LOVELAND & SMART INSURANCE SERVICES, INC

SELF - ADMINISTRATION QUESTIONNAIRE

COMPANY

Company name: _____

Street Address:_____

Mailing address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-Mail: _____

Number of years administering claims: _____

State jurisdiction(s) in which claims are handled: _____

Please indicate any other name your organization has gone by: _____

_____

CLAIM PERSONNEL

Please provide an organizational chart of your claims department.

Please complete the attached Staff Review.

CLAIM HANDLING

Please provide a copy of your claim guidelines or list what procedures are followed when a lost time claim is received.

_____

_____

_____

Please indicate which of the following medical management programs are in place: ☐ Medical Bill Review ☐ Fee Schedule Reduction ☐ Panel Physician List ☐ PPO Network Member ☐ other programs: _____

_____

Please indicate what approach is taken to move claims toward conclusion/settlement: _____

_____

RESERVING PRACTICES

Who will set reserves: _____

Please indicate what reserving method is used: ☐ 12 Month Projection ☐ Block ☐ Ultimate Value ☐ other

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How frequently are reserves reviewed and payments reconciled? _____
_____

COMPUTER SYSTEMS

Please indicate what PC based or mainframe systems are used: _____
_____

Please indicate which of the following features are provided by system: ☐ Claim activity notepad ☐ Payment history ☐ Reserve history ☐ Accident information ☐ Ad Hoc report writing capability ☐ other
_____

Does your system have on-line, Internet, FTP, and/or Datalink capability? ☐ Yes ☐ No
Would you be interested in establishing a Datalink with Midwest Employers Casualty? ☐ Yes ☐ No

Please identify any outside vendors that are used to store your loss data. _____
_____

If applicable, please provide your web site or e-mail address: _____

REPORTING TO EXCESS CARRIER

Our reporting requirements have been attached for your review.

Please advise what procedures are in place to identify any reportable claim(s): _____

Please advise who will have the responsibility for reporting losses to the insurance carrier. _____
_____

Is there an opportunity or desire to report loss information electronically? _____

OUTSIDE SERVICES USED

Please identify any outside vendors you will be using for the following services: ☐ Legal Counsel: _____ ☐ Medical Case Management: _____ ☐ Vocational Rehabilitation: _____ ☐ Surveillance: _____ ☐ Loss Control: _____ ☐ other services: _____

Who is responsible for choosing and monitoring these vendors? _____

Completed By: _____ Title: _____ Date: _____

Phone: _____ Fax: _____ E-Mail: _____

Washington Fraud Warning: "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."

STAFF REVIEW

Date: _____

Name of
Company:_____

Address:
_____

City, State, Zip:
_____

Phone: _____ Fax: _____ E-Mail:
_____

TITLE	NAME	TOTAL YEARS OF CLAIMS EXPERIENCE	TENURE WITH CURRENT COMPANY	NO. OF LOST TIME CASES (ALL ACCOUNTS)	NO. OF MEDICAL ONLY CASES (ALL ACCOUNTS)	NO. OF CLAIMS OTHER THAN COMP
BRANCH / CLAIM MANAGER E-MAIL PHONE NO.						
SUPERVISOR E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						

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