

<b>ARTCS Use only:</b>
Date Received: _____
Date Verified: _____
Date Approved/Denied: _____
Approval signature and title: _____
_____
_____

**ART Corporate Solutions, Inc.  
(ART EPN)  
Elite Provider Application**

**Provider Information**

_____	_____	_____
Last Name	First Name	Professional Degree

_____	_____	_____
Date of Birth	Social Security #	Years In Practice

_____	_____
Years Practicing ART	National Provider ID # (NPI)

_____	_____
Medicare Provider #	Tax ID:

**Office #1**

Practice Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ email \_\_\_\_\_

**Office #2**

Practice Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ email \_\_\_\_\_

Please list any other office locations from which you will be practicing on a separate sheet and attach to this application.

**Licensure:** (Attach a copy of professional license for each state that you have or have ever had a professional license to provide clinical/medical services.)

_____	_____	_____	_____	_____
State	License Type	License#	Year Obtained	Exp Date

_____	_____	_____	_____	_____
State	License Type	License#	Year Obtained	Exp Date

_____	_____	_____	_____	_____
State	License Type	License#	Year Obtained	Exp Date

_____	_____	_____	_____	_____
State	License Type	License#	Year Obtained	Exp Date

**Professional Liability Insurance**

Attach copy of face sheet of current liability insurance policy.

Name of Entity or Provider Covered		Coverage limits
Current Carrier	Policy #	Exp Date
Address		Initial Coverage Date
City	State	Zip

**Education & Training** (Chiropractic, PT, OT, MD, Massage Therapy, other professional school) Please start with Undergraduate Degree(s) then Professional Training

1. \_\_\_\_\_

School Name	City	State
From (date)	to (date)	Specialty
Degree Obtained	Name on Degree (please note any name changes)	

2. \_\_\_\_\_

School Name	City	State
From (date)	to (date)	Specialty
Degree Obtained	Name on Degree (please note any name changes)	

3. \_\_\_\_\_

School Name	City	State
From (date)	to (date)	Specialty
Degree Obtained	Name on Degree (please note any name changes)	

4. \_\_\_\_\_

School Name	City	State
From (date)	to (date)	Specialty
Degree Obtained	Name on Degree (please note any name changes)	

**Professional And Health Status Information:** Please check Yes or No.

In the event you answer "Yes" to any question, please attach an explanation to this application.

1. Has any license or certification you've had to practice in any Jurisdiction (state or country) been restricted, suspended, placed under probation, revoked, or surrendered involuntarily?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

2. Have you been denied membership, or been subject to disciplinary proceedings, by any medical or professional organization  
\_\_\_\_\_ Yes \_\_\_\_\_ No

3. Has any disciplinary action been taken against you or your license by any state licensing board and/or is any such action pending and/or is any investigation of you by any such board underway?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

4. Have your privileges been restricted, refused, suspended, revoked, or terminated involuntarily from any Hospital, other care institution, or health plan/network?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

5. Have any malpractice allegations been filed against you or have you settled or lost any malpractice action?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

7. Has your professional liability coverage been restricted, suspended, refused, revoked, or denied?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

8. Have you been convicted of a felony or any other criminal charge?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

**Malpractice History:**

Complete this form in detail for any malpractice action (open, closed, settled, litigated) that has occurred or is currently open. Information provided is **confidential**.

Complete clinical details and settlements amounts are required on all cases regardless of status or date of occurrence. If more than one case, please photocopy this form for each case.

**Incomplete forms will delay your application.**

\_\_\_\_\_ I have not had any malpractice actions.

If you check this line, please skip the next section and go to Certification and sign/date.

**Malpractice Reporting:**

Patient's Name: \_\_\_\_\_

Complaint: \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_

Were you the treating professional? \_\_\_ Yes \_\_\_ No Carrier Name: \_\_\_\_\_

If No, describe your role: \_\_\_\_\_

What was the condition of the patient leading up to the occurrence? What were the specifics in reference to the malpractice action? What is/was your role in this event?

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Was the occurrence documented in the medical record? \_\_\_ Yes \_\_\_ No

If so, by whom? \_\_\_\_\_

*Describe your actions with any request for information hereunder.*

*The Applicant, and only the Applicant, is responsible for the accuracy and completeness of the information provided on, and in support of, this Application including any attached sheet or photocopy, which is part of this application.*

**THE SUPPLYING OF INACCURATE, MISLEADING, AND/OR INCOMPLETE INFORMATION ON OR IN SUPPORT OF THIS APPLICATION MAY SUBJECT THE APPLICANT TO CIVIL AND/OR CRIMINAL PENALTIES** subsequent to the occurrence:

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What is/was your status in the action: \_\_\_ Primary defendant \_\_\_ co-defendant \_\_\_ other

Status of case: \_\_\_ open \_\_\_ dropped \_\_\_ dismissed

If open, amount reserved by carrier: \$ \_\_\_\_\_

If settled, settlement amount: \$ \_\_\_\_\_ Date \_\_\_\_\_

Your share of settlement amount: \$ \_\_\_\_\_

**Certification:**

I \_\_\_\_\_ (applicant name) hereby certify and warrant that the Malpractice Information reported above is correct as of the date of this Agreement.

Practitioner's Name: \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Authorization to Release Information**

I, \_\_\_\_\_ (applicant name), authorize the release of all information necessary to validate my application to the ART Corporate Solutions, Inc. Elite Provider Network and to certify or verify the current validity of my license, malpractice activity, legal actions, past medical staff status and any other information that shall be required to validate my assertions.

I hereby release from liability any organization or individual that provides in good faith requested information to ART. I further release ART from any liability in connection with requests to validate my application.

A photocopy of this form shall be as effective as an original.

I represent and warrant that the information contained in the forgoing application is true and complete to the best of my knowledge and belief, and I agree to inform ART Corporate Solutions, Inc. within 5 business days if any material change in such information occurs.

Practitioner's Name: \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Tax Information**

ART requires all EPN members to complete the appropriate tax forms so that ART can compensate you for your services. Please complete the appropriate form (W-9) or (W-8) and fax or mail it to ART with your application. (The 2008 W-9 form is attached to this application; or, you can also download the appropriate form from [www.irs.gov/](http://www.irs.gov/) . The appropriate form must be completed and attached to this application.)

**Payment**

Upon securing and starting an on-site care contract, I agree to pay the membership fee of \$750 to ART Corporate Solutions. Once I secure an on-site care contract I shall pay for my ART EPN membership by: (indicate choice) \_\_\_\_\_ credit card \_\_\_\_\_ check.

If by credit card, ART shall charge the credit-card number provided below either upon receipt of this application, or, upon receipt of a corporate contract. Please indicate which you prefer: On receipt of this application: \_\_\_\_\_ On receipt of a corporate contract: \_\_\_\_\_.

Amount Due: \$750 Amount authorized for charge: \$\_\_\_\_\_

Additionally, I authorize ART EPN to withdraw \$75 on a monthly basis from the following credit card account to pay for the ART web broadcast, if not already a subscriber. The ART web broadcast is mandatory for all EPN members. The web broadcast subscription, access and monthly dues starts immediately (regardless if one has an on-site contract or not):

\_\_\_\_\_ Visa Card \_\_\_\_\_ Master-Card

\_\_\_\_\_  
Name as it appears on card Card number

\_\_\_\_\_  
Billing address for card City State Zip

\_\_\_\_\_  
Expiration Date on Card

\_\_\_\_\_  
Signature of Cardholder: Date

Mail or fax application to:

ART Corporate Solutions, Inc., EPN  
175 S. Union Blvd, Ste 230  
Colorado Springs, CO 80910  
1-866-369-9182 PH - 1-719-442-1504 FAX

**Reminder**

- Attach Professional Liability Insurance face sheet.
- Current State License (copy)
- Curriculum Vitae
- Completed W-9 or W-8 form (for ART Corporate Solutions, Inc.)
- Completed Statements regarding Workers' Compensation Exemption
- Any other required supporting documentation

Initials: \_\_\_\_\_

**Active Release Techniques®  
ART Corporate Solutions, Inc. EPN  
Participating Provider Agreement**

THIS Agreement is made by and between \_\_\_\_\_,  
(hereinafter referred to as "PROVIDER"), located at \_\_\_\_\_,  
a provider of health care services or items, licensed to practice or administer such services or  
items in the state or states where such services or items are provided, and ART Corporate  
Solutions, Inc. (ART EPN) hereinafter referred to as "NETWORK".

**WITNESSETH:**

WHEREAS NETWORK is engaged in the clinical integration and education of a select group of  
providers in the clinical system, process and practice of Active Release Techniques® and in the  
development and utilization management of PAYOR and EMPLOYER contracts and networks  
which allow member access to NETWORK providers.

WHEREAS NETWORK provides an opportunity for PROVIDERS who have been certified in the  
ART® treatment of soft tissue conditions to contract with NETWORK to participate in the clinically  
integrated model and to treat enrollees (hereinafter referred to as "MEMBERS") of accessing  
PAYORS and EMPLOYERS which have entered into agreements with NETWORK, (hereinafter  
sometimes referred to collectively as "PAYORS"); and

WHEREAS, PROVIDER desires to contract with NETWORK and its affiliates to provide services  
to MEMBERS and to accept as payment in full for contracted services in the amounts set forth in  
the attached Exhibit A.

THEREFORE, in consideration of the mutual covenants herein contained and for the good and  
valuable consideration, receipt of which is hereby acknowledged the parties agree as follows:

**I. DEFINITIONS**

Covered Services shall be defined as those services contracted under this Agreement by PAYOR  
or EMPLOYER relating to ART treatments or other services as may be defined by PAYOR or  
EMPLOYER and customarily provided by PROVIDER. PROVIDER shall be defined as a "full-  
body" certified ART® Provider that has been accepted into NETWORK and selected by PAYOR  
or EMPLOYER to provide services. NETWORK PROVIDERS are not guaranteed access to all  
NETWORK contracts, due to PAYOR or EMPLOYER de-selection.

**II. COVERED SERVICES**

PROVIDER does hereby agree to provide clients with Covered Services that PROVIDER  
customarily provides within its licensed scope of services at the rates set forth in this Agreement  
and that are defined in the PAYOR Agreement. All services to be provided by PROVIDER under  
this Agreement shall be performed, or ordered and approved by PROVIDERS who are members  
in good standing of PROVIDER's staff and are certified by ART and credentialed by ART EPN to  
provide care to clients.

### III. NON-DISCRIMINATION

Covered Services shall be accessible to clients and made available to them, without limitation or discrimination, to the same extent as they are made available to other patients of PROVIDER and in accordance with accepted clinical and professional practices and standards applicable to PROVIDER'S other patients.

### IV. PROVIDER RESPONSIBILITIES

**a. Applicable Laws.** PROVIDER shall comply with all applicable state and federal laws and regulations, including but not limited to the Federal Ethics in Patient Referrals Act, as amended ("Stark I" and "Stark II") and the Federal Medicare and Medicaid Patient and Program Protection Act of 1987, as amended.

**b. Reporting Actions Against PROVIDER.** PROVIDER shall use its best efforts to notify NETWORK and provide a description within 10 calendar days of any action taken to suspend or revoke PROVIDER'S license; any judgment, suit or arbitration regarding malpractice; any felony information, indictment or investigation instituted by state or federal agencies with regulatory authority; any cancellation or material adverse modification of professional liability insurance; any action taken to restrict, suspend or revoke participation in Medicare or Medicaid; and any occurrences that could materially affect the ability of PROVIDER to fulfill the obligations of the Agreement. PROVIDER shall submit a written summary of the final disposition of such occurrences.

**c. Conditions of Participation.** PROVIDER must meet the following minimum Conditions of Participation and Network Regulations, which may be modified by the NETWORK and shall assist NETWORK in validating the following requirements:

- 1) Current State Licensure
- 2) Adequate malpractice insurance or levels required by PAYOR or EMPLOYER
- 3) Eligibility to participate in good standing with the Federal Medicare and Medicaid Program as applicable
- 4) Active Participation in the NETWORK clinical resource management program including:
  - a. Sharing of de-identified patient information via the ART Utilization Management database (outcomes reporting system) found at [www.artcorpsolutions.com](http://www.artcorpsolutions.com) and [www.arthealthcare.com](http://www.arthealthcare.com) .
  - b. Use of official ART® diagnostic tools (symptom pattern chart system) and clinical protocols, unless deemed medically inappropriate by PROVIDER
  - c. Adherence to established performance targets including outcomes, continuing education and ART® certification requirements
- 5) Must adhere to ART® standards, allow site visits and pass any ART® clinical audits
- 6) Develop a Compliance Plan for improvement on any areas of clinical deficiency noted by the ART UM and Clinical Integration Committees based upon clinical performance targets, outcomes targets or MEMBER or PAYOR complaints.

**d. Competition.** PROVIDER may contract with any PAYOR or EMPLOYER independently of the NETWORK. However, in the event the PROVIDER has both a direct and NETWORK Contract, the NETWORK contract shall prevail.

PROVIDER shall not share practice specific pricing information or provider contract compensation with other Participating PROVIDERS.

**Non-competition.** As ART Corporate Solutions, Inc. will provide education, training, support, and access to proprietary systems the PROVIDER agrees to pursue new corporate first aid/wellness business only through, or in conjunction with, ART Corporate Solutions, Inc. In the event PROVIDER terminates or is terminated from the NETWORK, PROVIDER shall not solicit or directly contract with existing NETWORK PAYORS or EMPLOYERS for a period of two (2) years from the expiration of the Agreement for the purposes of providing ART treatment services.

PROVIDER agrees that NETWORK shall be able to enforce this provision via an injunction or other necessary means to protect NETWORK relationships and PROVIDER shall bear the cost of such enforcement.

**e. Treatment Decisions.** PROVIDER shall be solely responsible for all decisions regarding appropriate treatment to MEMBERS. NETWORK is not a provider of clinical treatment or other medical services, and shall not exercise any control over the manner in which PROVIDER treats MEMBERS, other than to offer ART diagnostic tools and training that PROVIDER, in his or her independent judgment, shall utilize when appropriate based upon the MEMBER's needs. **Exception:** If working at a corporation, at the First Aid level, only ART treatment is to be provided.

## V. LICENSURE

PROVIDER shall, throughout the duration of the Agreement maintain all licenses, certifications and other designations as may be required by the state or commonwealth in which the PROVIDER provides services and maintain certification and credentialing requirements as defined by NETWORK and ART®.

## VI. INSURANCE

During the term of this Agreement, PROVIDER shall, at its sole cost and expense, procure and maintain such policies of comprehensive general liability and professional liability insurance or a program of self-insurance sufficient to insure it and its employees against liability for damages directly or indirectly related to the performance of any service provided hereunder, and the use of any property and facilities provided by PROVIDER in connection with this Agreement. **ART provider shall add ART Corporate Solutions, Inc. and any corporation where ART provider is providing services, as additionally insured entities to Providers professional liability plan.** PROVIDER shall use best efforts to provide NETWORK with not less than fifteen (15) calendar day's written notice prior to any reduction in coverage, expiration or cancellation of any such coverage. Prior to a reduction in coverage, expiration or cancellation of any such coverage, PROVIDER shall secure replacement of such coverage upon the same terms and conditions and furnish NETWORK with a certificate describing such replacement coverage. PROVIDER shall furnish NETWORK with certificates of such insurance coverage at any time during the term of this Agreement upon NETWORK'S written request.

## VII. REIMBURSEMENT

**a. Work Comp Level:** If or when a company, under contract with ART, refers a patient/employee to the ART provider's office for care, it will be considered a worker's compensation case. In these cases the provider will utilize their office's current billing and or collecting systems. ART may charge the company, where the patient works, a nominal access fee for the utilization of the EPN providers.

**b. On-site Care Compensation:** ART negotiates hourly rates with each company it contracts. In general the contract rate allows for ART to pay out to the EPN provider at the rate of either \$175/hour or \$200/hour. ART also strives to negotiate automobile drive-time compensation at \$25/15 minutes of driving. However, not every company will agree to pay drive time.

Once a master contract is in place between ART and the corporation, then ART will produce a contract between the EPN provider and ART. This contract secures the contract for that provider and defines compensation for that particular contract. The EPN member will be informed about his compensation and shall have the opportunity to agree to the dollar amount per hour, long before receiving his contract from ART.

In order to be compensated in a timely manner the EPN member must log his treatment notes and electronic time sheets after each visit to the corporation.

In the event that a client corporation sends a first aid/wellness case to the EPN member's office for care the EPN member will render a 15-minute ART-only treatment and shall bill through the electronic billing system (found at [www.artcorpsolutions.com](http://www.artcorpsolutions.com)). The provider will be compensated 25% of their hourly rate, example: \$50 for 15 minutes (if hourly rate is \$200/hour).

## VIII. COORDINATION OF BENEFITS

In the event a third party other than PAYOR or EMPLOYER should have primary responsibility for the payment of the services provided to a MEMBER, PROVIDER agrees to collect payment from such other sources prior to requesting payment from PAYOR or EMPLOYER. Any payment made by PAYOR or EMPLOYER to PROVIDER for obligations which are primary responsibility of a third party, shall be refunded to the PAYOR or EMPLOYER by PROVIDER.

## IX. PROMPT PAYMENT

Payment by PAYOR or EMPLOYER may be reduced by co-insurance, co-payments and/or deductibles. NETWORK shall use its reasonable best efforts to cause PAYOR or EMPLOYER to (1) make payments within thirty (30) days of receipt of claims, unless written notice of dispute or discrepancy is mailed to PROVIDER within thirty (30) days and (2) allow PROVIDER to the right to deny the negotiated rates set forth in Exhibit A and seek billed charges, if claim is not paid within sixty (60) days on undisputed clean claims. This does not apply to Medicare claims. Claims must be filed within 90 days from date of service to be considered eligible for payment.

## X. SILENT PPO

NETWORK is not a Silent PPO and will not knowingly allow unauthorized use of network to PAYORS or EMPLOYERS. Accessing PAYORS or EMPLOYERS must provide ID Cards or other identification to MEMBERS provides for steerage or direction to PROVIDERS and provides an out of network differential to MEMBERS.

## **XI. MEMBER HOLD HARMLESS**

PROVIDER hereby agrees that in no event, including, but not limited to non-payment by PAYOR or EMPLOYER, PAYOR or EMPLOYER insolvency, or breach of this Agreement, shall PROVIDER bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against MEMBER, or persons other than PAYOR or EMPLOYER acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges (non-covered services) or co-payments made in accordance with the terms of the applicable plan between PAYOR or EMPLOYER and MEMBER, nor shall it prohibit PROVIDER from collecting payment from MEMBER for non-covered services requested by MEMBER after being advised that such services are non-covered.

PROVIDER further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of MEMBER, and that (2) this provision supercedes any oral or written contrary agreement now existing or hereafter entered into between the PROVIDER and MEMBER or persons acting on their behalf. Any modifications, addition or deletion to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the Commissioner of Insurance has approved such changes.

## **XII. MEDICAL RECORDS**

All medical records and other protected health information of MEMBERS will be maintained as confidential and disclosed in accordance with the PROVIDER'S policies and all applicable state and federal laws. All medical records shall belong exclusively to the PROVIDER. The release, removal or transfer of such records shall be governed by the PROVIDER'S established policies and procedures.

To the extent allowed under local, state, and federal laws governing confidentiality, PROVIDER will make available to NETWORK or PAYOR or EMPLOYER copies of all medical records, for the purpose of maintaining a quality assurance program, required by NETWORK or PAYOR or EMPLOYER for a period of the greater of five (5) years from the date of treatment or consultation, or as required by NCQA or prevailing state laws.

Upon request, PROVIDER shall furnish one copy without charge, information reasonably required by NETWORK to verify and substantiate its provision of clinical services, the charges for such services, and medical necessity for such services. MEMBERS shall be provided without charge and upon request, one copy of their medical record.

In accordance with the HIPAA Privacy Regulations set forth at 45 CFR Parts 160 and 164, Subparts A and E, NETWORK and participating PROVIDERS shall be deemed an "Organized Health Care Arrangement" under which participants may share protected health information for purposes of utilization review and quality assessment and improvement activities. To the extent that NETWORK performs other functions on PROVIDER's behalf using protected health information, the parties shall be bound by the provisions of Article XXXVI regarding business associate obligations.

## **XIII. PRE-CERTIFICATION**

It is the responsibility of PROVIDER to verify with PAYOR or EMPLOYER prior to the delivery of ART® services in non-emergent situations and within twenty-four (24) hours or the next business day in emergency situation, that any patient is a MEMBER in good standing under the applicable plan, eligible for benefits, and to obtain information as to the extent and nature of the MEMBER'S benefits.

PROVIDER shall verify eligibility and benefits, allowing PROVIDER to determine, if/when pre-certification (pre-authorization) and certification (authorization) is required by the plan.

PROVIDER understands that a MEMBER'S membership identification card is not a guarantee that the cardholder is a MEMBER in good standing. MEMBER'S I.D. card will display appropriate telephone numbers for benefits/eligibility verification.

Additionally, PROVIDER must immediately contact ART Corporate Solutions, Inc. EPN Quality Management Department upon the acceptance and pre-certification of an accessing MEMBER.

#### **XIV. CHANGE IN TERMS OF MEMBERS COVERAGE**

It is agreed by the parties hereto that the benefits, terms and conditions of the various Agreements between PAYOR or EMPLOYER and MEMBER of any plan may be changed during the term of this Agreement without notice. However, such changes will not affect this Agreement, unless agreed to by PROVIDER and NETWORK.

Coverage for each MEMBER may be terminated by PAYOR, EMPLOYER or MEMBER. When a MEMBER whose coverage has terminated receives services from PROVIDER, PROVIDER agrees to bill MEMBER directly. PAYOR or EMPLOYER shall not be liable to PROVIDER for any bills incurred by an MEMBER whose coverage has been terminated.

#### **XV. TERM**

The initial term of this Agreement shall be a period of one (1) year from the date of execution of this Agreement by NETWORK. This Agreement shall automatically renew for successive one (1) year terms on the anniversary date of this Agreement and shall remain in force until termination, as provided for below.

#### **XVI. TERMINATION**

Either party to this Agreement may elect to terminate this Agreement without cause at any time after the initial term by providing one hundred twenty (120) days prior written notice to the other party. Said notice shall clearly explain the reason-giving rise to termination to be considered in compliance with this Section.

Either NETWORK or Provider may terminate this Agreement for immediate cause, which includes, but is not limited to, the following:

- a. Either party's filing of bankruptcy (whether voluntary or involuntary), declaration of insolvency, or the appointment of a receiver or conservator of its assets.
- b. PROVIDER'S failure to maintain appropriate certification or accreditation required by NETWORK.
- c. Concern by NETWORK for the safety and welfare of MEMBERS
- d. PROVIDER'S failure to adhere to clinical integration protocols and established quality standards
- e. PROVIDER'S failure to participate in educational requirements of NETWORK
- f. PROVIDER'S failure to maintain active ART® certification
- g. Other reasons that may necessitate NETWORK'S termination of PROVIDER.

In the event this Agreement is terminated for immediate cause, termination shall be effective upon receipt of written notification.

## **XVII. TERMINATION RESPONSIBILITIES**

In accordance with any termination of this Agreement, said termination shall have no effect upon the rights or obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. PROVIDER agrees to accept, as payment in full, the rates in Exhibit A for services rendered to a MEMBER who is in treatment upon the effective date of such termination, until MEMBER is discharged or safely transferred to another participating NETWORK provider.

## **XVIII. ACCURACY OF INFORMATION**

PROVIDER represents and warrants that all information provided by PROVIDER to NETWORK is true and accurate in all respects and acknowledges that NETWORK is relying on the accuracy of such information in entering into and continuing the term of this Agreement. PROVIDER shall promptly notify NETWORK, without request, of any change in the information provided.

## **XIX. INDEPENDENT CONTRACTOR**

It is expressly acknowledged by the parties that such parties are independent contracting entities and that nothing in this Agreement is intended or shall be construed to create a principal-agent, employer employee or joint venture relationship, or to allow either party to exercise control or direction over the manner or method by which the other party transacts its business affairs or provides its services.

## **XX. CONFIDENTIALITY**

During the term of this Agreement and thereafter, NETWORK and PROVIDER shall ensure that NETWORK and PROVIDER, and their directors, officers, employees, contractors and agents hold Confidential Information in the strictest confidence and in accordance with state and federal law. "Confidential Information" shall include without limitation all information and records whether oral or written or disclosed prior to or subsequent to the execution of this Agreement regarding the following: patients, utilization review, quality assurance, finances, volume of business, contracts, and prices. The parties agree that disclosure of a party's Confidential Information other than in accordance with this Section shall cause irreparable injury to such party, and that, in addition to money damages, the injured party shall be entitled to injunctive relief to prevent the other party's breach of this Section.

## **XXI. GRIEVANCE PROCEDURE**

NETWORK, PAYOR or EMPLOYER has developed a grievance procedure for the purpose of resolving MEMBER grievances. PROVIDER agrees to cooperate in the implementation of the grievance procedure as provided by the NETWORK, PAYOR or EMPLOYER.

**XXII. DISPUTE RESOLUTION**

NETWORK shall use its reasonable best efforts to require PAYORS and EMPLOYERS to resolve any dispute, controversy or claim arising out of or relating to PROVIDER'S services including but not limited to the payment or non-payment of a claim, the eligibility of a MEMBER, the determination of Covered Services, or the determination of medically necessary procedures, by mutual cooperation. Nothing in this Agreement shall preclude NETWORK, PAYOR, EMPLOYER or PROVIDER from exercising, at any time, the right to seek resolution through legal remedies as the law may provide. The prevailing party shall be entitled to reasonable attorneys' fees, costs and expenses from the other party, in addition to any other relief to which such party is entitled. If any arbitration or any other judicial proceeding is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees, costs and expenses from the other party, in addition to any other relief to which such party is entitled. If the parties mutually agree to the use of arbitration, the decision of the arbitrator shall be binding in a court of law.

**XXIII. INDEMNIFICATION**

Within the limits of its policies of professional and general liability insurance PROVIDER shall indemnify, exonerate, and hold harmless the NETWORK and PAYOR or EMPLOYER from and against any claim loss, cost, damage, expense or other liability attributable to the willful misconduct or the willful, wanton, or reckless failure by PROVIDER or PROVIDER'S servants or employees or officers to perform their respective obligations under the Agreement or PROVIDER'S negligence or the negligence of PROVIDER'S servants or employees or officers. This indemnity agreement shall include indemnity against all costs, expenses, and liabilities incurred in and in connection with any such claim, liability, or proceeding brought thereon, and the reasonable cost of the defense thereof.

**XXIV. NOTICES**

Any notices or other communications required or contemplated under the provisions of this Agreement shall be in writing and delivered in person, evidenced by a signed receipt, or mailed by certified mail, return receipt requested, postage prepaid, or via overnight delivery service to the addresses indicated below or to such other persons or addresses as NETWORK or PROVIDER may provide by notice to the other. The date of the notice shall be the date of delivery if the notice is personally delivered or sent via overnight delivery, or the third day following the date of mailing if the notice is mailed by certified mail.

If to NETWORK:

ART Corporate Solutions, Inc.  
175 S. Union Blvd, Suite #230  
Colorado Springs, CO 80910  
  
Attention: EPN Development

If to PROVIDER:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
  
Attention: \_\_\_\_\_

Either party may change the address to which communications are to be sent by giving written notice. All communications will be directed to PROVIDER at the most current address on file with NETWORK.

## **XXV. SEVERABILITY**

The provisions of this Agreement are independent of and severable from each other, and no provision shall be affected or rendered invalid or unenforceable by virtue of the fact that for any reason any other or others of them may be invalid or unenforceable in whole or in part.

## **XXVI. ASSIGNMENT**

PROVIDER may not assign any of its rights or delegate any of its duties hereunder without prior written consent of NETWORK. PROVIDER acknowledges NETWORK's rights to assign its rights or delegate any of its duties hereunder to another entity controlled by or affiliated with NETWORK.

## **XXVII. WAIVER OF BREACH**

The failure of NETWORK or PROVIDER to object to or to take affirmative action with respect to any conduct of the other which is a breach of this Agreement shall not be construed as a waiver of the breach or of any prior or future breaches of this Agreement.

## **XXVIII. GOVERNING LAW**

This Agreement and all questions relating to its validity, interpretation, performance and enforcement shall be governed by and construed in accordance with the laws of the state of Colorado.

## **XXIX. CONFORMITY**

Any provision of this Agreement that is in conflict with the statutes, local laws, or regulations of the state in which services are provided, is hereby amended to conform to the minimum requirements of such statutes.

## **XXX. ENTIRE AGREEMENT**

This Agreement constitutes the entire agreement of the parties with respect to subject matter covered herein, and supersedes any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of the Agreement. This Agreement may not be amended except as provided below or in writing duly executed by both parties.

## **XXXI. AMENDMENT**

NETWORK may communicate changes to this Agreement via written notification. If the PROVIDER does not disapprove and respond via written notification within thirty- (30) days, such notice will be considered accepted and binding. No other third party, including but not limited to MEMBERS, PAYORS or EMPLOYERS, shall be required to consent or receive notice of any such amendment or notice in order for the notices or amendments to be effective and binding upon the parties to this Agreement. Contractual modifications that are required by state or federal law or statute shall not be subject to this approval process; such modifications will be mailed to PROVIDER as notice.

## **XXXII. SECTION HEADINGS**

The headings of Sections in the Agreement are for reference only and shall not affect the maintaining of this Agreement.

## **XXXIII. EXECUTION IN COUNTERPARTS**

This Agreement may be executed in any number of counterparts, including facsimiles, each of which are incorporated herein and shall be deemed to be an original as against any part whose signature appears thereon, and all of which shall together constitute one and the same instrument.

## **XXXIV. UNFORESEEN CIRCUMSTANCES**

Neither party shall be liable for or deemed to be in default for any delay or failure to perform any act under this Agreement (other than the payment of money) resulting, directly or indirectly, from Acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, failure of transportation, strikes or other work stoppages by either party's employees, or any other cause beyond the reasonable control of such party.

## **XXXV. SURVIVAL**

As noted within the Agreement specific sections will survive the termination of this Agreement.

## **XXXVI. BUSINESS ASSOCIATE REQUIREMENTS**

To the extent that NETWORK provides services for PROVIDER that involve the use and/or disclosure of individually identifiable health information relating to PROVIDER's patients ("Protected Health Information" or "PHI"), NETWORK will be deemed to be a business associate of PROVIDER under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the federal privacy regulations ("Privacy Regulations") set forth at 45 CFR Part 160 and Part 164. Effective April 14, 2003 or, if different, the date by which PROVIDER is required to comply with the Privacy Regulations, NETWORK agrees to comply with the following:

- A. Permitted Uses and Disclosures. NETWORK shall not use or disclose any Protected Health Information other than (a) as permitted by this Agreement in order to perform NETWORK's obligations hereunder, (b) as required by law, and/or (c) as approved in writing by PROVIDER. NETWORK shall not use or disclose the PHI in any way that would be prohibited if used or disclosed in such a way by PROVIDER. In addition to the foregoing, NETWORK may use or disclose PHI as required for NETWORK's proper management and administration, provided that if NETWORK discloses any PHI to a third party for such a purpose, NETWORK shall enter into a written agreement with such third party requiring that party (i) to hold the PHI confidentially and to use or further disclose the PHI only as required by law, and (ii) to notify NETWORK of any instances of which it becomes aware in which the confidentiality of the PHI is breached.
- B. Minimum Necessary Information. NETWORK shall only request from PROVIDER, and shall only use and disclose, the minimum amount of PHI necessary to carry out NETWORK's responsibilities under this Agreement.

- C. Reporting. If NETWORK becomes aware of any use or disclosure of PHI in violation of this Agreement, NETWORK shall promptly report such information to PROVIDER. NETWORK shall also require its employees, agents, and subcontractors to promptly report any use or disclosure of PHI in violation of this Agreement. NETWORK shall cooperate with, and take any action required by, PROVIDER to mitigate any harm caused by such improper disclosure.
- D. Agents and Subcontractors. NETWORK shall require its employees, agents, and subcontractors to agree not to use or disclose PHI in any manner except as specifically allowed herein, and shall take appropriate disciplinary action against any employee or other agent who uses or discloses PHI in violation of this Agreement. NETWORK shall require any agent or subcontractor that carries out any duties for NETWORK involving the use, custody, disclosure, creation of, or access to PHI to enter into a written contract with NETWORK containing provisions substantially identical to the restrictions and conditions set forth herein.
- E. Policies, Privacy Practices, and Restrictions. PROVIDER shall provide NETWORK with copies of any PROVIDER notices, policies and procedures with which NETWORK is expected to comply. If PROVIDER makes any changes to such policies or notices, or if a patient revokes or restricts PROVIDER's right to use or disclose PHI and PROVIDER expects NETWORK or its employees or agents to comply with such changes or restrictions, PROVIDER shall immediately advise NETWORK and shall allow NETWORK a reasonable period in which to bring its own practices into compliance.
- F. Patient Rights. NETWORK acknowledges that the Privacy Regulations require PROVIDER to provide patients with a number of privacy rights, including (a) the right to inspect PHI within the possession or control of PROVIDER, its business associates, and their subcontractors, (b) the right to amend such PHI, and (c) the right to obtain an accounting of certain disclosures of their PHI to third parties. NETWORK shall establish and maintain adequate internal controls and procedures allowing it to readily assist PROVIDER in complying with patient requests to exercise any patient rights granted by the Privacy Regulations. If PROVIDER receives a request to exercise such rights, and PROVIDER reasonably believes NETWORK is in possession or control of all or portions of such PHI that is not already in the possession or control of PROVIDER, PROVIDER shall notify NETWORK in writing of the request. NETWORK shall promptly comply with all PROVIDER requests to amend, provide access to, or create an accounting of disclosures of the PHI in the possession of NETWORK or its agents and subcontractors. If NETWORK receives a request directly from a patient to exercise any patient rights granted by the Privacy Regulations, NETWORK shall immediately forward the request to PROVIDER.
- G. Safeguards. NETWORK shall use appropriate physical, technical, and administrative safeguards to prevent the use or disclosure of a patient's PHI other than as provided for by this Agreement and by PROVIDER's privacy and security policies. Upon request, NETWORK shall allow PROVIDER to review such safeguards. If NETWORK uses electronic media to obtain, transmit, or store PHI, NETWORK shall implement appropriate security measures and procedures for its data systems, which shall maintain the PHI and otherwise prevent unauthorized access to the PHI as required by this Agreement.

- H. Disclosure to DHHS. NETWORK shall make its internal practices, books, and services relating to the use and disclosure of PHI available to the Secretary of Health and Human Services to the extent required for determining PROVIDER's compliance with the Privacy Regulations. Notwithstanding the above, no attorney-client, accountant-client, or other legal privilege shall be deemed waived by PROVIDER or NETWORK by virtue of this provision.
  
- I. Termination and Return of PHI. Notwithstanding anything to the contrary in this Agreement, PROVIDER may suspend this Agreement immediately if, in PROVIDER's reasonable opinion, NETWORK breaches any provision of this Section, and PROVIDER may terminate this Agreement immediately if NETWORK fails to cure the breach within thirty (30) days following written notice from PROVIDER. Upon termination of this Agreement for any reason, NETWORK shall, if feasible, return or destroy all PHI received from PROVIDER or created by NETWORK on behalf of PROVIDER. If such return or destruction is not feasible, the parties agree that the requirements of this Section shall survive termination of this Agreement and that NETWORK shall limit all further uses and disclosures of PHI to those purposes that make the return or destruction of such information infeasible.

**Effective Date:**

This Agreement is effective upon the following effective date \_\_\_\_\_, 20\_\_\_\_\_.  
(To be completed by NETWORK.)

For and on behalf of:

For and on behalf of:

ART Corporate Solutions, Inc.  
175 S. Union Blvd, Suite #230  
Colorado Springs, CO 80910

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Title

\_\_\_\_\_  
Participating Provider (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider TAX ID

\_\_\_\_\_  
Practice Name

\_\_\_\_\_  
Provider's Signature

Form <b>W-9</b> (Rev. October 2007) Department of the Treasury Internal Revenue Service	<b>Request for Taxpayer                  Identification Number and Certification</b>	<b>Give form to the                  requester. Do not                  send to the IRS.</b>
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Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

<b>Part I Taxpayer Identification Number (TIN)</b>						
Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Social security number</td> </tr> <tr> <td style="text-align: center;">: : :</td> </tr> <tr> <td style="text-align: center;">or</td> </tr> <tr> <td style="text-align: center;">Employer identification number</td> </tr> <tr> <td style="text-align: center;">: : :</td> </tr> </table>	Social security number	: : :	or	Employer identification number	: : :
Social security number						
: : :						
or						
Employer identification number						
: : :						
<b>Note.</b> If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.						

<b>Part II Certification</b>
Under penalties of perjury, I certify that:
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined below).
<b>Certification instructions.</b> You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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**General Instructions**  
 Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**  
 A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

This form can also be downloaded directly from the website at [www.irs.gov](http://www.irs.gov)

Initials: \_\_\_\_\_

## STATEMENT OF EXEMPTION FROM WORKERS' COMPENSATION FOR PROVIDERS NOT IN THE STATE OF COLORADO

Date: \_\_\_\_\_

I, \_\_\_\_\_, do hereby state  
that (Company Name) \_\_\_\_\_  
has **NO EMPLOYEES** and therefore is exempt from the State of  
\_\_\_\_\_ Worker's Compensation requirements.

I also understand that it is my responsibility in the hiring of  
subcontractors to make certain that they are in compliance with the  
State of \_\_\_\_\_ Worker's Compensation Insurance  
requirements.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Company: \_\_\_\_\_

Initials: \_\_\_\_\_

Please, if you are an ART Provider in the State of Colorado, you must complete the following form. On this Declaration of Independent Contractor Status Form:

ART Corporate Solutions, Inc. is the PH (policy holder)  
Our address is 175 S. Union Blvd, #230, Colorado Springs, CO  
80910.  
We'll put in the policy number.  
Our phone is 719-473-2026

In second Paragraph with questions 1 - 9 initial next to the IC for all 9 questions.

Then please have this form notarized, signed and dated by the notary (in the middle section).

We will complete the bottom section.

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*If you are not an ART Provider in the State of Colorado please complete the "Statement of Exemption from Workers' Compensation" form on the preceding page (20).*  
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## Declaration of Independent Contractor Status Form

According to the Colorado Workers' Compensation Act, a person is an independent contractor, not an employee, if *both* of the following statements are true.

1. He/she is free from control and direction in the performance of the service (unless control is exercised under the requirement of any state or federal statute or regulation).
2. He/she is customarily engaged in an independent trade, occupation, profession, or business related to the services performed.

The Colorado Workers' Compensation Act also outlines nine criteria (listed on page 2) to help determine whether or not the above statements are true. For an individual to be considered an independent contractor, he/she must meet only those criteria that are appropriate to the situation. He/she does not need to meet all of the nine criteria.

This Declaration of Independent Contractor Status Form documents the business relationship as defined in the Colorado Workers' Compensation Act. *It is the responsibility of our policyholders and their independent contractor(s) to correctly and truthfully complete this form.* Pinnacol Assurance will accept this form only when it is initialed where applicable, signed, and notarized by both parties. If you do not understand this form, do not sign it.

**Please make copies of this form as needed. You should complete this form only once for each independent contractor for the lifetime of your Pinnacol Assurance policy or until the business relationship changes. This form is not valid unless the notarized original form is returned to Pinnacol Assurance. Keep one copy for your records and send the notarized original to:**

**Pinnacol Assurance  
P.O. Box 469011  
Denver, CO 80246-9011**

*Call your Pinnacol Assurance underwriter at 303-361-4000 or 1-800-873-7242 if you have questions.*

## Declaration of Independent Contractor Status Form

We certify UNDER PENALTY OF PERJURY that: (name and trade name) \_\_\_\_\_  
 performing (type of work) \_\_\_\_\_  
 Social Security or Federal Employer Identification # \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 is an independent contractor (IC) and is not an employee of the following policyholder (PH): \_\_\_\_\_  
 Address: \_\_\_\_\_ Policy # \_\_\_\_\_ Phone: \_\_\_\_\_

We also certify, by OUR initials WHERE APPLICABLE, that the above business for which the above individual performs services meet the following criteria:

IC \_\_\_\_ PH \_\_\_\_ 1. The business DOES NOT require the individual to work ONLY for the business for whom services are performed (except that the individual may DECIDE to work only for the business for a definite period);

IC \_\_\_\_ PH \_\_\_\_ 2. The business DOES NOT establish a quality standard for the individual (except that the business may provide plans and specifications regarding work but cannot oversee the actual work or instruct the individual as to how work will be performed);

IC \_\_\_\_ PH \_\_\_\_ 3. The business DOES NOT pay the individual a salary or an hourly rate instead of a fixed or contract rate;

IC \_\_\_\_ PH \_\_\_\_ 4. The business DOES NOT terminate the work or the service provided during the contract period unless the individual violates the terms of the contract or fails to produce a result that meets the specifications of the contract;

IC \_\_\_\_ PH \_\_\_\_ 5. The business DOES NOT provide more than minimal training for the individual;

IC \_\_\_\_ PH \_\_\_\_ 6. The business DOES NOT provide tools or benefits to the individual (except that materials and equipment may be supplied);

IC \_\_\_\_ PH \_\_\_\_ 7. The business DOES NOT dictate the time of performance (except that a completion schedule and a range of agreeable work hours may be established);

IC \_\_\_\_ PH \_\_\_\_ 8. The business DOES NOT pay the individual personally instead of making payment or checks payable to the trade or business name of the individual;

IC \_\_\_\_ PH \_\_\_\_ 9. The business DOES NOT combine the business operations in any way with the individual's business operations instead of maintaining all such operations separately and distinctly.

### CERTIFICATION BY INDEPENDENT CONTRACTOR

**THE INDEPENDENT CONTRACTOR UNDERSTANDS THAT HE/SHE:**

- **WILL NOT BE ENTITLED TO ANY WORKERS' COMPENSATION BENEFITS IN THE EVENT OF INJURY.**
- **IS OBLIGATED TO PAY ALL FEDERAL AND STATE INCOME TAX ON ALL MONEY EARNED WHILE PERFORMING SERVICES FOR THE BUSINESS.**
- **IS REQUIRED TO PROVIDE WORKERS' COMPENSATION INSURANCE FOR ALL WORKERS THAT HE/SHE HIRES.**

Independent Contractor Signature \_\_\_\_\_ Title \_\_\_\_\_ Social Security # \_\_\_\_\_  
 STATE OF COLORADO, COUNTY OF \_\_\_\_\_  
 Subscribed and sworn before me by \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
 Commission expires: \_\_\_\_\_

NOTARY PUBLIC

Acceptance of the Independent Contractor named on this form does not change any party's responsibility under the Workers' Compensation Act. If individuals or organizations hired or contracted by the Independent Contractor are not covered by other workers' compensation insurance, the policyholder specified on this form will be charged premium for coverage of those individuals or organizations.

### CERTIFICATION BY BUSINESS

I certify that I am authorized by the business listed above to state that all of the information on this form is true and accurate. I understand that if the above person does not qualify for independent contractor status, the proper premium can be assessed.

Signature \_\_\_\_\_ Title \_\_\_\_\_  
 STATE OF COLORADO, COUNTY OF \_\_\_\_\_  
 Subscribed and sworn before me by \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
 Commission expires: \_\_\_\_\_

NOTARY PUBLIC