PLRisk
Professional Liability Risk Advisors

SUPPLEMENTAL APPLICATION FOR MANAGING GENERAL AGENTS/MANAGING GENERAL UNDERWRITERS, PROGRAM ADMINISTRATORS, 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 a sample contract of engagement.

Name of Applicant(s): _____
(Include names of all subsidiaries or affiliated companies to be insured, attach a separate sheet, if necessary)

MGA/MGU/PROGRAM ADMINISTRATORS COVERAGE: (If yes, complete Questions 1-7)

1. (a) The Firm is a Managing General Agent (MGA) Managing General Underwriter (MGU) or 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 ___
			$	____% ____% ____%
			$	____% ____% ____%
			$	____% ____% ____%
			$	____% ____% ____%
			$	____% ____% ____%

Attach a separate page for additional information

(b) How often are audits performed by the carriers: _____
_____
_____

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

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

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

3. Please list all functions performed as an MGA/MGU or Program Administrator and the Maximum Limit of authority for each:

Quoting	☐ Yes ☐ No	$
Underwriting	☐ Yes ☐ No	$
Binding	☐ Yes ☐ No	$
Policy Issuance	☐ Yes ☐ No	
Claims Adjusting	☐ Yes ☐ No	$
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 from whom you accept business: _____
   c) Number of producers/agents with binding authority: _____
      Premium Volume: $ _____

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-procedures: _____
_____
_____

7. Do you require sub-producers to carry their own E&O coverage? ☐ Yes ☐ No

TPA/CLAIM ADMINISTRATORS COVERAGE: (If yes, complete Questions 1-5)

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

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

2. Please indicate the following for your top 5 clients:

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

3. Does the Firm have:
   a) Draft authority? ☐ Yes ☐ No
      If **yes,** the amount is: $_____
   b) 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,** provide details regarding their role: _____
      _____
      _____

4. Does the Firm:
   a) Refer others to healthcare providers or healthcare provider networks for medical evaluation? ☐ Yes ☐ No
      If **yes,** 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,** 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**, attach procedures for selecting those third parties
   d) Have the authority to deny medical services because of medical necessity? ☐ Yes ☐ No
      If **yes,** attach utilization review/management procedures and resumes for all personal 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**, attach procedures for selecting those third parties

5. Does the Firm have:
   a) HIPAA compliance policies and procedures in place? ☐ Yes ☐ No
      If **yes,** attach a copy of the procedures If **no,** attach an explanation
   b) Other regulatory compliance policies and procedures which regulate how the Firm performs professional services? ☐ Yes ☐ No
      If **yes,** attach an explanation

(c) Claim file audit procedures? ☐ Yes ☐ No
If **yes,** attach a copy of the procedures

(d) Procedures to ensure that claim payments are calculate accurately and within the Firms' authority? ☐ Yes ☐ No
If **yes,** 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,** 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.

Applicant Signature: _____ Broker Name: _____

Name Printed: _____ Address: _____

Title: _____ Company Name: _____

Date: (mm/dd/yyyy): _____ Email: ___ _____

Phone Number: _____