

# SERVICE COMPANY QUESTIONNAIRE

Company Name: \_\_\_\_\_

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

Street 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: \_\_\_\_\_

If you have a parent company, please indicate: \_\_\_\_\_

How many self-insured workers' compensation accounts are you currently servicing? \_\_\_\_\_

What other lines of coverage service do you provide: \_\_\_\_\_

How do you acquire accounts? \_\_\_\_\_

If growth is expected in the next year how many accounts do you anticipate adding? \_\_\_\_\_

## 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: \_\_\_\_\_



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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? \_\_\_\_\_

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Do your clients have any input into reserve establishment? \_\_\_\_\_

How is loss information from claims inherited (tail) handled? \_\_\_\_\_

How often do you meet with your clients? \_\_\_\_\_

## COMPUTER SYSTEMS

Please indicate what PC based or mainframe systems are used: \_\_\_\_\_

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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: \_\_\_\_\_

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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. \_\_\_\_\_

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

## REPORTING TO INSURANCE 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. \_\_\_\_\_

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Marketing Contact: \_\_\_\_\_

## OTHER SERVICES OFFERED

Please indicate if you provide any of these services:  Loss Control  Risk Management  Client Payroll Audits  
 other: \_\_\_\_\_

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If applicable please advise if your company has a brokerage arm that places excess workers compensation or deductible coverage?  Yes  No \_\_\_\_\_



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A COPY OF A MARKETING BROCHURE OR OTHER INFORMATION ABOUT YOUR COMPANY WOULD BE APPRECIATED

## 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."

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# 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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# REPORTING REQUIREMENTS

AS OUTLINED BY THE EXCESS POLICY

1. Written notice is required as soon as you learn of any claim involving a loss, which exceeds, or might in the future exceed, 50% of the self-insured retention.
2. Written notice is required on any claim in which the injured employee's disability exceeds 52 weeks, even if the claim is being contested.
3. Immediate (within 30 days) written notice\* is required on any claim involving:
  - a. Fatality
  - b. Spinal cord injury
  - c. A permanent total disability by statute
  - d. Serious burn injury
  - e. Brain injury
  - f. Amputation of a major member
4. Immediate (within 30 days) written notice is required on all occurrences involving two or more employees.

If written notice is not provided within one year of when required, reimbursement will be reduced by 15%. If written notice is not provided within three years of when required, reimbursement will be reduced by 40%.

If you have any questions about the reporting requirements, please contact our claims department.

\* Please telephone us at 1-877-975-2667 (toll free) to report catastrophic claims.

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