

EMPLOYEE BENEFITS  
THIRD PARTY ADMINISTRATOR  
(TPA)  
  
APPOINTMENT QUESTIONNAIRE

**SIIA**

**SELF-INSURANCE INSTITUTE OF AMERICA, INC.**

Endorsed as an Industry Standard form for assistance in the evaluation of third party administration companies (TPAs) by excess of loss insurers and managing general underwriters (MGUs).

# EMPLOYEE BENEFITS 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. T.I.N. # \_\_\_\_\_  
Type of Business:     Corporation     Partnership     Sole Proprietor     Sub-Chapter S Corp
  
4. List of Officers: (Attach additional list if necessary. Submit resumes of Officers, Directors and Owners)  
President \_\_\_\_\_ Secretary \_\_\_\_\_  
Vice President \_\_\_\_\_ Treasurer \_\_\_\_\_
  
5. Please list other companies with whom you have financial interested (i.e., Insurance companies, PPO's, 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 our 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 named?                       YES     NO  
If yes, previous name was:  
\_\_\_\_\_

9. Branch Offices:

Name of Contact \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

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 directly
- TPA
- Other, describe \_\_\_\_\_

12. If you compensate brokers/agents or other services providers for business development, do you disclose to client the amount of compensation paid?  YES  NO

13. When do you disclose fees, compensation, etc. to client (check all that apply)

- In initial proposal
- In service agreement
- At time of 5500 filing
- Other, explain \_\_\_\_\_

---

PART II – Systems – Administration and Claims (Hardware and Software)

---

	<u>Administration</u>	<u>Claims</u>
1. Is system on-line or manual?	_____	_____
2. Name of software system	_____	_____
3. Who developed?	_____	_____
4. Year of development	_____	_____
5. Is software leased, timeshared, or owned?	_____	_____
6. If owned, year purchased	_____	_____
7. Name of hardware	_____	_____
8. Is hardware leased, timeshared or owned?	_____	_____
9. Have you changed/upgraded systems within 12 months	_____	_____
If yes, please describe:		
A. Administration	_____	
B. Claims	_____	

---

PART III – 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. May clients have system access in their offices?  YES  NO

If yes, which administrative functions can the client perform?

\_\_\_\_\_

3. Can you provide census and premium funding data electronically?  YES  NO

4. System(s) Security and Audit Procedures:

A. Describe security for master file (i.e., who can enter new groups, changes).

\_\_\_\_\_

B. Describe security for client funds

\_\_\_\_\_

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

\_\_\_\_\_

D. Describe back-up system in the event that the computer master file is destroyed.

\_\_\_\_\_

5. Does your system calculate individual or group premium for fully insured plans, or calculate levels of funding for self-funded plans?  YES  NO

Or, are they manually calculated and entered in the master file?  YES  NO

6. Describe procedures for adding, deleting and changing Plan Participants and their benefits.

\_\_\_\_\_

7. What is your philosophy in serving a client's interest if the client asks you to accelerate claim payments in the last quarter, month of the plan year end?

\_\_\_\_\_

\_\_\_\_\_

8. Do you perform bank account reconciliations on Client Accounts?  YES  NO  
If no, why not?

\_\_\_\_\_

9. How often do you generate premium billings for insurance coverage? \_\_\_\_\_

On what days? \_\_\_\_\_

10. When are premium reminder notices sent? \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

NOTES/COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

---

PART IV – 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. How many terminals are in use? \_\_\_\_\_

3. Is eligibility determined on-line?  YES  NO

4. How long is claim history maintained on-line? \_\_\_\_\_

5. 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

6. Can you provide claims data electronically?  YES  NO

7. Claims are largely (i.e.: +75%)  
A. processed  Manually  On-Line  
B. filed  By family  By day batch

8. What does a claim represent? *(check one)*  
 line item  
 check  
 E.O.B  
 Other (define) \_\_\_\_\_

9. Based on the above definition:  
Average number of claims processed per processor per hour is \_\_\_\_\_

10. What is your payment accuracy objective:  
A. Statistical: Number of claims paid \_\_\_\_\_  
B. Financial: Dollar amount paid without error \_\_\_\_\_

11. Describe the payment authority limitation for the claims staff and describe the criteria for internal audits.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. What is your payment accuracy performance during the last twelve months? \_\_\_\_\_

13. What is your turnaround objective? \_\_\_\_\_

14. What is your average turnaround time over the last twelve months? \_\_\_\_\_

15. Surgical R & C is based upon: *(check primary source)*

- HIAA
- Internal
- MDR
- Med-Index
- Other

If other, please describe:

Surgical: \_\_\_\_\_

Medical: \_\_\_\_\_

Dental: \_\_\_\_\_

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

17. How often is R & C date updated? \_\_\_\_\_

18. Are ICD-9 codes captured?  YES  NO

19. Are CPT codes captured?  YES  NO

20. For what period of time are hard copy claims files retained? \_\_\_\_\_

21. 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

\_\_\_\_\_

\_\_\_\_\_

22. Do you subcontract any data processing activities?  YES  NO

If yes, please specify

\_\_\_\_\_

\_\_\_\_\_

23. Do you utilize off-site or home claim processors?  YES  NO

If yes, please specify

\_\_\_\_\_

\_\_\_\_\_

24. Describe your procedures for professional Medical and Dental claims review:

---

---

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

---

---

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

---

---

27. Describe the Managed Care Procedures you are using:

---

---

---

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 \$\$
--------------	------------	------------	-------------------------------

---

---

---

---

2. Has any carrier terminated their relationship with you in the last 5 years?  YES  NO  
If yes, who and why

---

---

---

---

PART VI – Compliance/Legal/License

---

1. Describe any previous or pending material lawsuits in the last 10 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 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):

List States/License Number

- Third Party Administrator \_\_\_\_\_
- Managing General Agent \_\_\_\_\_
- Agent \_\_\_\_\_
- Broker \_\_\_\_\_
- 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  JFEBP  HIRA  NALU  NAHU

Other *(please list)* \_\_\_\_\_

---

---

PART VII – Insurance/Bonding

---

1. Do you carry an Errors and 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? \_\_\_\_\_

5. Do you require employee bonding?  YES  NO

If yes, which employees? \_\_\_\_\_

6. Have claims been made against any of these policies in the past two years?  YES  NO

If yes, please provide details.

\_\_\_\_\_

\_\_\_\_\_

---

PART VIII – Financial

---

1. May we conduct an initial and ongoing financial review of your organization and/or principals using an independent agency, such as Equifax or Dun & Bradstreet?  YES  NO  
If no, why not?

---

---

2. Principal Banking relationship (to be sued as a reference):

Name of Bank \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Contact \_\_\_\_\_ Contact Title \_\_\_\_\_

---

PART IX – 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 and Omissions Policy, Professional Liability Policy, and/or Bond no in effect
  - If applicable, Last Two Fiscal Year Income Statement and Balance Sheets
  - Copy of TPA, MGU, Agency, Broker and Agent License for each applicable state
  - Marketing Proposal
  - Marketing Brochure
  - Sales Literature on PPO and Managed Care
  - Service Agreement (sample of standard agreement used)
  - Premium Account Flowchart/Description
  - Claim Account Flowchart/Description
  - Sample Billing
  - Disclosure Form (P.T.E. 77-9)
  - Evidence of Good Health Form
  - Samples of Administrative Services Reports available to insurers and/or reinsurers
  - Samples of Claims Reports available to insurers and/or reinsurers
  - Sample Plan Document

---

---

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 \_\_\_\_\_

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 01-92-TPA/AQ, has been approved by the Self-Insurance Institute of America, Inc. (SIIA) as an acceptable industry standard form.

The contents of this form/questionnaire represent the work of a special industry study group comprised of representatives from the excess market and TPA industry. The work of this group was submitted to SIIA for its review and approval. SIIA commends the members of this independent working group for their volunteer service to the industry and is proud to adopt this form/questionnaire as an industry standard form to assist in gathering data on and about third party administrators. A listing of the individuals who served on this ad hoc industry study group and their company affiliation may be obtained by writing SIIA.

Please note – This Form, its content and questions contained therein, have 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, etc. Evaluation of who to do business with is left to the sole discretion of the parties involved and each should consult their respective counsel and others as the case may be.

Comments and suggestions may be sent to:

SIIA Industry Documents  
Standard Forms Division  
P.O. Box 15466  
Santa Ana, CA 92705

SIIA

Self-Insurance Institute of America, Inc.

# STANDARDS OF CONDUCT

*As a member of the Self-Insurance Institute of America, Inc., I pledge myself to:*

- Maintain complete loyalty to the Institute and aggressively pursue its objectives.
- Neither engage in, nor countenance, any exploitation of the Institute, industry or profession.
- Recognize and discharge my responsibility and that of the Institute to uphold all laws and regulations relating to the Institute.
- Exercise and insist on sound business principles in the conduct of the affairs of the Institute.
- Use only legal and ethical means if I should seek to influence legislation or regulation.
- Issue no false or misleading statements to the public.
- Refrain from the dissemination of any malicious information concerning other associations.
- Utilize every opportunity to improve public understanding of the principles of the Institute.
- Maintain high standards to personal conduct.

This form has been developed to serve as a guide and shall not be legally binding on any party. Use of this form and interpretation of data submitted rest solely on the parties involved. SIIA, its officers, directors and contract staff assume no responsibility.

This form is intended to “assist” the industry in establishing a standard format for the collection of basic data. The form is provided to SIIA members free of charge. For non-members, a service fee applies. Please contact SIIA at (714) 261-2553 for current charges. SIIA reserves the right to modify charges for this form at its sole discretion.

## SIIA

Self-Insurance Institute of America, Inc.  
P.O. Box 15466  
Santa Ana, California 92705  
Telephone: (714) 261-2553  
Fax: (714) 261-2594