

Third Party Administrators Professional Liability Application

1. Contact Information

Name of Applicant: _____

Street Address: _____

City, State, ZIP: _____

Telephone Number: _____ Fax Number: _____

2. Applicant is (please check one):

Individual Partnership Corporation Individual LLC

3. Year Established: _____

4. Please List Addresses of All Branch Offices (attach a separate sheet if necessary):

5. Is the applicant controlled by, owned by, or associated with any organization, or does the applicant own or control any other corporation or company? Yes No

6. In the past five (5) years, has the name of the applicant been changed or has any other business been purchased, merged, or consolidated with the applicant? Yes No

7. Number of Employees: Full-time: _____ Part-time: _____

7a. Name of All Partners/ Principals/Key Employees	Professional Qualifications	Date Qualified	How Long in Practice	How Long as Partner
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7b. Number of Employed:

Accountants: _____

Actuaries: _____

Claims Administration Personnel: _____

Data Processing Personnel: _____

Insurance Agents/Brokers: _____

Other; Describe: _____

Applicant Operations:

8. Please provide the approximate percentage of total business and corresponding revenues for each of the following operations:

Operations	Percentage	Revenues
Providing Actuarial Services:	% _____	\$ _____
Administration of Health & Welfare Plans		
Single Employer Plans:	% _____	\$ _____
Multi-Employer Benefit Plans		
(Taft-Hartley Trusts):	% _____	\$ _____
Multiple Employer Welfare Arrangement (MEWAS):	% _____	\$ _____
Multiple Employer Trusts (METS):	% _____	\$ _____
Administration of Pension Plans:	% _____	\$ _____
Computer Services		
Electronic Data Processing:	% _____	\$ _____
Electronic Data Consulting:	% _____	\$ _____
Software Design, Development, or Customization (coverage is not provided for software design, development, and customization):	% _____	\$ _____
Employee Assistance Plans (EAP)		
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 Underwriting Authority/Policy Issuance:	% _____	\$ _____
Other Services		
Providing Premium Collection and Billing Services:	% _____	\$ _____
Benefit Enrollment Services:	% _____	\$ _____
Cost Containment Services:	% _____	\$ _____
Other:	% _____	\$ _____
Total (must equal 100%)	100%	\$ _____

9. Is the applicant engaged in any business or profession other than as described in question 8? Yes No

If yes, please provide details: _____

10. List the total gross receipts for the past two years. In addition, please list projected receipts for the current year.

Receipts estimated for the upcoming year: _____

Past Year: _____

Past Two Years: _____

11. Number of plans administered: _____

Number of accounts: _____

Number of participants in plans administered: _____

12. Please describe procedures utilized to ensure that plans administered comply with ERISA: _____

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

14. Are actuarial certifications reviewed by a member of the Society of Actuaries or American Academy of Actuaries? Yes No

15. Do you place stop-loss? Yes No

16. Does the applicant firm, its partners, directors, officers, or employees act as a trustee for any clients or non clients? Yes No

If yes, please explain in detail: _____

17. Does your firm administer any self-funded Multiple-Employer Trusts (METS) or Multiple-Employer Welfare Arrangements (MEWAS)? Yes No

If yes, please provide details: _____

18. Describe how your firm screens and qualifies plan sponsors: _____

19. Total dollar amount of claims paid last year: \$ _____ Claim draft limit: \$ _____

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

21. How do you determine denial of benefits? _____

22. How are claimants informed of denial of benefits? _____

23. What is the appeal process for the denial of claims? _____

24. Does the applicant firm use a written contract with clients? Always Sometimes Never
(Please attach a copy of contracts)

25. Please provide the applicant's five largest clients during the past three years:

Client's Name	Nature of Service(s) Provided	Revenue From Those Services

26. What percentage of the applicant firm's business involves subcontracting of work to others? _____%
What type of work? _____

27. How often does the applicant do an internal audit? _____

28. Have any clients canceled or refused to renew any contracts with you in the past five (5) years? Yes No
If yes, please attach details.

29. Has the applicant firm or any of the individuals listed in question 7a & 7b ever been subject of disciplinary action by authorities as a result of any professional activities? Yes No
If yes, please provide details: _____

30. Does the applicant belong to professional association(s)? Yes No

31. Do you currently have Errors & Omissions Insurance? Yes No
If yes, please provide information for the last three years:

Policy Period	Insurance Company	Limits of Liability	Deductible	Premium

If "Retroactive Date" prior to policy inception is requested, please advise date: _____
Please attach a copy of the expiring Declaration Page showing the retroactive date.




32. Limits of Liability Desired:
 \$100,000 \$300,000 \$500,000 \$500,000/\$1M \$1,000,000
 Deductible Desired:
 \$2,500 \$5,000 \$7,500 \$10,000 Other: _____

33. In the past five (5) years, has any claim been made against the Insured or any of their past or present owners, officers, partners, directors, or employees? Yes No

34. Is any person to be insured aware of any incident or circumstance which may result in a claim being made against the Insured or any past or present owners, partners, officers, directors, employees, or predecessors in business? Yes No
If yes, please complete the attached Claim Supplement information sheet for each incident or circumstance.

It is agreed, with respect to questions 32 and 33 above, that if such knowledge or information exists, any claim or action arising there from is excluded from the proposed coverage.

Please attach the following information to the application:

-  Résumés of Key Personnel
-  Marketing Brochures
-  Most Recent Audited Financial Statements

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be signed by the applicant. Signing this form does NOT bind the Company to complete the insurance.

Producer: _____ Insured: _____
Address: _____ By: _____
Title: _____
Date: _____