SUPPLEMENTAL APPLICATION FOR MANAGING GENERAL AGENTS, MANAGING GENERAL UNDERWRITERS AND PROGRAM ADMINISTRATORS, AND THIRD PARTY ADMINISTRATORS AND CLAIM ADMINISTRATORS

Please read this entire Supplemental Application carefully before signing. Whenever used in this Supplemental Application, the term "Applicant" means the Named Insured(s) and the term "Firm" means the Named Insured(s) and any other entity proposed for coverage. Please also attach the following:

□ **Sample Contract of Engagement**

Name of Applicant: _____

MGA/MGU/PROGRAM ADMINISTRATORS COVERAGE: □ Yes (Answer Questions 1-6) □ No

1. (a) The Firm is a Managing General Agent (MGA), Managing General Underwriter or a Program Administrator for the following carriers:

Carrier	Lines of Insurance	Number of Years	Annual Gross Premium Volume	Loss Ratio Last 3 Years 20___ 20___ 20___
			$	%__ %__ %__
			$	%__ %__ %__
			$	%__ %__ %__
			$	%__ %__ %__

To enter more information, please attach a separate page.

(b) How often are audits performed by the carriers?

(c) Recommendations/Criticisms made as a result of audits over the past 3 years: _____

(d) Steps taken to address Recommendations/Criticisms: _____

2. Describe ALL programs that were terminated or moved to another carrier during the last 5 years and the reason for the termination/move: _____

3. Please list all functions performed as an MGA, MGU or Program Administrator:

Quoting	□ **Yes** □ **No**	Maximum limit of authority:
Underwriting	□ **Yes** □ **No**	Maximum limit of authority:
Binding	□ **Yes** □ **No**	Maximum limit of authority:
Policy Issuance	□ **Yes** □ **No**	
Claims Adjusting	□ **Yes** □ **No**	Maximum limit of authority:
Claims Administration	□ **Yes** □ **No**	Describe:
Actuarial Service	□ **Yes** □ **No**	
Loss Control	□ **Yes** □ **No**	
Reinsurance Placement	□ **Yes** □ **No**	Facultative: ____ % Treaty: ____ %

4. Please indicate:
   (a) Number of policies issued annually: _____.
   (b) Number of producers business is received from: ___.
   (c) Number of producers with binding authority: _____Premium Volume: $ _____
   (d) What checks/supervision you exercise over sub-producers:_____

5. Describe the procedures used to ensure adherence to client's quoting, underwriting, binding, claims adjusting/administration and other procedures: _____

6. Describe the procedures to select sub-producers:_____

TPA/CLAIM ADMINISTRATORS COVERAGE: □ Yes (Answer Questions 7-11) □ No

7. Please indicate the percentage of the total annual revenue for each of the following:

Insurance Company Claims Adjusting	%
Self Insured/RRG Claims Adjusting	%
Reinsurance Claims Adjusting	%
Public Adjusting	%
Utilization Reviews	%
Medical Bill Review/Cost Containment	%
Other:	%

8. Please indicate the following for the top 5 clients:

Client	Description of Services	Revenues Last 12 Months
		$
		$
		$
		$
		$

9. Does the Firm have:
   (a) Draft authority? □ **Yes** □ **No If "YES,"** the amount is: $ _____
   (b) Its authority and/or limitations by clients defined in writing? □ **Yes** □ **No**
   (c) A fee collection process to minimize the need to file suit to collect fees? □ **Yes** □ **No**
   (d) Medical doctors/nurses on staff? □ **Yes** □ **No If "YES," please attach details regarding their role.**

10. Does the Firm:
   (a) Refer others to healthcare providers or healthcare provider networks for medical evaluations? □ **Yes** □ **No If "YES,"** please attach procedures for credentialing healthcare providers or selecting healthcare provider networks.
   (b) Contract with healthcare providers or healthcare provider networks to provide medical care to others? □ **Yes** □ **No If "YES,"** please attach procedures for credentialing healthcare providers or selecting healthcare provider networks.
   (c) Refer others to third parties who provide repair, restoration, remediation, construction or other services or products? □ **Yes** □ **No If "YES,"** please attach procedures for selecting those third parties.
   (d) Have the authority to deny medical services because of medical necessity? □ **Yes** □ **No If "YES,"** please attach utilization review/management procedures and resumes for all personnel who have authority

to deny medical services because of medical necessity.
(e) Contract with third parties who have the authority to deny medical services because of medical necessity? □ **Yes** □ **No If "YES,"** please attached procedures for selecting those third parties.

11. Does the Firm have:
(a) HIPAA compliance policies and procedures? □ **Yes** □ **No If "YES,"** please attach a copy of the procedures. **If "NO,"** please attach an explanation .
(b) Other regulatory compliance policies and procedures which regulate how the Firm performs professional services? □ **Yes** □ **No If "YES,"** please attach a copy of the procedures.
(c) Claim file audit procedures? □ **Yes** □ **No If "YES,"** please attach a copy of the procedures.
(d) Procedures to ensure that claim payments are calculated accurately and within the Firm's authority and are paid in a timely manner? □ **Yes** □ **No If "YES,"** please attach a copy of the procedures.
(e) Procedures to ensure that clients report claims to the Firm and the Firm reports claims to insurers or other payors in a timely manner? □ **Yes** □ **No If "YES,"** please attach a copy of the procedures.
(f) Procedures to comply with other client procedures? □ **Yes** □ **No**

By signing this Supplemental Application, the Applicant understands and agrees that the information submitted herein and all attachments becomes a part of, is deemed attached to, and is subject to the same representations and conditions of, its application for professional liability insurance.

This Supplemental Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.

_____
Date (Mo./Day/Yr.)

_____
Applicant Signature

_____
Print or Type Name

_____
Title