



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

**EMPLOYEE BENEFITS**

**THIRD PARTY ADMINISTRATOR**

**(TPA)**

**APPOINTMENT QUESTIONNAIRE**

Endorsed as an Industry Standard Form for Assistance in the Evaluation of Third Party Administration Companies (TPAs) by Stop-loss (Excess) Insurers and Managing General Underwriters (MGUs).



*Protecting and Promoting Self-Insurance and  
Alternative Risk Transfer since 1981*

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-06-01-TPA/AQ has been approved by the Self-Insurance Institute of America, Inc. (SIIA) as an acceptable industry standard form.

Please note – This questionnaire has 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. Evaluation of who to do business with is left to the sole direction of the parties involved.

Comments and suggestions may be sent to:

SIIA  
P.O. Box 1237  
Simpsonville, SC 29681

**EMPLOYEE BENEFITS THIRD PARTY ADMINISTRATOR APPOINTMENT  
QUESTIONNAIRE**

Information provided on this form is to be held in confidence by the recipient.  
**Due to spacing constrictions, you will likely need to attach additional sheets.**

**PART I - Entity, Location, Ownership, Affiliation**

1. Name of Entity: \_\_\_\_\_

2. Street Address: \_\_\_\_\_

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

Mailing Address \_\_\_\_\_

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

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

Web Site: \_\_\_\_\_

E-mail: \_\_\_\_\_

3. T.I.N. #: \_\_\_\_\_

Type of Business:     Corporation     Partnership     Sole Proprietor     LLC

4. List of Officers: *Attach additional list if necessary. Submit resumes of Officers, Directors and Owners*

President: \_\_\_\_\_ Secretary: \_\_\_\_\_

Vice Pres: \_\_\_\_\_ Treasurer: \_\_\_\_\_

Other Officers: \_\_\_\_\_

\_\_\_\_\_

5. Please list other companies with whom you have financial interest greater than 10% (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 greater than 10%?

Yes     No

If yes, please describe: \_\_\_\_\_

7. In the last five years, has your business entity ever had a change in ownership of greater than 51%?

Yes     No

If yes, please describe: \_\_\_\_\_

8. Has your business entity had a change of name, and/or used a dba or is it operating under an assumed name?  Yes  No

If yes, previous names were: \_\_\_\_\_

9. Branch Offices:

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

E-mail: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

E-mail: \_\_\_\_\_

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?
- TPA?
- Other? Describe: \_\_\_\_\_

12. If you compensate brokers/agents or other service providers for business development, how do you disclose to client the amount of compensation paid?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. When do you disclose fees, compensation, etc., to client? *Check all that apply.*
- In the initial proposal
  - In the service agreement
  - At time of 5500 filing
  - Other, explain: \_\_\_\_\_
14. How many years have you been in business? \_\_\_\_\_
15. How many clients do you have? \_\_\_\_\_
16. How many total employee lives are covered by your collective client base? \_\_\_\_\_

**PART II - Systems - Administration and Claims (Hardware and Software)**

	Administration	Claims
1. Is your system on-line or manual?	_____	_____
2. Version of the software system	_____	_____
3. Who developed the system?	_____	_____
4. Year it was developed?	_____	_____
5. Is your software leased, timeshared or owned?	_____	_____
6. If owned, year it was purchased.	_____	_____
7. Name of the hardware	_____	_____
8. Is the hardware leased, timeshared or owned?	_____	_____
9. Have you changed/upgraded systems within 12 months?	_____	_____

If yes, please describe:

A. Administration: \_\_\_\_\_

B. Claims: \_\_\_\_\_

C. Is conversion complete?  Yes  No

10. Is your system EDI compliant to HIPAA standards?  Yes  No

11. Is your system compliant to HIPAA security standards?  Yes  No

12. Have you modified the standard system in any way?  Yes  No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

**PART III - Administrative Services (Financial, Eligibility, and Premium Accounting)**

1. Staff: Total number of employees in department: \_\_\_\_\_

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

Name/Job Title of Key Personnel and Managers	Years Experience	Years w/Current Employer
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

3. May clients have system access in their offices?  Yes  No

If yes, which administrative functions can clients perform? \_\_\_\_\_

\_\_\_\_\_

4. Can you provide census and premium funding data electronically?  Yes  No

5. Can you accept and send ACH financial transactions?  Yes  No

6. System(s) Security and Audit Procedures:

A. Describe security of master file (i.e., who can enter new groups, make changes, etc.):

\_\_\_\_\_

B. Describe security of client funds: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

D. Describe your back-up system(s) in the event that the computer master file is destroyed: \_\_\_\_\_

\_\_\_\_\_

7. Does your system calculate individual or group premium for fully insured plans, or calculate levels of funding for self-funded plans?  Yes  No

8. How is eligibility determined for claims adjudication? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Describe procedures for adding, deleting and changing plan participants and their benefits:

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

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11. Do you perform bank account reconciliation's on client accounts?  Yes  No

If no, why not? \_\_\_\_\_

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

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

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

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

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

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16. Do you remit premiums to carriers on behalf of clients? \_\_\_\_\_

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17. If yes, do you remit gross or net of commissions? \_\_\_\_\_

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18. Do you audit your administration area?  Yes  No

If yes, please describe \_\_\_\_\_

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19. Do you have a disaster recovery plan?  Yes  No

If yes, please describe \_\_\_\_\_

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20. Provide a list of outside vendors contracted with your TPA and the services they perform?  
(Attach a separate sheet)

**PART IV - Claims Administration**

1. Staff: Total number of employees in:

Adjudication: \_\_\_\_\_

Support: \_\_\_\_\_

Managers: \_\_\_\_\_

Name/Job Title of Key Personnel and Managers	Years Experience	Years w/Current Employer
--	------------------	--------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

3. Has the department been audited by a third party for accuracy/security?  Yes  No  
If yes, how recently? Please give name of audit firm: \_\_\_\_\_

Name the type of audit performed: *Check all that apply, and note date.*

- CPA/5500 \_\_\_\_\_
- Carrier/MGU \_\_\_\_\_
- SAS 70 – Type 2 \_\_\_\_\_
- CPA/Performance \_\_\_\_\_
- Independent Claims Audit \_\_\_\_\_

4. What is the percent of auto adjudication? \_\_\_\_\_

A. What percent of claims are received electronically? \_\_\_\_\_

5. Based on the above definition, what is your average number of claims received daily: \_\_\_\_\_

6. What is your payment accuracy objective?

A. Procedural: Number of claims paid: \_\_\_\_\_

B. Financial: Dollar amount paid without error: \_\_\_\_\_



7. What procedures do you have in place for identifying and reporting potentially large claims (exceeding 50% of the specific deductible trigger diagnosis)?  
 \_\_\_\_\_  
 \_\_\_\_\_
8. What procedures do you have in place to detect and enforce reimbursement for subrogation, COB or workers' compensation? \_\_\_\_\_  
 \_\_\_\_\_
9. What was your payment accuracy performance during the last twelve months? \_\_\_\_\_  
 \_\_\_\_\_
10. Describe the payment authority limitation for the claims staff and describe the criteria for internal audits: \_\_\_\_\_  
 \_\_\_\_\_
11. What is your average turnaround time from date of receipt to date of payment on a clean claim submission? \_\_\_\_\_
12. What is your source for determining R&C?  
 Surgical  
 Medical  
 Dental
13. If other, please describe:  
 Surgical: \_\_\_\_\_  
 Medical: \_\_\_\_\_  
 Dental: \_\_\_\_\_
14. Is your R&C database on-line?  Yes  No
15. How often is R&C data updated? \_\_\_\_\_
16. Are the ICD-9 codes captured?  Yes  No
17. Are the CPT codes captured?  Yes  No
18. For what period of time are hard copy claims files retained? \_\_\_\_\_

19. 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 fund transaction through your office: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Do you subcontract any data processing activities?  Yes  No

If yes, please specify \_\_\_\_\_

\_\_\_\_\_

21. Do you utilize off-site or home claim processors?  Yes  No

If yes, please explain \_\_\_\_\_

22. What services do you provide for COBRA administration? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

23. What compliance services do you provide? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

24. What other services do you provide? Please list. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

25. What percentage of claims are audited? \_\_\_\_\_

A. How often? \_\_\_\_\_

B. Client specific or aggregated? \_\_\_\_\_

**PART V - Managed Care**

1. Please list the PPOs you use for the majority of your cases: \_\_\_\_\_  
\_\_\_\_\_
2. When there isn't a PPO in place, do you reprice hospital bills? If yes, what vendors do you use and at what claim level? \_\_\_\_\_  
\_\_\_\_\_
3. Describe any other claim cost management providers and processes you may use (i.e., demand management, hospital bill audits, subrogation, fee negotiation, service, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. What level of utilization review services are performed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Are utilization review services performed in-house or through an outside vendor? \_\_\_\_\_  
\_\_\_\_\_
6. Describe your procedures for professional medical and dental claims review: \_\_\_\_\_  
\_\_\_\_\_
7. Describe your procedures for auditing and/or negotiating provider bills: \_\_\_\_\_  
\_\_\_\_\_
8. Describe your procedures for using large case management (LCM): \_\_\_\_\_  
\_\_\_\_\_
9. Describe the managed care procedures you are using: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. How are cases identified for possible case management? \_\_\_\_\_  
\_\_\_\_\_

11. Please list the companies you use for Large Case Management services or describe your internal programs: \_\_\_\_\_  
\_\_\_\_\_

11 a. Disease Management and Predictive Modeling Service: \_\_\_\_\_  
\_\_\_\_\_

12. Is there a direct linkage between the UR/pre-cert process and case management? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**PART VI – 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 VII - Compliance/Legal/Licensing**

1. Describe any previous or pending material lawsuits in the last seven (7) 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 ever 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):

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Third Party Administrator | <u>List States/License Number</u> |
| <input type="checkbox"/> Managing General Agent    | _____                             |
| <input type="checkbox"/> Agent                     | _____                             |
| <input type="checkbox"/> 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       IFEBP     HCAA  
 NALU       NAHU       LIMRA       Other (please list): \_\_\_\_\_

**PART VIII - Insurance/Bonding**

1. Do you carry a TPA errors & 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? \_\_\_\_\_

What are the total annual aggregate funds handled for all clients? \_\_\_\_\_

5. Do you purchase criminal liability insurance?  Yes  No

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

6. Have claims been made against any of the above policies in the past two (2) years?  Yes  No

If yes, please provide details. \_\_\_\_\_

**PART IX – Financial**

1. Principal banking relationship (to be used as a reference):

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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

**PART X - Attachments**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Bios of officers, directors, owners and key claims personnel
- Certificate of Insurance for Errors and Omissions Policy, Professional Liability Policy, and/or Bond now in effect (declaration pages are sufficient)
- Copy of TPA, MGU, agency, broker and agent license for each applicable state
- Marketing proposal
- Marketing brochure
- Service agreement (sample of standard agreement used)
- Claim account flowchart/description
- Samples of administrative service reports for Stop Loss reporting
- Samples of aggregate claims reports available to insurers and/or reinsurers
- Sample plan document

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_