

THIRD PARTY ADMINISTRATOR QUESTIONNAIRE

PART I - ENTITY, LOCATION, OWNERSHIP, AFFILIATION

1. Name of Entity: _____

2. Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

3. T.I.N. #: _____

Type of Business: Corporation Partnership Sole Proprietor Sub-Chapter Corp.

4. List of Officers: (Attach additional list if necessary. Submit resumes of Officers, Directors and Owners).

President: _____ Secretary: _____

Vice Pres: _____ Treasurer: _____

5. Please list other companies with whom you have financial interest (i.e., Insurance companies, PPOs, HMOs, MGUs, Brokerage operations, etc.).

6. In the last five years, has your business entity ever been involved in a merger?

YES NO If yes, please describe: _____

7. In the last five years, has your business entity ever had a change in ownership?

YES NO If yes, please describe:

8. Has your business entity had a change of name, and/or used a d.b.a. or is it operating under an assumed name? YES NO If yes, previous name was: _____

9. Branch Offices:

NAME OF CONTACT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

NAME OF CONTACT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

10. How do you produce business (clients): (check all that apply)

TPA Staff Direct Independent Brokers/Agents

Other, describe: _____

11. If you use independent brokers/agents to produce business, is their compensation for service paid by:

Client Directly TPA Other, describe: _____

12. If you compensate brokers/agents or other service providers for business development, do you disclose to client the amount of compensation paid? YES NO

13. When do you disclose fees, compensation, etc. to client (check all that apply)

In initial proposal In service agreement At time of 5500 filing

Other, explain: _____

PART II - SYSTEMS - ADMINISTRATION AND CLAIMS (HARDWARE AND SOFTWARE)

	<u>Administration</u>	<u>Claims</u>
1. Is system on-line or manual?	_____	_____
2. Name of software system.	_____	_____
3. Who developed?	_____	_____
4. Year of development.	_____	_____
5. Is software leased, time shared or owned?	_____	_____
6. If owned, year purchased.	_____	_____
7. Name of hardware.	_____	_____
8. Is hardware leased, time shared or owned?	_____	_____
9. Have you changed/upgraded systems within 12 months?	_____	_____
If Yes, please describe:		

A. Administration: _____
 B. Claims: _____

PART III - ADMINISTRATIVE SERVICES (FINANCIAL, ELIGIBILITY AND PREMIUM ACCOUNTING)

1. Staff: Total number of employees in department: _____

Name/Job Title of Key Personnel and Managers	Yrs. Experience	Yrs. w/Current Employer
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If necessary, list additional names on a separate page and attach. Please attach resumes.

2. May clients have system access in their offices? YES NO
 If Yes, which administrative functions can the client perform? _____

3. Can you provide census and premium funding data electronically? YES NO

4. System(s) Security and Audit Procedures:

A. Describe security for master file (i.e., who can enter new groups, changes).

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 file is destroyed.

5. Does your system calculate individual or group premium for fully insured plans, or calculate levels of funding for self-funded plans? YES NO

Or are they manually calculated and entered in the master file? YES NO

6. Describe procedures for adding, deleting and changing Plan Participants and their benefits:

7. 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?

8. Do you perform bank account reconciliations on Client Accounts? YES NO
If no, why not? _____

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

10. When are premium reminder notices sent? _____

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

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

NOTES/COMMENTS: _____

11. Describe the payment authority limitation for the claims staff and describe the criteria for internal audits:

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

13. What is your turnaround objective? _____

14. What is your average turnaround time over the last twelve months? _____

15. Surgical R&C is based upon: (check primary source)
 HIAA Med-Index MDR
 Internal Other

If other, please describe:

Surgical: _____
Medical: _____
Dental: _____

16. Is your R&C database on-line? YES NO

17. How often is R&C data updated? _____

18. Are ICD-9 codes captured? YES NO

19. Are CPT codes captured: YES NO

20. For what period of time are hard copy claim files retained? _____

21. 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 established for Funded Plans? YES NO
d) Do you utilize "sweep" accounts for any clients? YES NO

Describe a "Typical" client funds transactions through your office: _____

22. Do you subcontract any data processing activities? YES NO

If Yes, please specify: _____

23. Do you utilize off-site or home claim processors? YES NO
 If Yes, please specify: _____

24. Describe your procedures for professional Medical and Dental claims review: _____

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

26. Describe your procedures for using Large Case Management (LCM): _____

27. Describe the Managed Care Procedures you are using:

PART V - CARRIERS (INSURERS)

1. Please list the excess/stop loss insurers (carriers) with which you have business:
 Carrier Name # of Cases # of Lives Estimated Annual Premium \$\$
- | Carrier Name | # of Cases | # of Lives | Estimated Annual Premium \$\$ |
|--------------|------------|------------|-------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
2. Has any carrier terminated their relationship with you in the last 5 years? YES NO
 If Yes, who and why: _____

PART VI - COMPLIANCE/LEGAL/LICENSE

1. Describe any previous or pending material lawsuits in the last 10 years: _____

2. Have any of the principals in your firm or any of your employees (former or current) ever been indicated or convinced of mishandling/misappropriating any insurance company or client funds? YES NO
 If Yes, please give details: _____

3. Describe your current procedures for handling client or insured complaints and State Insurance Department complaints: _____

4. Has the company (TPA) or its principals ever been adjudged bankrupt? YES NO
If Yes, please explain: _____

5. Have you been involved in an audit by the Department of Labor (DOL)? YES NO
If Yes, please give details: _____

6. If your operating jurisdiction(s) require licensing, are you licensed as a(n):

List States/License Number
 Third Party Administrator _____
 Managing General Agent _____
 Agent _____
 Broker _____
 Other, define: _____

Please provide a copy of current license(s) listed above.

7. How are you kept informed of changing legal requirements within your market area?

How do you inform your clients of these changes? _____

8. What membership(s) do you hold in professional and trade associations? (check all that apply)
 SIIA SPBA RIMS IFEBP HIRA NALU NAHU
 Other (please list) _____

PART VII - INSURANCE/BONDING

1. Do you carry an Errors & Omissions Policy? YES NO
If Yes, who is the carrier? _____
What is the expiration date of the policy? _____
What are the limits of coverage for the policy? _____
What is the deductible? _____
Is contract a claims made policy? YES NO

2. Do you carry a Comprehensive General Liability Policy? YES NO
If Yes, who is the carrier? _____
What is the expiration date of the policy? _____
What are the limits of coverage for the policy? _____
What is the deductible? _____

3. Do you carry a Professional Liability Policy for UR (Utilization Review) and/or other services?
 YES NO
If Yes, who is the carrier? _____

What is the expiration date of the policy? _____

What are the limits of coverage for the policy? _____

What is the deductible? _____

4. Do you carry a Fidelity Bond? YES NO

If Yes, who is the carrier? _____

What is the expiration date of the policy? _____

What are the limits of coverage for the policy? _____

What is the deductible? _____

What is the total annual aggregate funds handled for all clients? _____

5. Do you require employee bonding? YES NO

If Yes, which employees? _____

6. Have claims been made against any of these policies in the past two years? YES NO

If Yes, please provide details: _____

PART VIII - FINANCIAL

1. May we conduct an initial and ongoing financial review of your organization and/or principals using an independent agency, such as Equifax or Dun & Bradstreet?

YES NO If No, why not? _____

2. Principal Banking relationship (to be used as a reference):

Name of Bank: _____

Address: _____

Telephone: _____

Contact: _____ Contact Title: _____

PART IX - ATTACHMENTS

1. Please use this checklist and provide the following attachments. If any of these items cannot be provided, please explain: _____

- Resumes of Officers, Directors, Owners and Key Personnel
- Copy of each: Errors & Omissions Policy, Professional Liability Policy, and/or Bond now in effect.
- If applicable, Last Two Fiscal Year Income Statements and Balance Sheets
- Copy of TPA, MGU, Agency, Broker and Agent License for each applicable state
- Marketing Proposal
- Marketing Brochure
- Sales Literature on PPO and Managed Care
- Service Agreement (sample of standard agreement used)
- Premium Account Flowchart/Description
- Claim Account Flowchart/Description
- Sample Billing
- Disclosure Form (P.T.E. 77-9)
- Evidence of Good Health Form
- Samples of Administrative Services Reports available to insurers and/or reinsurers
- Samples of Claims Reports available to insurers and/or reinsurers
- Sample Plan Document

I certify that the information on this application is accurate to the best of my knowledge and belief. I also understand that a routine inquiry may be made of any or all of the individuals and firms noted herein as references.

Signature: _____ Date: _____

Print Name: _____ Title: _____