

**EMPLOYEE BENEFITS THIRD PARTY ADMINISTRATOR QUESTIONNAIRE**

*Information provided on this form is to be held in strict confidence by the recipient.*

**PART I - Entity, Location, Ownership, Affiliation:**

1. Name of Entity \_\_\_\_\_

2. Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing Address, if different \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name of Contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address: \_\_\_\_\_

3. T.I.N. # \_\_\_\_\_

Type of Business:  Corporation  Partnership  Sole Proprietor  Sub-Chapter S 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 had a change in ownership or been involved in a merger?  YES  NO

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

7. Has your business entity had a change of name, and/or used a d.b.a. or is it operating under more than one name?  YES  NO

If yes, previous name was: \_\_\_\_\_

\_\_\_\_\_

8. Branch Offices or Subsidiaries:

Name of Entity \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name of Contact \_\_\_\_\_ E-mail address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Name of Entity \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name of Contact \_\_\_\_\_ E-mail address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

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

- TPA Staff Direct
- Independent Brokers/Agents
- Other, define \_\_\_\_\_

10. Company Profile

- Geographic Area Served: \_\_\_\_\_
- Number of Corporate Clients: \_\_\_\_\_
- Number of Taft Hartley Trust Clients: \_\_\_\_\_
- Number of Association Clients: \_\_\_\_\_
- Number of New Clients Added in Past Year: \_\_\_\_\_
- Number of Clients Lost in Past Year: \_\_\_\_\_

Types of Clients for which you provide Administrative Services:

	Number of Cases	Number of Covered Employees
A: Fully Insured Cases:	_____	_____
B: Partially Self Funded Cases:	_____	_____
C: Self Funded Cases:	_____	_____

Client Size (Self Funded Cases Only)

	Number of Cases
A: Less than 100 Employees	_____
B: 100 to 200 Employees	_____
C: 200 to 400 Employees	_____
D: 400 to 1000 Employees	_____
E: 1000 to 5000 Employees	_____
F: Over 5000 Employees	_____

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 online or manual?		
2. Name of software system		
3. Who developed?		
4. Year of development or last update		
5. Is software leased, timeshared, or owned		
6. If owned, year purchased		
7. Name of hardware		
8. Is hardware leased, timeshared or owned		
9. Have you changed or upgraded systems in the past 12 months? Do you have plans to do so in the next 6 months?		
Administration:		
Claims:		
10. Will your system produce the following reports? <ul style="list-style-type: none"> <li>• Aggregate month by month report with census and specific excess claims? Yes/No</li> <li>• Specific Excess report with ICD-9 codes or diagnosis? Yes/No</li> <li>• Individual claim detail paid report to include CPT codes? Yes/No</li> <li>• Detail report of all claims paid outside the aggregate coverage? Yes/No</li> <li>• Claim analysis by line of coverage? Yes/No</li> </ul>		

<ul style="list-style-type: none"> <li>• Claim LAG study and/or turnaround time? Yes/No</li> <li>• Daily check register? Yes/No</li> <li>• Monthly check register? Yes/No</li> <li>• Hospital utilization analysis? Yes/No</li> <li>• Provider charge profile? Yes/No</li> <li>• Diagnostic related profile? Yes/No</li> <li>• Pending file listing? Yes/No</li> </ul> <p><b>For any "No" answer please explain the reports used to provide this data.</b></p>		
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**PART III - Administrative Services (Financial, Eligibility, and Premium Accounting)**

1. Staff: Total number of employees in administrative services, including financial, eligibility, and premium accounting staff \_\_\_\_\_

Name/Job Title of Key Personnel and Managers	Years <u>Experience</u>	Years with <u>Current Employer</u>
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**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? What audit control procedures are in place to assure accuracy? \_\_\_\_\_

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. Has the system been audited by a third party for security control and accuracy?  
\_\_\_\_\_

C. Describe security for client funds.  
\_\_\_\_\_

D. Describe record retention program for enrollment cards, billing files, etc.

\_\_\_\_\_

E. Describe back-up system or disaster recovery process in the event that the computer master 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 are your procedures in the event of insufficient funds?

\_\_\_\_\_  
\_\_\_\_\_

8. 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?

\_\_\_\_\_  
\_\_\_\_\_

9. Do you perform bank account reconciliations on Client Accounts?  YES  NO  
If no, why not? \_\_\_\_\_

10. How often do you generate premium billings for insurance coverage? \_\_\_\_\_  
On what days? \_\_\_\_\_

11. When are premium reminder notices sent? \_\_\_\_\_

12. For non-payment of excess/stop loss premiums, when are lapse notices sent?  
\_\_\_\_\_

13. On what date(s) are premium payments run for insurers and excess insurers?  
\_\_\_\_\_  
\_\_\_\_\_

14. Do you remit premiums to carriers on behalf of clients?  YES  NO  
If yes, do you remit gross or net of commissions? \_\_\_\_\_

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

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

17. Who prepares Plan Documents for your Self Funded Clients? \_\_\_\_\_



10. What does a claim represent? (check one)

line item

check

E.O-B.

Other (define) \_\_\_\_\_

11. Based on the above definition:

Average number of claims processed per processor per hour is \_\_\_\_\_

12. What is your payment accuracy objective?

A) Statistical: Number of claims paid \_\_\_\_\_

B) Financial: Dollar amount paid without error \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. What is your payment accuracy performance during the last twelve months? \_\_\_\_\_

15. What is your turnaround objective? \_\_\_\_\_

16. What is your average turnaround time over the last twelve months? \_\_\_\_\_

17. How is backlog handled? \_\_\_\_\_

\_\_\_\_\_

18. Surgical R & C is based upon: (check primary source and indicate percentile)

HIAA \_\_\_\_\_%

ADP \_\_\_\_\_%

Ingenix (MDR) \_\_\_\_\_%

Med-Index \_\_\_\_\_%

Internal

Other \_\_\_\_\_

If other or internal, please describe:

Surgical: \_\_\_\_\_

Medical: \_\_\_\_\_

Dental: \_\_\_\_\_

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

20. How often is R & C data updated? \_\_\_\_\_

21. Are ICD-9 codes captured?  YES  NO

22. Are CPT codes captured?  YES  NO

23. How do you handle unbundling and rebundling CPT codes? \_\_\_\_\_  
\_\_\_\_\_

24. For what period of time are hard copy claims files retained? \_\_\_\_\_

25. 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

Describe a "typical" client funds transaction through your office

\_\_\_\_\_  
\_\_\_\_\_

26. Detail when claims are funded (i.e. when funds are on deposit in the claim account)? \_\_\_\_\_  
\_\_\_\_\_

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

If yes, please specify \_\_\_\_\_  
\_\_\_\_\_

28. Do you utilize off-site or home claim processors?  YES  NO

If yes, please specify \_\_\_\_\_  
\_\_\_\_\_

#### **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 (\$)
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 indicted or convicted of mishandling/misappropriating any insurance company or client funds?  YES  NO

If yes, please give details

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3. Do you object to periodic audits of your firm by our representatives?  YES  NO

4. Describe your current procedures for handling client or insured complaints and State Insurance Department complaints.

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5. Has the company (TPA) or any of its principals ever been adjudged bankrupt?  YES  NO  
If yes, please explain.

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

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7. If your operating jurisdiction(s) requires licensing, are you licensed as a(n): List States and License Number

- Third Party Administrator \_\_\_\_\_  
 Managing General Agent \_\_\_\_\_  
 Agent \_\_\_\_\_  
 Broker \_\_\_\_\_  
 Other, define \_\_\_\_\_

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

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

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How do you inform your clients of these changes?

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Who in your firm is responsible for handling compliance with various federal and state regulations?

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9. 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), LCM (Large Case Management) 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 – Managed Care**

1. Please list the PPOs you use for the majority of your cases: \_\_\_\_\_  
\_\_\_\_\_
2. When there isn't a PPO in place, do you reprice hospital bills? If yes, what vendors do you use and at what claim level? \_\_\_\_\_  
\_\_\_\_\_
3. Describe any other claim cost management providers and process you may use (e.g. demand management, hospital bill audits, subrogation, fee negotiation, service, etc.): \_\_\_\_\_  
\_\_\_\_\_
4. Describe your procedures auditing and/or negotiating provider bills:  
\_\_\_\_\_  
\_\_\_\_\_
5. What level of utilization review services are performed? \_\_\_\_\_  
\_\_\_\_\_
6. Are utilization review services performed in-house or through an outside vendor? Please list the vendor. \_\_\_\_\_
7. Describe your procedures for professional Medical and Dental claims review:  
\_\_\_\_\_  
\_\_\_\_\_
8. Is there a direct linkage between the UR/pre-cert process and case management? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. How are cases identified for possible case management? \_\_\_\_\_  
\_\_\_\_\_
10. Please list the companies you use for Medical Case Management services: \_\_\_\_\_  
\_\_\_\_\_

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

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**PART X – Attachments**

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

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- Resumes of Officers, Directors, Owners and Key Personnel
- Copy of each; Errors and Omissions Policy, Professional Liability Policy, and/or Bond now in effect (declaration pages are sufficient)
- 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
- 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
- TPA license or certificate for each applicable state in which you do business.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

**Include Notes or Additional Information Below**