EAST COAST UNDERWRITERS, LLC
THIRD PARTY CLAIMS ADMINISTRATOR QUESTIONNAIRE AND APPLICATION FOR APPROVAL

PART I – ENTITY, LOCATION, OWNERSHIP, AFFILIATION

1. Company Name _____
   Street Address _____
   City_____ State _____ Zip _____

2. Location of Sub-Offices and Telephones:
   _____ Phone: _____
   _____ Phone: _____
   _____ Phone: _____

3. Is your firm owned by or affiliated with any other organization(s) involved, directly or indirectly, in any area or aspect of insurance or reinsurance? ☐ Yes ☐ No. If so, please indicate name, relationship of business _____

4. How long has your organization been operating as claim payor?
   _____

5. Principal Officers:
   (A) List Top Three Executives:

Name	Title	Length in Service
_____	_____	_____
_____	_____	_____
_____	_____	_____

   (B) Person to Contact for:
   Company Relations: _____
   Premium: _____
   Claims: _____
   Administration: _____

6. Are you a member of any professional society? ☐ Yes ☐ No.
   If Yes, please specify: _____

7. Bank Reference:

_____	_____	_____
Bank	*Contact/Title*	*Phone*

8. How is new business developed? ☐ Brokers ☐ Salaried Reps ☐ Principals

9. Are any substantial changes in your organization projected in the foreseeable future?
☐ Yes ☐ No. If Yes, please explain: _____
_____

10. Has the company (TPA) or its principals ever been adjudged bankrupt? ☐ Yes ☐ No. If Yes, please explain: _____

PART II – CARRIERS/INSURERS

11. List Excess Insurers (Stop-Loss Carriers) who have granted your firm their authorization to administer claims for their self-funded policyholders: (Attach supplemental sheet if additional space is needed):

Carrier	% Inforce Stop-Loss Policies	Contact	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Has any carrier withdrawn their claims-paying authority or TPA approval ☐ Yes ☐ No.
If yes, please provide details. _____
_____

13. Approximate number of stop-loss quotations you expect to request during the next twelve months _____. What percent do you expect to close? _____%.

14. Are all stop-loss markets used in every situation? ☐ Yes ☐ No.

PART III – ADMINISTRATIVE SERVICES

15. May clients have system access in their offices? ☐ Yes ☐ No. If Yes, which administrative functions can the client perform? _____

16. Can you provide census and premium funding data electronically? ☐ Yes ☐ No.

17. System(s) Security and Audit Procedures:
    (A) Describe security for master file (i.e., who can enter new groups, changes). Who can add, delete, and change Plan Participants and their benefits?
    _____
    (B) Describe security for client funds
    _____
    (C) Describe record retention program for enrollment cards, billing files, etc.
    _____
    (D) Describe back-up system in the event that the computer master file is destroyed.
    _____

18. Have you ever been involved in an audit by the Department of Labor (DOL)? ☐ Yes ☐ No. If Yes, please explain: _____

19. Are separate bank accounts maintained for each client? ☐ Yes ☐ No.
    (A) What is included in each account? _____
    (B) Who has disbursement authority? _____
    (C) Is there a trust establishment for Funded Plans? _____
    (D) Describe a "Typical" client funds transaction through your office _____
    _____

20. What is your philosophy in serving a client's interest if the client asks you to accelerate claim payments in the last quarter, month of the plan year-end?
    _____

21. Do you perform bank account reconciliation's on Client Accounts? ☐ Yes ☐ No.
    If No, why not? _____

22. How often do you generate premium billings for insurance coverage? _____ On what days? _____

23. When are premium reminder notices sent? _____

24. For non-payment of excess/stop loss premiums, when are lapse notices sent? _____

25. On what date(s) are premium payments run for insurers and excess insurers? _____

26. What procedures do you have in place to detect and enforce reimbursement for subrogation, COB or workers' compensation? _____

27. What procedures do you have in place for identifying and reporting potentially large claims (exceeding 50% of spec deductible)? _____

28. Do you remit premiums to carrier on behalf of clients? ☐ Yes ☐ No. If yes, do you remit gross or net of commissions? ☐ Gross ☐ Net.

PART IV – CLAIMS ADMINISTRATION

29. How many trained claims examiners (excluding supervisor) are employed? _____
    How many other personnel? _____

30. What qualifications (including experience) have been established as minimum standards for your claims examiners? _____

31. Are there specified dollar limits at which supervisory personnel become automatically involved in any given claim situation? _____

32. Are all claims examiners, supervisors, draft typists, and claims clerks bonded? ☐ Yes ☐ No.
    If yes, state limits _____ Insurance Co. _____
    Policy # _____ Term _____

33. What claims system do you use? How are benefits calculated?
    ☐ Manual ☐ Automated
    ☐ System computes the claim
    ☐ System accepts manually calculated data

34. What is your process for auto adjudication?
    _____
    _____
    _____

35. Are records maintained which would allow retrieval of the following information:
    (A) Date Medical Expense was incurred by Claimant ☐ Yes ☐ No.
    (B) Date Medical Expense was Paid by Fund ☐ Yes ☐ No.
    (C) Enrollment, Eligibility, & Employment Dates ☐ Yes ☐ No.
    (D) Liability Determination (i.e. COB; Wo. Comp.) ☐ Yes ☐ No.

36. Is eligibility determined on-line? ☐ Yes ☐ No.

37. Can you provide claims data electronically? ☐ Yes ☐ No.

38. What is your payment accuracy objective? *(check one)*
    ☐ Statistical: Number of claims paid
    ☐ Financial: Dollar amount paid without error

39. What is your payment accuracy performance during the last twelve months? _____

40. What is your average turnaround time from date of receipt to date of payment on a clean claim submission? _____

41. What is your basis for determining R&C? *(check one)*
☐ Surgical
☐ Medical

42. Is your R & C database on-line? ☐ Yes ☐ No. How often is R & C data updated? _____

43. Are the ICD-10 and CPT codes captured? ☐ Yes ☐ No.

44. Do you subcontract any data processing activities? ☐ Yes ☐ No. If Yes, please specify:
_____

45. What is your level of service provided for COBRA, HIPAA, and Flex Plans, Cafeteria Plans and/or Section 125 Plans administration? _____

PART V – MANAGED CARE

46. Please list the companies you use for Medical Case Management services.
_____

47. Is there a direct linkage between the UR/Pre-Cert process and case management?
☐ Yes ☐ No. If Yes, please explain:_____

48. Please list the PPOs you use for the majority of your cases. _____
_____

49. When there isn't a PPO in place, do you reprice hospital bills? ☐ Yes ☐ No. If yes, what vendors do you use and at what claim level? _____

50. Describe any other claim cost management providers and processes you may use; e.g. demand management, hospital bill audits, subrogation, fee negotiation, service, etc.
_____

51. Describe your procedures for auditing and/or negotiating provider bills: _____
_____

PART VI – COMPLIANCE, LEGAL, LICENSE

52. Have any legal actions been brought against your firm or any of the principals during the past three years? ☐ Yes ☐ No. If Yes, please attach details.

53. Are there any pending law suits or Insurance Dept. complaints, and/or were there any during the last Year? ☐ Yes ☐ No. If Yes, please attach details regarding nature of action and status.

54. Enclose a copy Fiduciary and/or E & O Insurance? ☐ Yes ☐ No. If Yes, please provide:
    Name of Carrier: _____
    Policy Number: _____
    Limit of Liability: _____
    Term: _____

55. Are you audited annually by an outside firm? ☐ Yes ☐ No. If Yes, please state name and address:
    _____

56. Are you in a state that requires Administrators to be licensed? ☐ Yes ☐ No. If Yes, please provide a copy of your license and your current State A & H License(s) for either your firm or any individuals, if the state requires same.

57. Please attach the following to this completed questionnaire:
    (☐) Brief resume on executives
    (☐) Brief resume on claims supervisor and senior claims staff
    (☐) Sample of plan document format currently used
    (☐) Copy of promotional material currently used
    (☐) Sample of claim and management reports provided to clients
    (☐) Copy of administrator license if required
    (☐) Details of law suits or Insurance Department complaints, if applicable
    (☐) Copy of your latest financial report

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 THIS QUESTIONNAIRE.

Date _____ Signed _____

Title _____