

American International Companies ®

Name Of Insurance Company To Which Application is Made:
(herein called the Company)

THIRD PARTY ADMINISTRATORS PROFESSIONAL LIABILITY APPLICATION

NOTICE: IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS-MADE BASIS. THE POLICY PROVIDES THAT THE LIMIT OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE. FURTHER NOTE THAT AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.

1. NAME OF APPLICANT: _____
ADDRESS: _____

2. APPLICANT IS:
A) _____ CORPORATION _____ PARTNERSHIP _____ INDIVIDUAL
B) _____ NONPROFIT _____ FOR PROFIT
3. EFFECTIVE DATE DESIRED: _____
4. YEAR ESTABLISHED: _____
5. A) IS THE APPLICANT FIRM CONTROLLED BY, OWNED BY OR ASSOCIATED WITH, OR DOES THE APPLICANT FIRM OWN OR CONTROL ANY OTHER FIRM, CORPORATION OR COMPANY?
____ YES ____ NO IF YES, PLEASE ATTACH A DETAILED EXPLANATION.
B) ARE ANY SERVICES LISTED IN QUESTION 9 PROVIDED TO SUCH ORGANIZATIONS DESCRIBED IN A)?
____ YES ____ NO
6. A) NUMBER OF PRINCIPALS, PARTNERS, OFFICERS AND PROFESSIONAL EMPLOYEES DIRECTLY ENGAGED IN PROVIDING SERVICES TO CLIENTS:

B) NUMBER OF CLAIMS ADJUSTERS: _____
C) NUMBER OF NON-PROFESSIONAL EMPLOYEES (clerks, secretaries, etc):

7. LIMITS OF LIABILITY DESIRED:
_____ \$500,000 _____ \$1,000,000 _____ \$3,000,000 each wrongful act or series of continuous, repeated or related wrongful acts
_____ \$500,000 _____ \$1,000,000 _____ \$3,000,000 Aggregate

8. DEDUCTIBLE:
 _____ \$5,000 _____ \$10,000 _____ \$25,000 _____ \$50,000
 _____ Other, Specify \$ _____

9. GIVE APPROXIMATE PERCENTAGE OF REVENUES DERIVED FROM ALL OPERATIONS ENGAGED IN:

OPERATION DESIRED	PERCENTAGE of 12A) RECEIPTS	IF COVERAGE DESIRED (CHECK HERE)
Providing Actuarial Services	_____ %	_____
Administration of Health and Welfare Plans (specify type of plan)		
Single Employer Plans	_____ %	_____
Multiple employer benefit plans (Taft-Hartley Trusts)	_____ %	_____
Multiple Employer Welfare Arrangements (MEWAS)	_____ %	_____
Multiple Employer Trusts (METS)	_____ %	_____
Administration of Pension Plans	_____ %	_____
Computer Services		
Electronic data processing/collection	_____ %	_____
Electronic data consulting	_____ %	_____
Software design, development or customization	_____ %	_____
The design development or customization of computer software sold or provided to third party outside the normal operations of the applicant as a TPA	_____ %	_____
Employee Assistance Programs		
Administrator	_____ %	_____
Provider	_____ %	_____
Providing Utilization Review Services	_____ %	_____
Insurance Related Services		
Acting as an Insurance agent or Broker	_____ %	_____
Acting as an advisor/consultant	_____ %	_____
Premium collection and billing	_____ %	_____
Hold any underwriting authority/policy issuance	_____ %	_____
Providing Cost Containment services	_____ %	_____
Providing Case Management services	_____ %	_____
Providing employee "wellness" or other health related program literature or correspondence	_____ %	_____
Acting as an Administrator for Credentialing services (verification of a health care provider's credentials)	_____ %	_____
Acting as a Notary Public	_____ %	_____
Other _____	_____ %	_____
Total	_____ %	_____
Must equal 100%		

10. WHAT TYPES OF CLIENTS DOES YOUR FIRM SERVICE?

Health And Welfare Plans	Pension Plans	Profit Sharing	Other (Please Specify)
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Single
Employer

METS/MEWAS

HMO's

PPO's

PUBLIC/
GOVT
PLANS

TAFT
HARTLEY

INSURANCE
COMPANY

11. IS THE APPLICANT ENGAGED IN ANY BUSINESS OR PROFESSION OTHER THAN AS DESCRIBED IN QUESTION 9?
 _____YES _____NO IF YES, PLEASE ATTACH AN EXPLANATION AND ESTIMATED REVENUES.

12. LIST THE TOTAL GROSS RECEIPTS FOR THE PAST THREE YEARS DERIVED FROM THOSE ACTIVITIES IN QUESTION 9. IN ADDITION, PLEASE LIST PROJECTED RECEIPTS FOR THE CURRENT YEAR AND THE NEXT YEAR.

	YEAR	AMOUNT
A)	NEXT YEAR PROJECTED	\$
B)	CURRENT	\$
C)	_____	\$
D)	_____	\$
E)	_____	\$

13. (A) NUMBER OF PLAN SPONSORS _____

(B) NUMBER OF PARTICIPANTS FOR PLANS ADMINISTERED BY THE APPLICANT: _____

(C) TOTAL ANNUAL CONTRIBUTIONS TO THE PLANS ADMINISTERED BY THE APPLICANT: _____

(D) TOTAL ANNUAL BENEFIT PAYMENTS ISSUED IN THE ADMINISTRATION OF ALL SUCH PLANS: _____

(E) NUMBER OF PLAN SPONSORS ADDED AND DELETED IN THE PAST YEAR: _____

(F) WHAT PERCENTAGE OF ALL PLANS ARE:
SELF FUNDED WITH STOP LOSS _____
SELF FUNDED WITH NO STOP LOSS _____
FULLY INSURED _____

(G) LIST CARRIERS THAT STOP LOSS COVERAGES ARE PLACED WITH:

14. DOES THE APPLICANT FIRM, ITS PARTNERS, DIRECTORS, OFFICERS OR EMPLOYEES ACT AS TRUSTEE FOR ANY CLIENTS OR NON CLIENTS?
___YES ___NO

IF YES, PLEASE EXPLAIN IN DETAIL

15. DOES YOUR FIRM ADMINISTER ANY SELF-FUNDED MULTIPLE EMPLOYER TRUSTS (METS) OR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAS)?
___YES ___NO IF YES, PLEASE EXPLAIN IN DETAIL ON SEPARATE SHEET.

16. A) NAME AND ADDRESS OF LAW FIRMS ACTING AS COUNSEL TO THE APPLICANT FIRM AND NATURE OF SERVICES PROVIDED:

B) NAME AND ADDRESS OF ALL FIRMS PROVIDING ACCOUNTING SERVICES TO THE APPLICANT AND THE NATURE OF SERVICES PROVIDED:

17. PLEASE PROVIDE THE FOLLOWING Information Regarding Your Firm (or detailed resumes may be substituted):

NAME IN FULL OF ALL PARTNERS/ PRINCIPALS/ OFFICERS/ DIRECTORS	PROFESSIONAL QUALIFICATIONS	DATE QUALIFIED	HOW LONG IN PRACTICE	HOW LONG AS PARTNER/ PRINCIPAL/ OFFICER/ DIRECTOR
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

18. TO WHAT PROFESSIONAL ASSOCIATION(S) DOES THE APPLICANT FIRM BELONG?

19. TO WHICH PROFESSIONAL AND GOVERNMENT PUBLICATIONS DOES THE APPLICANT FIRM SUBSCRIBE? _____

20. A) DOES THE APPLICANT HAVE PROFESSIONAL LIABILITY ERROR AND OMISSIONS INSURANCE IN FORCE?

_____ YES ___ NO

(if yes, please provide coverage details)

Name of Carrier: _____

Limit of Liability: _____ Deductible: _____

Policy Period: _____

Premium: _____

Claims Experience: On the supplemental claims form please attach full details of claims history for the past 5 years. If no claims, check here. _____

B) DOES THE APPLICANT HAVE DIRECTORS & OFFICERS INSURANCE IN FORCE?

_____ YES _____ NO

(if yes, please provide coverage details)

Name of Carrier: _____

Limit of Liability: _____ Retention _____

Policy Period: _____

Premium: _____

Claims Experience: On supplemental claims form please attach full details of claims history for the past 5 years.

If no claims, check here. _____

Claims Experience:

C) DOES THE APPLICANT HAVE A FIDELITY BOND?

___ YES _____ NO

(if yes, please provide coverage details)

Name of Carrier: _____

Amount of Insurance: _____ Deductible: _____

Policy Period: _____

Premium: _____

Claims Experience: On the supplemental claims form please attach full details of claims history for the past 5 years.

If no claims, check here. _____

D) DOES THE APPLICANT HAVE ERISA FIDUCIARY LIABILITY COVERAGE IN FORCE?

___ YES ___ NO

(if yes, please provide coverage details)

Name of Carrier: _____

Limits of Liability: _____ Retention: _____

Policy Period: _____

Premium: _____

Claims Experience: On a supplemental claims form, please attach full details of claims history for the past 5 years.

If no claims, check here. _____

21. PLEASE INCLUDE A LIST OF APPLICANT FIRM'S FIVE (5) LARGEST CLIENTS DURING THE PAST THREE (3) YEARS. PLEASE GIVE, IN DETAIL: 1) client name; 2) the nature of the services provided (type of plan administered); 3) number of lives; 4) the revenues obtained from those services.
22. DESCRIBE HOW YOUR FIRM SCREENS AND QUALIFIES PLAN SPONSORS.
23. PLEASE OUTLINE BELOW THE APPLICANT FIRM'S STANDARDS OF PRACTICE (PROCEDURAL PROTOCOLS).
- A) HOW DO YOU COMPLY WITH INDIVIDUAL PLAN ADMINISTRATION GUIDELINES?
- B) HOW DO YOU DETERMINE DENIAL OF BENEFITS?
- C) WHAT PERCENTAGE OF INQUIRIES ARE REFERRED TO A PHYSICIAN?
_____ %
- D) WHAT PERCENTAGE OF CLAIMS ARE DENIED? _____ %
- E) WHAT PERCENTAGE OF DENIALS ARE APPEALED? _____ %
- F) WHAT IS THE PROTOCOL FOR DENYING BENEFITS OR COVERAGE? _____
- G) HOW ARE CLAIMANTS INFORMED OF DENIAL OF BENEFITS? _____ %
- H) WHAT IS THE APPEAL PROCESS FOR DENIAL OF CLAIMS? _____ %
- I) WHAT IS THE AVERAGE ERROR RATE OF YOUR CLAIMS HANDLERS? _____
- J) PLEASE PROVIDE A COMPLETED COPY OF YOUR STANDARDS OF PRACTICE IF AVAILABLE..
24. A) WHICH OF THE FOLLOWING ARE FUNCTIONS OF YOUR FIRM'S ELECTRONIC DATA PROCESSING SYSTEM?
- _____ Calculation of Co-payments
 - _____ Calculation of Deductibles
 - _____ Claim Eligibility
 - _____ Confidentiality Safeguards
 - _____ Enrollment Information
 - _____ Monitoring of Duplicate Claims
 - _____ Management Reports
 - _____ Appeal Tracking
 - _____ Adjustors Accuracy
 - _____ Check Registers (weekly and monthly)
 - _____ Details on Large Claims
 - _____ Detailed Payment Registers/Analysis
 - _____ Independent Stop Loss Information
 - _____ Monthly Aggregate reports by case (claim or aggregate specific)
 - _____ Summaries by Policy Year

- _____ Telephone Tracking Systems
- _____ Number of Call backs Due to System Failure
- ___ Total Number Calls Received
- ___ Turn Around Time Service
- ___ Types of Losses
- _____ Cost Containment and Expense Control
- _____ Audit Results
- _____ Productivity Reports

B) DOES YOUR SYSTEM CONTAIN CHECKS AND BALANCES TO GUARD AGAINST:

- _____ Over payments
- _____ Under payments
- _____ Late payments
- _____ Payments to wrong party
- _____ Payments from wrong fund
- _____ Payments of non covered expenses
- _____ Improper refusal of benefits
- _____ Unfair/Unjust enrichments
- _____ Failure to follow payment guidelines or procedures

25. HOW OFTEN DOES YOUR ORGANIZATION DO AN INTERNAL AUDIT? WHAT SITUATIONS ARE THE AUDIT GUIDELINES DESIGNED TO REVEAL?

26. DOES THE APPLICANT FIRM USE A WRITTEN CONTRACT WITH CLIENTS?

___ In All Cases _____ Sometimes _____ Never

Please attach a copy of your standard contract.

27. WHAT PERCENTAGE OF THE APPLICANT FIRM'S BUSINESS INVOLVES SUBCONTRACTING OF WORK TO OTHERS? ___% LIST TYPES OF WORK SUBCONTRACTED OUT.

28. HAS THE APPLICANT FIRM OR ANY OF THE INDIVIDUALS LISTED IN QUESTION #17 EVER BEEN THE SUBJECT OF DISCIPLINARY ACTION BY AUTHORITIES AS A RESULT OF ANY PROFESSIONAL ACTIVITIES? ___ YES ___ NO (IF YES, PLEASE EXPLAIN.)

29. DOES ANY PROPOSED INSURED HAVE KNOWLEDGE OR INFORMATION OF ANY ACT, ERROR OR OMISSION WHICH MIGHT REASONABLY BE EXPECTED TO GIVE RISE TO A CLAIM? ___ YES ___ NO (IF YES, PLEASE ATTACH A FULLY COMPLETED SUPPLEMENTAL CLAIMS FORM.)

IT IS AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS ANY CLAIM OR ACTION ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED COVERAGE.

30. FOR ANY AND ALL CLAIMS MADE AGAINST ANY PROPOSED INSURED DURING THE PAST 5 YEARS, PLEASE ATTACH THE SUPPLEMENTAL CLAIMS FORM PROVIDED.

IF NONE, PLEASE CHECK HERE. _____ NONE

- 31. PLEASE ATTACH COPIES OF MARKETING BROCHURES.
- 32. PLEASE ATTACH COPIES OF MOST RECENT AUDITED FINANCIAL STATEMENTS.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION DOES NOT BIND THE APPLICANT TO BUY, OR THE COMPANY TO ISSUE THE INSURANCE, BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND MADE A PART OF THE POLICY. THE UNDERSIGNED APPLICANT DECLARES THAT THE STATEMENTS SET FORTH IN THIS APPLICATION ARE TRUE. THE APPLICANT FURTHER DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE TIME WHEN THE POLICY IS ISSUED, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

NOTICE: IN NEW YORK AND OHIO, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

PRODUCER: _____ ADDRESS: _____ _____	APPLICANT'S SIGNATURE: _____ TITLE: _____ DATE: _____
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IF A POLICY IS ISSUED THE APPLICATION IS ATTACHED TO AND MADE A PART OF THE POLICY SO IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED IN DETAIL.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW WHERE INDICATED. IF A POLICY IS ISSUED, THIS SIGNED STATEMENT WILL BE ATTACHED TO THE POLICY.

THE INSURED HEREBY ACKNOWLEDGES THAT HE IS AWARE THAT THE LIMIT OF LIABILITY CONTAINED IN THIS POLICY SHALL BE REDUCED, AND MAY BE COMPLETELY EXHAUSTED, BY THE COSTS OF LEGAL DEFENSE AND, IN SUCH EVENT, THE INSURER SHALL NOT BE LIABLE FOR THE COSTS OF LEGAL DEFENSE OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT TO THE EXTENT THAT SUCH EXCEEDS THE LIMIT OF LIABILITY OF THIS POLICY.

THE INSURED HEREBY FURTHER ACKNOWLEDGES THAT HE IS AWARE THAT LEGAL DEFENSE COSTS THAT ARE INCURRED SHALL BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.

INSURED: _____

BY: _____

TITLE: _____

DATE: _____