



National Underwriting Services, Inc.
14893 S. H. 16 North, Suite 1, Helotes, Texas 78023
(210) 695-2381 Fax (210) 695-2387

**THIRD PARTY ADMINISTRATOR
 APPROVAL APPLICATION**

The answers you provide to the following questions are necessary to give National Underwriting Services, Inc. a clear overview of your firm. Please answer all questions completely, and provide as much detailed information possible.

Section 1

1. Firm Name: _____
2. Address of Principle Office: _____
 Locations other than above: _____
3. Is the Firm a sole proprietorship, a partnership, or a corporation? _____
4. When was your company established? _____
5. Has the name of your firm been changed? YES _____ NO _____
 If yes, please give previous name and the year the name was changed: _____
6. Has any other firm been merged in or amalgamated with your firm? YES _____ NO _____
 If yes, please explain: _____
7. Is it a subsidiary of another firm? YES _____ NO _____
 If yes, give full details: _____

8. Please list the names and titles of all principals:

Name _____	Title _____
Name _____	Title _____
Name _____	Title _____
Name _____	Title _____

Section 2

1. Geographical area(s) serviced: _____

2. Number of corporate clients: _____
3. Taft-Hartley Trust clients: _____
4. Association clients: _____
5. Number of clients added in the past twelve months: _____

	<u>Number of Cases</u>	<u>Number of Covered EE's</u>
A. Fully Insured cases:	_____	_____
B. Partially Self-Funded: (Under \$15,000 Deductible)	_____	_____
C. Self-Funded Cases: (\$15,000 Deductible or greater)	_____	_____
Client Size (Self-Funded Only)	<u>Number of Cases</u>	
A. Less than 100 Employees	_____	
B. 100 to 200 Employees	_____	
C. 200 to 1,000 Employees	_____	
D. 1,000 to 5,000 Employees	_____	
E. Over 5,000 Employees	_____	

Section 3 Carrier Detail

List 3 Stop Loss Carriers that you currently use:

1. Name _____ Telephone () _____
Address _____ City _____ State _____
Date approved _____
2. Name _____ Telephone () _____
Address _____ City _____ State _____
Date approved _____
3. Name _____ Telephone () _____
Address _____ City _____ State _____
Date approved _____

Section 4 Claims Administration

1. Please give the name, title and years of experience of your senior claims staff. Attach resumes if available.

Name_____ Title_____ Experience_____

Name_____ Title_____ Experience_____

Name_____ Title_____ Experience_____

Name_____ Title_____ Experience_____

2. What claim dollar volume do you process per year for:

Medical Claims_____ Dental Claims_____

3. Are you paying claims on a draft book basis, for any commercial carrier? YES_____ NO_____

If yes, please list carrier:_____

4. Are claims processed, Manually _____ On-Line_____ Combination_____

5. What is the source of your R&C profiles? HIAA_____ Internal_____ Other_____

If other, please explain:_____

6. Can C.O.B. savings be reported by group? YES_____ NO_____

7. Can R&C (UCR) savings be reported by group? YES_____ NO_____

8. Do you keep separate Bank Accounts for each group? YES_____ NO_____

9. Do you do the bank account reconciliation? YES_____ NO_____

If no, how do you verify the funding of claims?_____

10. Do you maintain hardcopy claim files? YES_____ NO_____

If yes, how many years do you retain the files?_____

11. What is your average turn-around time from the date the claim is reported until the date the draft is issued?_____

12. What was your average turn-around time during the past twelve months?_____

13. How many claim examiners do you currently have?_____

14. What is the highest claim draft limit authorized by any of your accounts?_____

Section 5 Claim Payment System

1. Please give the name of the system you are currently using:_____

2. Are all checks, EOB's and letters produced on site? YES_____ NO_____

If no, please explain:_____

3. Are all benefit plans on-line? YES_____ NO_____

4. Is R&C (UCR) database on-line? YES_____ NO_____
5. Is all eligibility maintained on-line? YES_____ NO_____
6. Period (years/months) of history on-line:_____
7. Has your system been audited by a Third Party for security control and accuracy?
YES_____ NO_____ If yes, by what firm?_____
8. Please give the name, title and years of experience of persons responsible for data processing. Attach resumes if available.
- | | | |
|-----------|------------|-----------------|
| Name_____ | Title_____ | Experience_____ |
| Name_____ | Title_____ | Experience_____ |
| Name_____ | Title_____ | Experience_____ |
| Name_____ | Title_____ | Experience_____ |
9. Can your system sort claims by, incurred date and paid date and then by policy year? YES_____ NO_____
10. Does your system generate a claims lag report? YES_____ NO_____

Indicate the reports routinely available:

- | | | |
|--|-------------|--------------|
| ? Claim analysis by line of coverage | Client_____ | Carrier_____ |
| ? Claim lag study | Client_____ | Carrier_____ |
| ? Daily check register | Client_____ | Carrier_____ |
| ? Monthly check register | Client_____ | Carrier_____ |
| ? Automatic reconciliation mag tape | Client_____ | Carrier_____ |
| ? Hospital utilization (length of stay) | Client_____ | Carrier_____ |
| ? Benefit utilization analysis | Client_____ | Carrier_____ |
| ? Provider charge profile | Client_____ | Carrier_____ |
| ? Diagnostic related profile | Client_____ | Carrier_____ |
| ? 1099-Med / 1099-misc. | Client_____ | Carrier_____ |
| ? Employee eligibility listing | Client_____ | Carrier_____ |
| ? List of pending claims | Client_____ | Carrier_____ |
| ? Time service report (lag report) | Client_____ | Carrier_____ |
| ? Aggregate loss fund summary | Client_____ | Carrier_____ |
| ? Claims paid in excess of any dollar amount | Client_____ | Carrier_____ |
| ? Utilization of Specific Excess Loss | Client_____ | Carrier_____ |
| ? Other (specify):_____ | | |

Section 6 Premium Administration

1. Can you bill/collect premium separately by line of coverage for:
Life_____ AD&D_____ Specific_____ Aggregate_____ Conversion_____
2. Do you list bill your clients? YES_____ NO_____
3. Do you function in any manner as a broker receiving commission? YES_____ NO_____
4. Do you write any of your business through Brokers? YES_____ NO_____
% Brokers_____ % Direct_____
5. Who has signature authority on claim checks?
TPA_____ Client_____ Dual signature required_____
6. Please explain you handling of premium dollars from the billing process through remittance to the carrier, including timing, bank accounts used, controls, security, etc.: _____

Section 7 General Information

1. Who prepares the Plan Documents for your self-funding clients? _____

2. Plan Documents are:
Standard Format YES_____ NO_____
Individually prepared schedule text to match prior carriers language YES_____ NO_____
3. Employee booklets/Sp.'s are prepared by: _____

4. Who maintains the enrollment card files? _____

5. Do you carry a Fidelity Bond? YES_____ NO_____
If yes, are all claim examiners, supervisors, persons that handle drafts, claim clerks bonded? _____

6. Do you have general liability and/or E&O coverage? YES_____ NO_____
If yes, please forward a copy of the policy to our office.
7. Has your firm had (or are there any pending) lawsuits or Insurance Department complaints files?
YES_____ NO_____ If yes, please describe: _____

Section 8 Quality Control

1. What is your payment accuracy standard (%)_____
2. What was your actual payment accuracy for the past twelve months? (%)_____
3. At what point do you perform routine internal claim audits? Please explain your internal procedures:_____

4. Do you permit client-sponsored audits? YES_____ NO_____
5. Do you have Medical/Dental consultants on staff? YES_____ NO_____ If yes, please list them:
Name_____ Title_____ Experience_____
Name_____ Title_____ Experience_____
Name_____ Title_____ Experience_____

Please attach copies of the following items:

- ? Any promotional material you currently use. (Brochures)
- ? Copy of your Administration Service Agreement
- ? Your current financial statement
- ? Samples of your EOB and premium statement
- ? Management information reports
- ? Proposal
- ? E&C Policy, Fidelity Bond and General Liability Policy

Do you understand and agree that your firm may be visited by Insurers or their appointed representative to inspect in more detail the procedures, which you utilize in your administration of self-funded plans?

YES_____ NO_____

Do you understand and agree that inquires will be made to other Insureds for whom you administer self-funding plans?

YES_____ NO_____

I/We hereby declare that the above statements and particulars given on this application are true and no material facts have been mis-stated or omitted.

Signed_____

Signed_____

Position_____

Position_____

Date_____

Date_____

**** Please note that this statement must be signed by a corporate officer ****