EMPLOYEE BENEFITS

THIRD PARTY ADMINISTRATOR

(TPA)

APPOINTMENT QUESTIONNAIRE

Endorsed as an Industry Standard Form for Assistance in the Evaluation of Third Party Administration Companies (TPAs) by Stop-loss (Excess) Insurers and Managing General Underwriters (MGUs).
To the user of the application/questionnaire:

As the self-insurance industry continues to expand, a degree of standardization is important to the level of professionalism of our industry. Over the years, a variety of forms and applications have been developed by various interest groups to assist in the evaluation of third party administrators by insurers and underwriting managers. As a result, there has been little conformity of information supplied, resulting in the use of a multiplicity of forms which has added unnecessary cost to doing business. This form, SIIA-06-01-TPA/AQ has been approved by the Self-Insurance Institute of America, Inc. (SIIA) as an acceptable industry standard form.

Please note – This questionnaire has been developed solely for the purpose of aiding the user and receiver of data to help establish a certain level of standardization for evaluation purposes. SIIA assumes no responsibility to any party regarding the completeness of questions asked, or any use of the information provided. Evaluation of who to do business with is left to the sole direction of the parties involved.

Comments and suggestions may be sent to:

SIIA
P.O. Box 1237
Simpsonville, SC 29681
EMPLOYEE BENEFITS THIRD PARTY ADMINISTRATOR APPOINTMENT QUESTIONNAIRE

Information provided on this form is to be held in confidence by the recipient.
Due to spacing constrictions, you will likely need to attach additional sheets.

PART I - Entity, Location, Ownership, Affiliation

1. Name of Entity: ________________________________________________________________

2. Street Address: ______________________________________________________________
   City: ___________________________ State: __________________________ Zip: _____________
   Mailing Address ______________________________________________________________
   City: ___________________________ State: __________________________ Zip: _____________
   Phone: __________________________ Fax: ________________________________
   Web Site: ______________________________ E-mail: ________________________________

3. T.I.N. #: __________________
   Type of Business:  ☐ Corporation  ☐ Partnership  ☐ Sole Proprietor  ☐ LLC

4. List of Officers: Attach additional list if necessary. Submit resumes of Officers, Directors and Owners
   President: __________________________ Secretary: ________________________________
   Vice Pres: __________________________ Treasurer: _____________________________
   Other Officers: ______________________________

5. Please list other companies with whom you have financial interest greater than 10% (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 greater than 10%?  ☐ Yes  ☐ No
   If yes, please describe: ________________________________________________

7. In the last five years, has your business entity ever had a change in ownership of greater than 51%?  ☐ Yes  ☐ No
8. Has your business entity had a change of name, and/or used a dba or is it operating under an assumed name?  
   □ Yes  □ No

   If yes, previous names were: ____________________________________________________________

9. Branch Offices:

   Name of Contact: _________________________________________________________________
   Address: __________________________________________________________________________
   City: ___________________ State: _______________ ZIP: _______________
   Phone: ___________________ Fax: ______________________________________
   E-mail: ________________________________________________________________

   Name of Contact: _________________________________________________________________
   Address: __________________________________________________________________________
   City: ___________________ State: _______________ ZIP: _______________
   Phone: ___________________ Fax: ______________________________________
   E-mail: ________________________________________________________________

10. How do you produce business (clients)? Check all those that apply

   □ TPA Staff Direct
   □ Independent Brokers/Agents
   □ Other, define: _________________________________________________________________

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

   □ Client?
   □ TPA?
   □ Other? Describe: ________________________________________________________________

12. If you compensate brokers/agents or other service providers for business development, how do you disclose to client the amount of compensation paid?

   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
13. When do you disclose fees, compensation, etc., to client? **Check all that apply.**
   - In the initial proposal
   - In the service agreement
   - At time of 5500 filing
   - Other, explain: ____________________________________________

14. How many years have you been in business? __________________________

15. How many clients do you have? __________________________

16. How many total employee lives are covered by your collective client base? __________

**PART II - Systems - Administration and Claims (Hardware and Software)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Administration</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is your system on-line or manual?</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>2. Version of the software system</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>3. Who developed the system?</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>4. Year it was developed?</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>5. Is your software leased, timeshared or owned?</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>6. If owned, year it was purchased.</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>7. Name of the hardware</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>8. Is the hardware leased, timeshared or owned?</td>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>9. Have you changed/upgraded systems within 12 months?</td>
<td>__________</td>
<td>______</td>
</tr>
</tbody>
</table>

If yes, please describe:

A. Administration: __________________________________________

B. Claims: __________________________________________

C. Is conversion complete? □ Yes □ No

10. Is your system EDI compliant to HIPAA standards? □ Yes □ No

11. Is your system compliant to HIPAA security standards? □ Yes □ No

12. Have you modified the standard system in any way? □ Yes □ No

If yes, please describe__________________________________________________________
PART III - Administrative Services (Financial, Eligibility, and Premium Accounting)

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

2. Name/Job Title of Key Personnel and Managers  Years Experience  Years w/Current Employer
   ___________________________________________  ________________  _________________________
   ___________________________________________  ________________  _________________________
   ___________________________________________  ________________  _________________________

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

3. May clients have system access in their offices?  □ Yes  □ No

   If yes, which administrative functions can clients perform? ________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

4. Can you provide census and premium funding data electronically?  □ Yes  □ No

5. Can you accept and send ACH financial transactions?  □ Yes  □ No

6. System(s) Security and Audit Procedures:
   A. Describe security of master file (i.e., who can enter new groups, make changes, etc.):
      __________________________________________________________________________________

   B. Describe security of client funds: __________________________________________
      __________________________________________________________________________________

   C. Describe record retention program for enrollment cards, billing files, etc.:
      ________________________________
      __________________________________________________________________________________

   D. Describe your back-up system(s) in the event that the computer master file is destroyed:
      ________________________________
      __________________________________________________________________________________

7. Does your system calculate individual or group premium for fully insured plans, or calculate levels
   of funding for self-funded plans?  □ Yes  □ No

8. How is eligibility determined for claims adjudication? ________________________________
   __________________________________________________________________________________
9. Describe procedures for adding, deleting and changing plan participants and their benefits:

____________________________________________________________________________________

____________________________________________________________________________________

10. What is your philosophy in serving a client’s interest if the client asks you to accelerate claim payments in the last quarter or month of the plan year-end?

____________________________________________________________________________________

____________________________________________________________________________________

11. Do you perform bank account reconciliation’s on client accounts? □ Yes □ No

If no, why not?

____________________________________________________________________________________

____________________________________________________________________________________

12. How often do you generate premium billings for insurance coverage?

On what days?

____________________________________________________________________________________

13. When are premium reminder notices sent?

____________________________________________________________________________________

14. For non-payment of excess/stop loss premiums, how are lapse notices sent?

____________________________________________________________________________________

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

____________________________________________________________________________________

16. Do you remit premiums to carriers on behalf of clients?

____________________________________________________________________________________

If yes, do you remit gross or net of commissions? 

____________________________________________________________________________________

18. Do you audit your administration area? □ Yes □ No

If yes, please describe

____________________________________________________________________________________

19. Do you have a disaster recovery plan? □ Yes □ No

If yes, please describe

____________________________________________________________________________________

20. Provide a list of outside vendors contracted with your TPA and the services they perform? (Attach a separate sheet)
PART IV - Claims Administration

1. Staff: Total number of employees in:

   Adjudication: __________________________________________

   Support: __________________________________________

   Managers: __________________________________________

   Name/Job Title of Key Personnel and Managers  Years Experience  Years w/Current Employer

   ____________________________________________  ________________  ________________________

   ____________________________________________  ________________  ________________________

   ____________________________________________  ________________  ________________________

   ____________________________________________  ________________  ________________________

   ____________________________________________  ________________  ________________________

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

2. How long is claim history maintained on-line? ______________________________

3. Has the department been audited by a third party for accuracy/security?  □ Yes  □ No
   If yes, how recently? Please give name of audit firm: ______________________________

   Name the type of audit performed: Check all that apply, and note date.

   □ CPA/5500 __________________________  □ CPA/Performance _________________________
   □ Carrier/MGU ________________________  □ Independent Claims Audit __________________
   □ SAS 70 – Type 2 _____________________

4. What is the percent of auto adjudication? ______________________________

   A. What percent of claims are received electronically? ______________________________

5. Based on the above definition, what is your average number of claims received daily:________

6. What is your payment accuracy objective?
   A. Procedural: Number of claims paid: ______________________________

   B. Financial: Dollar amount paid without error: ______________________________
7. What procedures do you have in place for identifying and reporting potentially large claims (exceeding 50% of the specific deductible trigger diagnosis)?

_________________________________________________________________________________

_________________________________________________________________________________

8. What procedures do you have in place to detect and enforce reimbursement for subrogation, COB or workers’ compensation?

_________________________________________________________________________________

_________________________________________________________________________________

9. What was your payment accuracy performance during the last twelve months?

_________________________________________________________________________________

_________________________________________________________________________________

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

_________________________________________________________________________________

_________________________________________________________________________________

11. What is your average turnaround time from date of receipt to date of payment on a clean claim submission?

_________________________________________________________________________________

12. What is your source for determining R&C?
   - Surgical
   - Medical
   - Dental

13. If other, please describe:
    - Surgical:
    - Medical:
    - Dental:

14. Is your R&C database on-line?  □ Yes  □ No

15. How often is R&C data updated?

_________________________________________________________________________________

16. Are the ICD-9 codes captured?  □ Yes  □ No

17. Are the CPT codes captured?  □ Yes  □ No

18. For what period of time are hard copy claims files retained?

_________________________________________________________________________________
19. 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 fund transaction through your office:

   __________________________________________________________________________
   __________________________________________________________________________

20. Do you subcontract any data processing activities?  
   [ ] Yes  [ ] No

   If yes, please specify
   __________________________________________________________________________

21. Do you utilize off-site or home claim processors?  
   [ ] Yes  [ ] No

   If yes, please explain
   __________________________________________________________________________

22. What services do you provide for COBRA administration?
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

23. What compliance services do you provide?
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

24. What other services do you provide? Please list.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

25. What percentage of claims are audited?  
   __________________________________________________________________________

   A. How often?
   __________________________________________________________________________

   B. Client specific or aggregated?
   __________________________________________________________________________
PART V - 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 processes you may use (i.e., demand management, hospital bill audits, subrogation, fee negotiation, service, etc.): __________________________

________________________________________________________________________________

________________________________________________________________________________

4. What level of utilization review services are performed? __________________________

________________________________________________________________________________

________________________________________________________________________________

5. Are utilization review services performed in-house or through an outside vendor? ________________

________________________________________________________________________________

6. Describe your procedures for professional medical and dental claims review: __________________________

________________________________________________________________________________

________________________________________________________________________________

7. Describe your procedures for auditing and/or negotiating provider bills: __________________________

________________________________________________________________________________

________________________________________________________________________________

8. Describe your procedures for using large case management (LCM): __________________________

________________________________________________________________________________

________________________________________________________________________________

9. Describe the managed care procedures you are using: __________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

10. How are cases identified for possible case management? __________________________

________________________________________________________________________________

________________________________________________________________________________
11. Please list the companies you use for Large Case Management services or describe your internal programs: ________________________________________________________________

11 a. Disease Management and Predictive Modeling Service: _______________________

12. Is there a direct linkage between the UR/pre-cert process and case management? If yes, please explain: ________________________________________________________________

PART VI – 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 $$
   ________________________________________________________________
   ________________________________________________________________

2. Has any carrier terminated their relationship with you in the last 5 years?  □ Yes  □ No
   If yes, who and why? ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

PART VII - Compliance/Legal/Licensing

1. Describe any previous or pending material lawsuits in the last seven (7) 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: ________________________________________________________________

__________________________________________________________________________________

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 ever been involved in an audit by the Department of Labor (DOL)?  
   □ Yes  □ No

If yes, please give details: ________________________________________________________________

__________________________________________________________________________________

6. If your operating jurisdiction(s) requires licensing, are you licensed as a(n):
   □ Third Party Administrator List States/License Number ________________________________
   □ Managing General Agent ________________________________
   □ Agent ________________________________
   □ 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    ☐ HCAA
☐ NALU    ☐ NAHU    ☐ LIMRA    ☐ Other (please list): ____________

PART VIII - Insurance/Bonding

1. Do you carry a TPA 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 are the total annual aggregate funds handled for all clients?

5. Do you purchase criminal liability insurance? □ Yes □ No
   If yes, on which employees?

6. Have claims been made against any of the above policies in the past two (2) years? □ Yes □ No
   If yes, please provide details.

PART IX – Financial

1. Principal banking relationship (to be used as a reference):
   Name of Bank:
   Address:
   Phone:
   Contact: Contact Title:

PART X - Attachments

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

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
☐ Bios of officers, directors, owners and key claims personnel
☐ Certificate of Insurance for Errors and Omissions Policy, Professional Liability Policy, and/or Bond now in effect (declaration pages are sufficient)
☐ Copy of TPA, MGU, agency, broker and agent license for each applicable state
☐ Marketing proposal
☐ Marketing brochure
☐ Service agreement (sample of standard agreement used)
☐ Claim account flowchart/description
☐ Samples of administrative service reports for Stop Loss reporting
☐ Samples of aggregate claims reports available to insurers and/or reinsurers
☐ Sample plan document

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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 of any or all of the individuals and firms noted herein as references.

Signature: ________________________________  Date: __________________________
Print Name: _______________________________  Title: __________________________