

PLAN SUPERVISOR

		-
Adm	inisti	rator:
/ (011)		utor.

Address:			
Other Offices:			
Telephone: ( )	Corporation	Partnership	Proprietorship
Number of Employees:			
Number of Claims Personnel:	Attach a summary of w	ork history of Clai	m Supervisory Personnel
Names of Principals:			
Partners of Officers:	Title:		

Person Responsible For:		
Underwriting:		
Claims		
Administration:		
Date organized:		
Number of years administrating claims:		
Insurance Companies with whom you Currently have approved TPA status:	Date Approved	Approximate Number of Stop-Loss Cases with Each

Insurance Company and Bank References:

Con	npany	,	Person			( Tel.	)		
Con	npany	,	Person			( Tel.	)		
Ban	ık		Person			( Tel.	)		
А.	Are	you presently providing admir	nistration on:						
	1.	Fully self-insured cases:	Yes	No					
	2.	Partially self-insured cases:	Yes		No				
B.	Det	ails on cases you are presently	administerin	ıg:					
				# Ca	ses:		# Cov	ered EEs:	
	1.	Fully Insured							
	2.	Other Partially self-insured ca	ases						
	3.	Fully self-funded cases							
	4.	MET, Associations or Unions							
C.	Des	cribe Claim Processing System	n:						
	1.	Is system: Manual	Computer	rized					
	2.	If computerized, does it com	pute the claim	n or accep	ot data fro	om work	(sheet ca	alculated manually?	,
	3.	Can you provide a listing of c date paid, check or draft num	-	-	-	ered par Yes	ticipant	showing name, dat No	e incurred,
	4.	As each claim is handled, do	you establish	an "incur	red date'	'?	Yes	No	
	5.	What is your definition of inc	urred date?						
	6.	What is your average claim to	urn around tir	ne?				days	
	7.	What is your definition of pai	d?						
	8.	Average number of claims pro	ocessed per p	rocessor	per day:				
	9.	Describe the payment author	ity levels for t	the claim	s staff an	d descri	be the ci	riteria for internal a	udits:

10. What percent of R & C do you reimburse at:

- D. Please attach a sample claim listing and check register illustrating your claim reporting procedures. Also furnish a copy of your claim worksheet and E.O.B.
- Please attach sample copy of the Plan Document and S.P.D. Format you are currently using, or plan to use for self-Ε. insured cases.

F.	How is new group business developed?	Brokers	Salaried Reps.	Principals		
G.	Your firm's gross annual income profile:	Marking:	%	Administration:	%	
H.	What type of fee structure is your firm using etc.):	<b>g? (Flat per claim charge</b> ,	flat per employee	charge, percent of claims p	aid,	
Ι.	I. How are fees disclosed to client? (Please attach sample of disclosure form)					
J. PI	J. Please provide the following for three (3) existing client references:					

Name of Firm Person to Contact Telephone No. Number of Lives

K. Please provide the average number of cases which you feel you will have the opportunity to quote in the next twelve (12) months:

Single Employer 25/25	0 lives	+25	50 lives			
MET or Assocations		No. Lives pe	er case			
Unions	No. Lives pe	er case				
L. Have any of the principals in misappropriating any compa If "Yes", please give de	ny funds?	rour employees Yes	ever been acc No	cused or convic	ted of mis	shandling or
M. Has any insurance company If "Yes", please give de		ms paying auth	ority or TPA a	ipproval?	Yes	No
N. Are you audited annually by	an outside independ	ent auditor?	Yes	No		
O. Are you in a state that requi	es Administrators to	be licensed?	Yes	No		

P. Please provide copies of your current State License(s) for either your firm or any individuals, if the state requires same.

Q. Have you ever had underwriting authority for Stop Loss In	Yes	No		
R. Do you currently have or intend to have underwriting auth If "Yes", please explain:	nority for Si	top Loss Insurance?	Yes	No
S. Do you carry a fiduciary liability or E & O policy? If "Yes", please provide:	Yes	No		
Name of carrier: Policy number: Limit of liability: Term:				
T. Do you carry a fidelity bond? Yes No If "Yes", please provide:				
Name of carrier: Policy number: Limit of liability: Term: Comments:				

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE ABOVE INFORMATION IS CORRECT. I ALSO UNDERSTAND THAT AS A MATTER OF PROCEDURE, A ROUTINE INQUIRY MAY BE MADE BY THE COMPANY OF ANY OR ALL OF THE INDIVIDUALS AND FIRMS NOTED ABOVE AS REFERENCES IN ORDER TO ASCERTAIN APPROVING ME AS A QUALIFIED THIRD PARTY ADMINISTRATOR.

Date:

Administrator: By: Title:

3279 Veterans Memorial Highway, Suite D-9, Ronkonkoma, NY 11779 Tel: 631-467-3901 Fax: 631-467-1862