M-D UNDERWRITING SERVICES, INC.

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. Address _____

   City _____ State _____ ZIP_____

   Phone _____ Fax _____

3. FEIN #_____WEB Address:_____

   Type of Business: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ L.L.C.

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 been involved in a merger? ☐ YES ☐ NO
   If yes, please describe:

   _____

7. In the last five years, has your business entity ever had a change in ownership? ☐ YES ☐ NO
   If yes, please describe:

   _____

8. Has your business entity had a change of name, and/or used a d.b.a.; or is it operating under an assumed name? ☐ YES ☐ NO
   If yes, previous name was:

   _____

PART II – Administrative Services (Financial, Eligibility, and Premium Accounting)

1. Staff: Total number of employees in department _____

   Name/Job Title of Key Personnel and Managers Yrs. Experience Yrs. W/Current Employer

   _____

   _____

   _____

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

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

   On what days? _____

3. When are premium reminder notices sent? _____

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

   _____

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

   _____

   NOTES/COMMENTS:

   _____

   _____

_____

PART III – Claims Administration

_____

1. Staff: Total number of employees in:
   Adjudication _____
   Support _____
   Managers _____

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

   _____

   _____

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

2. Has the department been audited by a third party for accuracy/security? ☐ YES ☐ NO
   If yes, how recently and give name of audit firm:

   _____

   And type of audit: *(check all that apply)*
   ☐ CPA/5500
   ☐ CPA/Performance
   ☐ Carrier/MGU
   ☐ Independent Claims Audit

3. What is your payment accuracy objective?
   A) Statistical: Number of claims paid _____
   B) Financial: Dollar amount paid without error _____

4. What is your payment accuracy performance during the last twelve months?_____

5. What is your turnaround objective? _____

6. What is your average turnaround time over the last twelve months?_____

7. Surgical R & C is based upon: (check primary source)
   - □ HIAA
   - □ Internal
   - □ MDR
   - □ Med-Index
   - □ Other

   If other, please describe:
   Surgical: _____
   Medical: _____
   Dental: _____

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

9. How often is R & C data updated?_____

10. 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 transactions through your office

    _____

    _____

11. Do you subcontract any data processing activities? □ YES □ NO
    If yes, please specify:

    _____

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

    _____

    _____

    _____

PART IV – 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 $$

PART V – Compliance/Legal/License

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

   _____

2. How is your company licensed, are you licensed as a(n)?:

	List States/License Number
☐ Third Party Administrator	_____
☐ Managing General Agent	_____
☐ Agent	_____
☐ Broker	_____
☐ Other, define _____	_____

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

PART VII – Attachments

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

   _____

   ☐ Resumes of Officers, Directors, Owners and Key Personnel
   ☐ Copy of each; Errors & Omissions Policy, Professional Liability Policy, and/or Bond now in effect
   ☐ List of Branch offices, addresses, telephone numbers and contact
   ☐ Copy of TPA, MGU, Agency, Broker and Agent License for each applicable state
   ☐ Provide the name, address and contact information for Pre-cert, Medical Review, Case Management and bill audit/negotiating vendors
   ☐ Service Agreement (sample of standard agreement used)
   ☐ Claim Account Flowchart/Description
   ☐ Samples of Claims Reports available to insurers and/or reinsurer

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

Signature _____ Date_____

Print Name _____ Title_____