



**Miscellaneous PROtectSM
Benefit Plan Consultant Supplemental Application**

BY COMPLETING THIS APPLICATION, THE APPLICANT IS APPLYING FOR COVERAGE WITH EITHER **COLONY INSURANCE COMPANY**, **COLONY SPECIALTY INSURANCE COMPANY** OR **PELEUS INSURANCE COMPANY**, AN AUTHORIZED SURPLUS LINES INSURER OR **ARGONAUT INSURANCE COMPANY**, A LICENSED INSURER.

INSTRUCTIONS –

- Answer all questions. The information provided herein is considered material to our underwriting and pricing decision for the policy or additional coverage under consideration at the time this supplemental application is submitted.
- This form must be completed, dated and signed by an authorized officer of the Applicant to include this completed form as part of the Application.

1. Applicant Name (as identified in the application submitted for the proposed insurance):

2. Provide approximate revenues derived from all services/operations:

Service/Operation	Revenue	Check if coverage is desired
Health Plan Consulting		
Single Employer Plans	\$	<input type="checkbox"/>
Multiple Employer Benefit Plans (Taft- Hartley Trusts)	\$	<input type="checkbox"/>
Multiple Employer Welfare Arrangements (MEWAS)	\$	<input type="checkbox"/>
Multiple Employer Trusts (METS)	\$	<input type="checkbox"/>
Health Maintenance Organizations (HMO's)	\$	<input type="checkbox"/>
Preferred Provider Organization (PPO's)	\$	<input type="checkbox"/>
Cafeteria Plans	\$	<input type="checkbox"/>
Employee Assistance Programs:		
I. Administrator	\$	<input type="checkbox"/>
II. Direct Provider	\$	<input type="checkbox"/>
Group Life Insurance	\$	<input type="checkbox"/>
AD&D	\$	<input type="checkbox"/>
Dental Plans	\$	<input type="checkbox"/>
Vision Plans	\$	<input type="checkbox"/>
Section 125 Plans	\$	<input type="checkbox"/>
Short and Long Term Disability Plans	\$	<input type="checkbox"/>
Key Person Life Insurance	\$	<input type="checkbox"/>
Other Consulting		
Actuarial Services	\$	<input type="checkbox"/>
Insurance Related Services:		
I. Insurance agent or broker	\$	<input type="checkbox"/>
II. Insurance advisor/consultant	\$	<input type="checkbox"/>
III. Premium collection and billing	\$	<input type="checkbox"/>
IV. Underwriting authority/policy issuance	\$	<input type="checkbox"/>
Administration of Pension Plans	\$	<input type="checkbox"/>
Defined Benefit Pension Plan Consulting	\$	<input type="checkbox"/>
Defined Contribution Plan Consulting	\$	<input type="checkbox"/>
Profit Sharing Plan Consulting	\$	<input type="checkbox"/>

Service/Operation	Revenue	Check if coverage is desired
Employee "wellness" or other health related program literature or correspondence	\$	<input type="checkbox"/>
Utilization Review Services	\$	<input type="checkbox"/>
Administrator for credentialing services (verification of a health care provider's credentials)	\$	<input type="checkbox"/>
Peer review services	\$	<input type="checkbox"/>
Cost containment services	\$	<input type="checkbox"/>
Case management services	\$	<input type="checkbox"/>
Notary Public	\$	<input type="checkbox"/>
Technology Services for others	\$	<input type="checkbox"/>

3. Are any of the Applicant's services provided to a parent organization? Yes No
 If "Yes", what percentage of revenues is derived from services provided to such parent organization? %

4. Describe how the Applicant screens and qualifies plan sponsors.

5. Does the Applicant have written procedures to address the following (check all that apply)?

<input type="checkbox"/> Compliance with plan administration	<input type="checkbox"/> Checks and balances to manage payment integrity (guarding against over or under payments, late payments, payments to the wrong party or from the wrong fund; unfair/unjust enrichments, etc.)
<input type="checkbox"/> Determination of the denial of benefits	
<input type="checkbox"/> Informing claimants of benefit denial	
<input type="checkbox"/> Appeal process for benefit denials	
<input type="checkbox"/> Internal audits	

6. Please provide the following (check all that apply):

<input type="checkbox"/> Percentage of inquiries referred to a physician?	%
<input type="checkbox"/> Percentage of claims denied?	%
<input type="checkbox"/> Percentage of denials appealed?	%
<input type="checkbox"/> Average error rate of the Applicant's claim handlers	%

Attach a copy of your "Standards of Practice", if available Attached

7. a. Number of Plan Sponsors:
 b. Number of participants for plans administered by the Applicant:
 c. Total annual contributions to the plans administered by the Applicant: \$
 d. Total annual benefit payments issued in the administration of all such plans: \$

8. Does the Applicant utilize professionals to advise and assist with providing Professional Services (check all that apply)?

<input type="checkbox"/> Lawyer	<input type="checkbox"/> Accountant
<input type="checkbox"/> Other (describe): <input type="text"/>	

9. Does the Applicant administer any self-funded Multiple Employer Trusts (METs) or Multiple Employer Welfare Arrangements (MEWAS)? Yes No
 If "Yes", please provide full details.

10. What percentage of all plans are:

a. Self-funded with Stop Loss	%
b. Self-funded with No Stop Loss	%
c. Fully Insured	%

11. List insurance carriers that stop loss coverages are placed with.

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12. Does the Applicant have any certifications, designations or credentials relating to the benefit consulting industry? Yes No

If "Yes", please provide list of all certifications, designations or credentials.

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13. Does the Applicant, its partners, directors, officers or employees act as Trustee for any clients or non-clients? Yes No

If "Yes", please provide full details.

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THIS SUPPLEMENTAL APPLICATION IS INCORPORATED BY REFERENCE INTO THE PRIMARY APPLICATION

APPLICANT'S SIGNATURE	DATE
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