?	Yes No
18	Have you ever used any other names or aliases?	Yes No
19	Do you have any unresolved matters pending with the Internal Revenue Service or other taxing authority? Have you ever had any liens or judgments against you ?	Yes No

If you answered any questions YES, provide an explanation that includes dates, actions, and descriptions. Attach additional paper if necessary.

I attest that the information I have provided is true to the best of my knowledge. I acknowledge that if any information changes, I will notify my agency office within 5 days of such change. Further, I understand that my agency may contact me when I need to answer carrier specific questions.

Signature: ____ Date: ________________

LETTER OF EXPLANATION

Date of Action:____/____/_____

Action:____

Reason:____

Explanation:____

____

____

Date of Action:____/____/_____

Action:____

Reason:____

Explanation:____

____

____

Date of Action:____/____/_____

Action:____

Reason:____

Explanation:____

____

____

Date of Action:____/____/_____

Action:____

Reason:____

Explanation:____

____

____

Attach Supporting Documents or Additonal Pages

History

Employment -- Please provide past 5 years of employment history: ****NOTE* Attach additional info if needed***

From: ________________ To: __________________

Company: ____________________________________ Position: ______________________________________

Location: ____

From: ________________ To: __________________

Company: ____________________________________ Position: ______________________________________

Location: ____

From: ________________ To: __________________

Company: ____________________________________ Position: ______________________________________

Location: ____

Address History -- Please Provide past 5 years of Address History: ****NOTE* Attach additional info if needed***

Line 1: ____ Line 2: ____________ Zipcode: ________________

City/State not needed

Start Date: _____________________________ End Date: ____

Line 1: ____ Line 2: ____________ Zipcode: ________________

City/State not needed

Start Date: _____________________________ End Date: ____

Line 1: ____ Line 2: ____________ Zipcode: ________________

City/State not needed

Start Date: _____________________________ End Date: ____

ELECTRONIC FUND TRANSFERS (EFT)

Account Owner Name (Required): ___________________________________

Transit/ABA #: ____________________________

Account #: ____

Financial Institution Name: ______________________________

Branch Address: ____

City: _____________________ State: __________________ Zip: ________

Account Type: ○ Checking ○ Saving Phone:

By signing below I hereby authorize the Company to initiate credit entries and, if necessary, adjustments for credit entries in error to the checking and/or savings account indicated on this form. This authority is to remain in full effect until the Company has received written notification from me of its termination. I understand that this authorization is subject to the terms of any agent or representative contract, commission agreement, or loan agreement that I may have now, or in the future, with the Company.

Signature: _____________________________ Date: _________________

Attach a copy of your check if using a checking account or a deposit slip for a savings account.

Signature Authorization

PLEASE READ THIS AUTHORIZATION, SIGN IN THE BOX BELOW AND SUBMIT THIS FORM BY FOLLOWING THE INSTRUCTIONS PROVIDED ON THE COVER PAGE.

I, ______________________________________, hereby authorize SuranceBay, LLC and its general agency customers (the "Authorized Parties") to affix or append a copy of my signature, as set forth below, to any and all required signature fields on forms and agreements of any insurance carrier (a "Carrier") designated by me through the SureLC software or through any other means, including without limitation, by e-mail or orally. The Authorized Parties shall be permitted to complete and submit all such forms and agreements on my behalf for the purpose of becoming authorized to sell Carrier insurance products. I hereby release, indemnify and hold harmless the Authorized Parties against any and all claims, demands, losses, damages, and causes of action, including expenses, costs and reasonable attorneys' fees which they may sustain or incur as a result of carrying out the authority granted hereunder.

By my signature below, I certify that the information I have submitted to the Authorized Parties is correct to the best of my knowledge and acknowledge that I have read and reviewed the forms and agreements which the Authorized Parties have been authorized to affix my signature. I agree to indemnify and hold any third party harmless from and against any and all claims, demands, losses, damages, and causes of action, including expenses, costs and reasonable attorneys' fees which such third party may incur as a result of its reliance on any form or agreement bearing my signature pursuant to this authorization.

PLEASE SIGN IN THE CENTER OF THE BOX BELOW

Do Not Go Outside the Lines

PRODUCERIDXXX

AIB Advisors Insurance Brokers

11 Executive Park Drive, Clifton Park, NY 12065
518-371-5522 | toll-free: 800-695-8224
fax: 518-371-6131
www.AdvisorsIB.com

"Who's Who?" at Advisors Insurance Brokers

Kevin Johnson x101
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KJohnson@advisorsib.com

Peter Kelly x117
Chief Operating Officer
Brokerage Underwriter
PKelly@advisorsib.com

Bob Vandy x105
President
Marketing/Business Development/Training
BVandy@advisorsib.com

Brian Johnson x154
Director of Business Development & Association Marketing
BJohnson@advisorsib.com

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Vice President – Life/DI/Annuity
Life Sales Support
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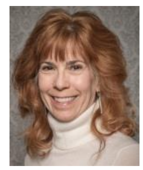

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RaymondHickson@gmail.com

Our Policy is Taking Care of You

Long-Term Care | Life | Disability | Annuities | Medicare | Benefits

Affiliate Company of

National Long-Term Care Brokers, Ltd. New York

Producer Agreement

This Producer Agreement is by and between "Advisors Insurance Brokers" (AIB) an Affiliate Company of New York Long Term Care Brokers, Ltd, DBA National Long Term Care Brokers, and the Producer named below (the "Producer").

Licensed Producer/Agent Name →	
Corporation Name →	
Mailing Address →	
Mailing Address →	
Social Security # Tax ID →	

WHEREAS, AIB is a general agent, managing general agent, and/or broker for insurance carriers under various contracts (AIB Carriers), and has the authority to recommend the appointment of the Producer to sell the insurance products of AIB Carriers: and

WHEREAS, Producer desires to be appointed through AIB to access such insurance products from AIB Carriers;

NOW THEREFORE, in consideration of the foregoing and the mutual provisions herein after set forth and for other good and valuable consideration and intending to be legally bound hereby, the parties agree as follows:

1) The Producer shall comply with all (I) federal, state and local laws, regulations and rules applicable to the Producer's solicitation of insurance products, and (ii) all rules, policies, procedures and standards which are provided to the Producer by AIB or by any AIB Carrier,

A. The Producer shall hold the appropriate insurance license(s) in the state of Solicitation and in the state where the application is signed prior to submitting an application for insurance to AIB.

B. The Producer shall complete pre-contracting or appointment paperwork With the AIB Carrier prior to soliciting the sale of a product, ii required.

C. The Producer shall not alter, modify, waive, or amend any of the terms, rates or conditions of any advertisement, brochures, applications, policies, contracts or other materials provided to the Producer by AIB or any AIB Carrier unless submitted and approved in writing by AIB and/or the AIB Carrier. The Producer shall not create any materials that reference AIB or AIB Carriers unless submitted and approved in writing by AIB and/or the AIB Carrier.

D. The Producer understands that he/she is *an* independent contractor, and is solely responsible for filing and submitting appropriate state and federal taxes.

2 The Producer shall be fully responsible for monitoring the information posted to the AIB Broker and Agent Services website **(wwwadvisorsib.com)** (Look under Broker & Agent Services).

3. The Producer shall at times maintain liability insurance covering the Producer and the Producer's agents and employees against claims for damages based on actual or alleged professional errors or omissions in an amount and with an insurer reasonably acceptable to AIB, Proof of such insurance coverage shall be furnished to AIB upon request and Producer shall notify AIB immediately if for any reason such insurance coverage ceases to be in effect. (Certain AIB Carriers require in force E&O in the name of the Producer in order to be appointed.)

4. The Producer shall immediately repay to AIB all compensation received from policies in which premiums have been returned or in which the policy has been subject to recapture or in which AIB is otherwise charged back. The Producer agrees that any reasonable attorneys' fees associated with the collection of such compensation shall be the responsibility of and shall be reimbursed by the Producer to AIB.

5. The Producer certifies that he or she has never been convicted of a federal or state felony involving dishonesty or breach of trust; or if so, that Producer has received written authorization from the applicable state insurance commissioner specifically referencing Section 1033 of the Violent Crime Control and Law Enforcement Act of 1094, subsection (3)(2) granting permission to work in the insurance industry.

6. The Producer will use his/her best efforts to place the sale of insurance products through AIB with AIB Carriers, when AIB has provided marketing support, advanced sales, new business or underwriting support on the sale.

7. Each party to this Agreement shall indemnify and hold harmless the other Party against any and all claims, actions, damages, losses and liabilities (including, without limitation, reasonable attorneys' fees) (collectively "Losses") arising from any wrongful, unlawful, or tortious act or omission, or allegedly wrongful, unlawful or tortious act or omission, on the part of the indemnifying party or any of the indemnifying party's agents or employees. Notwithstanding the forgoing, neither party shall be obligated to indemnify the other party for the amounts of any Losses which have actually been Reimbursed pursuant to errors and omissions liability insurance maintained by the other party.

8. Each party will not use or disclose nonpublic personal information, ie; personally identifiable information, including but not limited to financial or health information, that is not publicly available ("Protected information'), about individuals who seek to obtain insurance products and/or services through the Producer ('Consumers') or who have a continuing relationship wherein the individuals have one or more insurance products and/or services through Producer (Customers"), except as provided herein.

   Each party will treat Protected Information as confidential and access to Protected Information will be limited to those officers, employees, agents or representatives of each party who need to use the information in Connection with underwriting claims administration or other servicing of insurance products and/or services for a particular Consumer or Customer.

   Each party will not use or disclose or permit any of its officers, employees, agents or representatives to use or disclose Protected Information except: (1) as necessary in underwriting, administering claims, or otherwise Servicing the Consumer or Customer transaction requested or authorized by the Consumer or Customer (ii) as otherwise in compliance with AIB privacy policy; or (iii) as otherwise permitted under the Gramm-Leach-Bliley Act and/or state regulations and legislation.

   Each party will establish appropriate standards for safeguarding Protected Information within the Producer's control, i.e., the Producer will establish his/her own internal security guidelines.

9. The Producer agrees not to solicit or hire employees of AIB, unless preapproved by the President of AIB.

10. Producer understands that AIB may lower or increase Producer compensation levels based upon the productions levels reached by calendar year end. Producer compensation rates may also be changed due to AIB Carrier commission changes.

11. Producer understands that all commissions and renewals sold through AIB are fully vested to Producer, legal representatives or assigns, unless Producer is terminated for cause.

12. This agreement may be terminated by either party with a 30-day written notice to the other party.

In WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the later of the two dates below.

Agent /Producer

Signature →	X
Printed Name →	
Date →	

Advisors Insurance Brokers

Signature →	
Printed Name →	**Robert M Vandy, President**
Date →	

Please FAX to 518-688-8139 Attn. → Rich

Or if your mail is Secure Please Email To → RAltier@AdvisorsIB.com

Please Send, in addition to a copy of this Agreement, your Supporting Documents, including Insurance Licenses, E&O Coverage Certificate, Broker Profile, W-9, AML Training Certificates completed within the last two (2) years and any Long Term Care Training Certificates.

ADVISORS INSURANCE BROKERS,
AFFILIATE COMPANY OF NEW YORK LONG TERM CARE BROKERS, LTD
11 EXECUTIVE PARK DRIVE
CLIFTON PAK, NY 12065
800-695-8224 WWW.ADVISORSIB.COM

AIB Advisors Insurance Brokers

Affiliate Company of NATIONAL LONG-TERM CARE BROKERS, LTD. NEW YORK

AIB Advisors Insurance Brokers

Affiliate Company of NATIONAL LONG-TERM CARE BROKERS, LTD. NEW YORK

HIPAA Business Associate Agreement

Please note that the below Business Associate Agreement has been updated as of August 12, 2013 to reflect the new requirements set forth in the Health Information Technology for Economic & Clinical Health Act ("HITECH"), Subtitle D-Privacy (§§13400-13424),), as part of the American Recovery and Reinvestment Act of 2009, and as amended.

It is required that all entities having a business relationship with New York Long Term Care Brokers complete this updated version of our Business Associate Agreement

Please PRINT the LAST PAGE of this Agreement, COMPLETE the form and return a copy to our office as confirmation that you entered into this agreement.

BUSINESS ASSOCIATE AGREEMENT

This agreement ("Agreement") is effective upon its execution and delivery to New York Long Term Care Broker's (referred to as "Business Associate" hereafter), as further indicated below, by and between the Business Associate and the undersigned health care provider or other services provider (referred to as "Provider" hereafter).

RECITALS

Provider and Business Associate mutually agree to the terms of this Agreement to comply with the requirements of the Standards for Security and Privacy of Individually Identifiable Information (the "Security and Privacy Regulations"), as applicable, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, as well as with the Health Information Technology for Economic & Clinical Health Act ("HITECH"), Subtitle D-Privacy (§§13400-13424), as part of the American Recovery and Reinvestment Act of 2009, as amended.

Business Associate and Provider have a business relationship such that Provider may be deemed to be a covered entity, and in conducting such activities on behalf of Provider, Business Associate may be deemed a business associate of Provider.

Provider wishes to disclose certain information to Business Associate pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI") (as defined below).

Provider and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to this Agreement in compliance with the HIPAA Security and Privacy Regulations and HITECH.

HIPAA Security and Privacy Regulations and HITECH require Provider to enter into a contract containing specific requirements with Business Associate prior to the disclosure of PHI, as set forth in this Agreement.

A. Definitions

1. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.
2. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean The New York Long Term Care Brokers Company.
3. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103.
4. HIPAA Rules."HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

B. Obligations and Activities of Business Associate

Business Associate agrees to:

1. Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;
2. Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;
3. Report to Provider any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;
4. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information;
5. Make available protected health information in a designated record set to Provider as necessary to satisfy Provider's obligations, if any, under 45 CFR 164.524;
6. Make any amendment(s) to protected health information in a designated record set as directed or agreed to by Provider pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy Provider's obligations, if any, under 45 CFR 164.526;
7. Maintain and make available the information required to provide an accounting of disclosures to the Provider as necessary to satisfy Provider's obligations, if any, under 45 CFR 164.528;
8. To the extent Business Associate is to carry out one or more of Provider's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Provider in the performance of such obligation(s); and
9. Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules

C. Permitted Uses and Disclosures by Business Associate

1. Business Associate may only use or disclose protected health information as necessary to perform any services necessary or required as Provider's insurance company.
2. Business Associate may use or disclose protected health information as required by law.
3. Business Associate agrees to make uses and disclosures and requests for protected health information subject to the following minimum necessary requirements: as necessary or required in order to provide Provider's insurance.
4. Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Provider, except with regards to the data aggregation, management, administration and legal responsibilities of the Business Associate.
5. Business Associate may use protected health information for the Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.
6. Business Associate may disclose protected health information for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
7. Business Associate may provide data aggregation services relating to the health care operations of Provider.

D. Provisions for Provider to Inform Business Associate of Privacy Practices and Restrictions

Provider shall notify Business Associate of:

1. any limitation(s) in Provider's notice of privacy practices under 45 CFR 164.520;
2. of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information; or,
3. any restriction on the use or disclosure of protected health information that Provider has agreed to or is required to abide by under 45 CFR 164.522, to the extent that Business Associate's use or disclosure of protected health information will be affected.

E. Term and Termination

1. ***Term.*** This Agreement shall continue in force so long as any underlying contract between the Provider and Business Associate remains in force.
2. ***Termination for Cause.*** The Provider shall provide written notice if it determines that Business Associate has breached any material provision of this Agreement. The written notice must contain the facts necessary for Business Associate to evaluate and cure the alleged breach. If the breach is not cured within 30 days, the Provider may immediately terminate this Agreement.
3. ***Obligations of Business Associate Upon Termination.*** Upon termination of this Agreement for any reason, Business Associate, with respect to protected health information received from Provider, or created, maintained, or received by Business Associate on behalf of Provider, shall:
   a. Retain only that protected health information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
   b. Destroy the remaining protected health information that Business Associate still maintains in any form;
   c. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;
   d. Not use or disclose the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at above which applied prior to termination; and
   e. Destroy the protected health information retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

4. ***Survival.*** The obligations of Business Associate under this Section shall survive the termination of this Agreement.

F. Miscellaneous

1. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.
2. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.
3. Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, the Provider and the Business Associate execute this Business Associate Agreement to be effective as of the date signed and submitted by the Provider as indicated below:

Signed:

New York Long Term Care Brokers

Peter J. Kelly, Chief Operating Officer

11 Executive Park Dr.

Clifton Park, NY, 12065

***All fields are required*.**

BY SIGNING BELOW YOU ACKNOWLEDGE THAT YOU AGREE TO CONDUCT THIS TRANSACTION

Name	
Street Address	
City	
State	
Zip	
Email	
Date	