

**NOTE:** If this 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. Amounts incurred for legal defense shall be applied against the deductible amount.

1. Applicant name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Website URL: \_\_\_\_\_
2. Corporate structure:  Individual  Partnership  LLC  Corporation: Federal ID# \_\_\_\_\_
3. Year established: \_\_\_\_\_
4. 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, provide details:**
  
5. Are any services of the applicant provided to such organizations described in question 4 above?  Yes  No  
**If yes, provide details:**
  
6. Number of employed:  
Accountants: \_\_\_\_\_ Data processing personnel: \_\_\_\_\_  
Actuaries: \_\_\_\_\_ Insurance agents/brokers: \_\_\_\_\_  
Claims administration personnel: \_\_\_\_\_ Other: \_\_\_\_\_
7. Limit of liability desired:  \$500,000  \$1,000,000  \$2,000,000
8. Deductible desired:  \$5,000  \$10,000  \$25,000  \$50,000  \$100,000

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9. Approximate percentage of total business and corresponding revenues for each of the following operations:

Operation	Percentage	Revenues
Providing Actuarial Services	_____ %	\$ _____
<b>Administration of Health and Welfare Plans</b>		
Single Employer Plans	_____ %	\$ _____
<b>Multi-Employer Benefit Plans</b>		
Taft-Hartley Trusts	_____ %	\$ _____
Multiple Employer Welfare Arrangements (MEWAS)	_____ %	\$ _____
Multiple Employer Trusts (METS)	_____ %	\$ _____
Administration of Pension Plans	_____ %	\$ _____
<b>Computer Services</b>		
Electronic Data Processing	_____ %	\$ _____
Electronic Data Consulting	_____ %	\$ _____
Software Design, Development or Customization (coverage is not provided for software design, development or customization)	_____ %	\$ _____
<b>Employee Assistance Plans (EAP)</b>		
Administrator	_____ %	\$ _____
Provider	_____ %	\$ _____
Providing Utilization Review Services	_____ %	\$ _____
<b>Insurance Related Services</b>		
Acting as an Insurance Agent or Broker	_____ %	\$ _____
Acting as an Advisor/Consultant	_____ %	\$ _____
Premium Collection and Billing	_____ %	\$ _____
Hold 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	_____ %	\$ _____
<b>Other Services</b>		
Providing premium collection and billing services	_____ %	\$ _____
Benefit Enrollment Services	_____ %	\$ _____
Cost Containment Services	_____ %	\$ _____
Other (describe):	_____ %	\$ _____
<b>TOTAL (MUST EQUAL 100%)</b>	<b>100 %</b>	<b>\$ _____</b>



10. Is the applicant engaged in any business or profession other than as that described in question 9?  Yes  No

If yes, explain:

11. List the total gross receipts for the past three years derived from the activities in question 9.

Year	Amount
a. Next Year Projected	\$ _____
b. Current	\$ _____
c. _____	\$ _____
d. _____	\$ _____

12. Number of plan sponsors: \_\_\_\_\_

Number of participants for plans administered by the applicant: \_\_\_\_\_

Total annual contributions to the plans administered by the applicant: \$ \_\_\_\_\_

Total annual benefit payments issued in the administration of all such plans: \$ \_\_\_\_\_

Number of plan sponsors added in the past year: \_\_\_\_\_

Number of plan sponsors deleted in the past year: \_\_\_\_\_

Percentage of plans self funded with stop loss: \_\_\_\_\_ %

Percentage of plans self funded with no stop loss: \_\_\_\_\_ %

Percentage of plans fully insured: \_\_\_\_\_ %

List carriers that stop loss coverage is placed with:

13. Does the Applicant, or its Partners, Directors, Officers or Employees, act as Trustee for any clients or non-clients?  Yes  No

If yes, explain in detail:

14. Name and address of law firm(s) acting as counsel to the Applicant and nature of services provided:

15. Name and address of accounting firm(s) providing services to the Applicant and nature of services provided:

16. Does the Applicant administer any self-funded Multiple-Employer Trusts (METs) or Multiple-Employer Welfare Arrangements (MEWAS)?

Yes  No

If yes, provide details:

17. Does the Applicant firm belong to professional association(s)?  Yes  No

If yes, list:



18. List all Partners, Principals and Key Employees:

Full Name	Professional Qualifications	Date Qualified	Years in Practice	How Long in Role

19. Does the applicant have Professional Liability Errors and Omissions Insurance in force?  Yes  No

If yes, complete the following:

Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_  
Limit of Liability: \_\_\_\_\_ Deductible: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

20. Does the applicant have a fidelity bond?  Yes  No

If yes, complete the following:

Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_  
Limit of Liability: \_\_\_\_\_ Deductible: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

21. Does the applicant have ERISA Fiduciary Liability Coverage?  Yes  No

If yes, complete the following:

Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_  
Limit of Liability: \_\_\_\_\_ Deductible: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

22. Describe how your firm screens and qualifies plan sponsors:

23. How does the firm comply with individual plan administration guidelines?

24. a. What percentage of inquiries are referred to a physician? \_\_\_\_\_ %

b. What percentage of claims are denied? \_\_\_\_\_ %

c. What percentage of denials are appealed? \_\_\_\_\_ %

25. How do you determine denial of benefits?

26. How are claimants informed of denial of benefits?

27. What is the appeal process for the denial of claims?



- 28. What is the average error rate for your claims handlers? \_\_\_\_\_ %
- 29. Does the applicant firm use a written contract with clients?  Always  Sometimes  Never
- 30. List the Applicant's five largest clients during the past three (3) years, including: a) the client's Name; b) nature of service(s) provided (type of plan administered; c) number of lives; and d) revenues from those services:

31. What percentage of the applicant firm's business involves subcontracting of work to others? \_\_\_\_\_ %  
What type of work? \_\_\_\_\_

32. a. Which of the following are functions of your firm's Electronic Data Processing system?
- |   |  |
|---|--|
| <input type="checkbox"/> Calculation of co-payments           | <input type="checkbox"/> Independent Stop Loss Information Off                           |
| <input type="checkbox"/> Calculation of Deductibles           | <input type="checkbox"/> Monthly Aggregate reports by case (claim or aggregate specific) |
| <input type="checkbox"/> Claim Eligibility                    | <input type="checkbox"/> Summaries by Policy Year  |
| <input type="checkbox"/> Confidentiality Safeguards           | <input type="checkbox"/> Telephone Tracking Systems                                      |
| <input type="checkbox"/> Enrollment Information               | <input type="checkbox"/> Number of Callbacks Due to System Failure                       |
| <input type="checkbox"/> Monitoring of Duplicate Claims       | <input type="checkbox"/> Total Number of Calls Received                                  |
| <input type="checkbox"/> Managing Reports                     | <input type="checkbox"/> Turn Around Time  |
| <input type="checkbox"/> Appeal Tracking                      | <input type="checkbox"/> Time Service  |
| <input type="checkbox"/> Adjustors accuracy                   | <input type="checkbox"/> Types of Losses   |
| <input type="checkbox"/> Check Registers (weekly and monthly) | <input type="checkbox"/> Cost Containment and Expense control                            |
| <input type="checkbox"/> Details on Large Claims              | <input type="checkbox"/> Audit Results   |
| <input type="checkbox"/> Detailed Payment Registers/Analysis  | <input type="checkbox"/> Productivity Reports  |

- b. Does your system contain check and balances to guard against the following:
- |  |  |
|--|--|
| <input type="checkbox"/> Overpayment             | <input type="checkbox"/> Payments of noncovered expenses                     |
| <input type="checkbox"/> Underpayment            | <input type="checkbox"/> Improper refusal of benefits                        |
| <input type="checkbox"/> Late Payments           | <input type="checkbox"/> Unfair/unjust enrichments                           |
| <input type="checkbox"/> Payments to wrong party | <input type="checkbox"/> Failure to follow payment guidelines and procedures |
| <input type="checkbox"/> Payments to wrong fund  |  |

33. How often does your organization do an internal audit? \_\_\_\_\_

34. What situations are the audit guidelines designed to reveal? \_\_\_\_\_

35. Has the applicant firm or any of the individuals listed in question 18 ever been the subject of disciplinary action by authorities as a result of any professional activities?  Yes  No

**If yes, explain:**

36. Does the 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, 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.

37. For any and all claims made against any proposed insured during the past 5 years, **complete and attach the supplemental claims form.**

**If no claims, check here:**



38. Please attach the following information to the application:

- Resumes of key personnel
- Marketing brochures
- Most recent audited financial statements

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 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 SOME STATES, 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. IN NEW YORK, A PERSON WHO COMMITS SUCH CRIME SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

\_\_\_\_\_  
Authorized signature

\_\_\_\_\_  
Date

Typed or printed name: \_\_\_\_\_

Title: \_\_\_\_\_

Producer: \_\_\_\_\_

Address: \_\_\_\_\_

IF A POLICY IS ISSUED, THIS APPLICATION IS ATTACHED TO AND MADE A PART OF THE POLICY, SO IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED IN DETAIL.