



THIRD PARTY ADMINISTRATOR AND BENEFIT PLAN CONSULTANTS SUPPLEMENTAL APPLICATION

PLEASE COMPLETE THIS SUPPLEMENTAL APPLICATION FOR THE PROFESSION SHOWN IN THE TITLE ABOVE. THIS IS A SUPPLEMENTAL APPLICATION TO THE MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION FORM MEO 101 (08/08) OR MEO 102 (08/08) WHICH MUST BE COMPLETED AND ACCOMPANY THIS SUPPLEMENTAL APPLICATION. THIS SUPPLEMENTAL APPLICATION MUST BE SIGNED BY THE SAME PERSON WHO IS REQUIRED TO SIGN THE MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION.

THIS SUPPLEMENTAL APPLICATION ALONG WITH MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION FORM MEO 101 (08/08) OR MEO (08/08) ITS ATTACHMENTS AND ALL PREVIOUS APPLICATIONS SHALL SERVE AS THE BASIS FOR THE POLICY, AND SHALL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THE INSURER RELIES ON THE APPLICATION AND THIS SUPPLEMENTAL APPLICATION IN ISSUING THE POLICY. COVERAGE IS AFFORDED ONLY IF AND TO THE EXTENT INDICATED BY THE TERMS AND CONDITIONS OF THE POLICY IF ISSUED.

1. Applicant Name (SHOULD MATCH THAT GIVEN IN ANSWER TO QUESTION #1 OF THE MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION FORM MEO 101 (08/08) OR MEO 102 (08/08).

Three horizontal lines for entering the applicant name.

2. Indicate approximate percentage of all operations in which Applicant is engaged (must total 100%):

Administration of health & welfare plans \_\_\_\_\_%
Administration of pension plans \_\_\_\_\_%
Claims examination and handling - benefit plans \_\_\_\_\_%
Claims examination and handling - property/casualty insurance \_\_\_\_\_%
Actuarial services (related to administration of clients' plans) \_\_\_\_\_%
"Stand Alone" actuarial services \_\_\_\_\_%
If any, provide description: \_\_\_\_\_

Computer services related to administration of clients' plans \_\_\_\_\_%
If any, provide description: \_\_\_\_\_

"Stand Alone" computer services \_\_\_\_\_%
If any, provide description: \_\_\_\_\_

Placement of "stop- loss" or reinsurance products for a fee or commission \_\_\_\_\_%
Placement of A&H and/or life insurance products used to fund plans administered by the Applicant \_\_\_\_\_%
Utilization review/cost containment \_\_\_\_\_%
Risk management services \_\_\_\_\_%
Plan design/consulting services \_\_\_\_\_%
Loss control or engineering services \_\_\_\_\_%
Claims audit services \_\_\_\_\_%
Telemarketing services \_\_\_\_\_%
If any, provide description: \_\_\_\_\_

Workers' Compensation \_\_\_\_\_%
Litigation management services \_\_\_\_\_%
Data processing \_\_\_\_\_%
Placement of "stop-loss" or reinsurance \_\_\_\_\_%
Other\* \_\_\_\_\_%\*

Must total 100%

\*Detail: \_\_\_\_\_

3. Please give percentage of revenue derived from the following types of client insurance/benefit plans:

Property/Casualty Insurance/Risk Management	_____	%
Taft-Hartley (Union) Plans	_____	%
Multi-Employer Plans	_____	%
Single Employer Plans	_____	%
Pension and/or Profit Sharing Plans	_____	%
Multiple Employer Trusts (METs, MEWAs) *	_____	%*
Public/Government Plans	_____	%
Health and Welfare Plans	_____	%
Insurance Carriers	_____	%
Association Plans	_____	%
Corporate Plans	_____	%

\*If an entry, provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Total number of plans administered at present: \_\_\_\_\_

5. Total number of participants in all plans presently administered by the Applicant: \_\_\_\_\_

6. Total annual contributions to all plans administered by the Applicant: \$ \_\_\_\_\_

7. Total annual benefit and insurance payments issued for all plans administered by Applicant: \$ \_\_\_\_\_

8. Specify the percentage of clients' plans that are:

Fully Insured	_____	%
Split Funded (partially insured)	_____	%
Self Insured	_____	%

9. Does the Applicant, its partners, directors, officers or employees act as trustee for any clients or non-clients?  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Percentage of annual revenues derived solely from contract administration services: \_\_\_\_\_%

11. Does Applicant provide any investment advice or recommendations regarding funding mechanisms?  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. (a) Does Applicant performs utilization review or cost containment services in conjunction with administration of clients' employee benefit plans?  Yes  No

(b) If yes, has the Applicant established a separate company or corporate entity to perform such services?  Yes  No

If yes to (b), please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Describe the measures which the Applicant has instituted to ensure that various client plans are in compliance with ERISA or other applicable statutes: \_\_\_\_\_  
\_\_\_\_\_

14. To what extent are outside attorneys, accountants, actuaries and CPAs utilized in order to comply with ERISA or other applicable statutes? \_\_\_\_\_

15. Provide the name and address of law firm (s) utilized by Applicant in providing services: \_\_\_\_\_  
\_\_\_\_\_

16. Provide the name and address of accounting firm(s) utilized by Applicant in providing services: \_\_\_\_\_  
 \_\_\_\_\_
17. If actuarial services are provided, please list actuarial staff and certification level: \_\_\_\_\_  
 \_\_\_\_\_
18. Has the Applicant formed or managed any Preferred Provider or similar Managed Care Organizations?  Yes  No  
 If yes, please detail: \_\_\_\_\_  
 \_\_\_\_\_
19. Does (or has) the Applicant formed or managed any insurance captive, rent-a- captive, risk retention group or insurance pooling arrangement?  Yes  No  
 If yes, please detail: \_\_\_\_\_  
 \_\_\_\_\_
20. (a) Have "stop-loss" carryovers ever been changed?  Yes  No  
 If yes, when and why? \_\_\_\_\_  
 \_\_\_\_\_
- (b) What types of safeguards are in place in order to avoid potential claims arising out of such changes and/or disruptions in continuity? \_\_\_\_\_  
 \_\_\_\_\_
- (c) Are "stop-loss" placements ever made with carriers when there is a less than a 30 day window for turnaround and acknowledgement?  Yes  No  
 If yes, please describe what procedures are in place to ensure review and completion within such 30 day window?  
 \_\_\_\_\_  
 \_\_\_\_\_
21. Has there been any client turn-over in the past 12-24 months?  Yes  No  
 If yes, (a) the number of clients lost and (b) reason for the business relationship ending. \_\_\_\_\_  
 \_\_\_\_\_
22. Has the Applicant established procedures to ensure compliance with HIPPA?  Yes  No  
 If no, please explain. \_\_\_\_\_  
 \_\_\_\_\_
- a) Does the Applicant have a dedicated employee in charge of creating policies and monitoring procedures to ensure HIPPA compliance?  Yes  No
- b) Has the Applicant identified the permitted and required uses of Protected Health Information?  Yes  No
- c) Has the Applicant established policies to ensure proper usage and/or disclosure of Protected Health Information under HIPPA?  Yes  No
- d) Does the Applicant require that any sub-contractor utilized complies with the same HIPPA compliance procedures established by the Applicant?  Yes  No
- e) Does the Applicant have procedures in place to ensure client notification of misuse or disclosure of Protected Health Information of which the Applicant becomes aware?  Yes  No
- f) Does the Applicant have procedures in place to provide each plan participant with access to, and the ability to amend, Protected Health Information as required by HIPPA?  Yes  No

- g) Does the Applicant have procedures in place allowing for its books and records to be available for inspection by the Department of Health and Human Services for purposes of determining the plan's compliance with the HIPPA Privacy Rule?  Yes  No
- h) Has the Applicant taken steps to train/educate all employees on HIPAA exposures and compliance?  Yes  No
- i) Does the Applicant have procedures in place that will allow for the return or destruction of all Protected Health Information received from, created or obtained for administration of the plan?  Yes  No

THIS SUPPLEMENTAL APPLICATION MUST BE SIGNED AND DATED BY THE SAME PERSON REQUIRED TO SIGN AND DATE MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION FORM MEO 101 (08/08) OR MEO 102 (08/08).

SIGNED \_\_\_\_\_

DATE: \_\_\_\_\_