TRAVELERS

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Miscellaneous Professional Liability
Plan Administration
Additional Information Request

Travelers Casualty and Surety Company of America

THE INFORMATION BEING REQUESTED IS FOR A CLAIMS-MADE POLICY. IT IS IMPORTANT THAT YOU READ ALL OF THE PROVISIONS OF YOUR POLICY CAREFULLY.

DEFENSE EXPENSES ARE INCLUDED WITHIN THE LIMITS OF COVERAGE AND RETENTION, AND SUCH LIMITS MAY BE COMPLETELY EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES. THE COMPANY WILL NOT BE LIABLE FOR DEFENSE EXPENSES OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT AFTER EXHAUSTION OF THE LIMITS OF COVERAGE.

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise.

An Additional Information section is provided at the end of this document for any information that exceeds the space provided.

GENERAL INFORMATION

Proposed First Named Insured & Other Named Insured(s):	Today's Date:
Proposed Effective Date (*mm/dd/yyyy):*	Proposed Expiration Date *(mm/dd/yyyy):*

STAFFING INFORMATION

1. Indicate the number of claim adjusters: _____
2. Indicate the number of support staff: _____
3. What is the ratio of claim supervisors to claim handlers? _____
4. What is the average number of assignments per month per handler? _____
5. What is the average number of pending claims per handler? _____

PLAN INFORMATION

6. Indicate the gross revenue generated from all plan administration activities:

	Year	*Revenue*
Current Year		**$**
Past Year		**$**
Next Year Projected		**$**

7. Complete the following for each of the plans you administer: (please attach a separate sheet if necessary.)

Plan Name	*Plan Sponsor*	*Years Administered*	*Type of Plan(s)*	*Services Provided**	*Plan is:* *a. Self-Funded With Stop-Loss* *b. Self-Funded Without Stop-Loss* *c. Fully Insured*	*Plan Audited By:* *a. Applicant* *b. Plan Sponsor* *c. Outside Firm*	*No. of Audits Per Year*

*Indicate the services provided by the applicant for each plan by noting the corresponding letter(s) shown below in the Services Provided column above:

a. Claims adjusting
b. Employee enrollment/education
c. Plan design
d. Software development
e. Web-site design/maintenance
f. Utilization reviews
g. Peer reviews
h. Credentialing
i. Insurance placement (stop-loss)
j. Plan funding/actuarial
k. Cost containment services
l. Loss control/risk management
m. Other: _____
n. Other: _____

APPLICANT SERVICES

8. Are you involved in the formation, management, or administration of any HMO, PPO, RRG, RPG or other similar entity? ☐ Yes ☐ No
If yes, please provide details in the Additional Information section at the end of this Application.

9. Are you responsible for managing funds associated with the plans administered? ☐ Yes ☐ No
If yes, please provide details in the Additional Information section at the end of this Application.

10. If yes, is there a procedure in place for managing these funds? ☐ Yes ☐ No
If yes, please provide details in the Additional Information section at the end of this Application.

11. Does your firm, or any of your firm's partners, directors, officers or employees act as a trustee for any client? ☐ Yes ☐ No
If yes, please provide details in the Additional Information section at the end of this Application.

POLICIES AND PROCEDURES

12. Have you developed a policy or procedure manual to assist in complying with individual plan administration guidelines? ☐ Yes ☐ No

13. Describe your procedure for denying benefits or coverage: _____

14. Describe your authority for the payment of claims: _____

15. Describe your procedure for handling client or insured complaints: _____

16. Describe how you keep informed of changing legal requirements relevant to the plans administered: _____

OTHER INSURANCE

17. Do you maintain:
a. Directors, officers and trustees liability insurance? ☐ Yes ☐ No
b. A fidelity bond? ☐ Yes ☐ No
c. Fiduciary liability insurance? ☐ Yes ☐ No

REQUIRED ATTACHMENTS

Please provide the following for each plan administered:

- ☐ Contractual Agreement
- ☐ Service Agreement
- ☐ Marketing Brochures
- ☐ Certificates of Insurance for current Fiduciary, Fidelity, and D&O Policies
- ☐ Claim Account Flowchart
- ☐ Resumes of Key Personnel involved in Plan Administration

FRAUD STATEMENTS – Attention Applicants in the Following Jurisdictions:

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

SIGNATURES

I acknowledge that this document is to be read in conjunction with the core application and that all notices contained therein are deemed fully incorporated herein. I also affirm that any declarations made in the core application regarding the information contained therein also apply to the information contained herein, including any material submitted herewith.

Authorized Representative Signature:* (Chairman, President or CEO) X	Authorized Representative Name - Printed:
Title	Date:

*If you are electronically submitting this application to Travelers, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you hereby consent and agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative

PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE)

Producer Signature: *	Producer Name - Printed:	
X		
Agency Name:	Agency Code:	License Number:

ADDITIONAL INFORMATION

This area may be used to provide additional information to any question. Please reference the question number.