Third Party Administration and Claims Administrative Services Supplemental Application

NOTE: Please attach a sample contract of engagement.

1. Named Insured: _____

   DBA (if any):_____

   Home Office Mailing Address: _____

   Physical Address:_____

   Phone: ( )_____ FAX: ( )_____ EMAIL: _____

   Additional Locations:_____

   _____

2. Description of Operations**:**

   a). Please provide a breakdown showing the approximate percentages of the total operations:

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

   b). Percentage of annual gross revenues by line of business:

COMMERCIAL LINES		**PERSONAL LINES**	
Commercial Liability	%	**Automobile**	**%**
Commercial Property	%	**Homeowners**	**%**
Products Liability	%	**Other (Specify)**	**%**
Automobile	%		
Workers Compensation	%	**LIFE AND A&H**	**%**
Medical Malpractice	%	**Life**	**%**
Professional Liability—(Specify)	%	**A&H**	**%**
Other(Specify)	%	**HMO/PPO/DSP**	**%**
		Other (Specify)	**%**

c). Please describe **ALL** programs/classes and/or areas of specialization.

_____

_____

_____

d). Please list your top five clients, services provided and revenues generated:

Client	**Description of Services**	**Revenues**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does your firm:

a). Have draft authority? ☐ Yes ☐ No
If yes, please indicate amount. $_____

b). Have its authority and/or limitations by clients defined in writing? ☐ Yes ☐ No

c). Handle subrogation/salvage? ☐ Yes ☐ No

d). Have a fee collection process to minimize the need to file suit to collect your fees? ☐ Yes ☐ No

e). Provide any guarantees or warranties to your clients relative to the services provided? ☐ Yes ☐ No

f). Have medical doctors or nurses on staff to evaluate an/or provide opinions on recommended/appropriateness of medical treatments? ☐ Yes ☐ No

g). Does your firm have a specific orientation program/office manual review for all new employees? ☐ Yes ☐ No

4. Please describe the procedures/manual documentation used to ensure the adherence to client procedures.

_____

_____

It is hereby understood and agreed this Supplemental Application, and required attachment(s) becomes part of and is deemed attached to the INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABLITY INSURANCE POLICY APPLICATION.

Signature of Applicant_____
Print Name_____
Title:_____ Date Signed:_____