

REINSURANCE CLAIM ADMINISTRATION QUESTIONNAIRE

COMPANY

Company name: _____

Mailing address: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-Mail: _____

Number of years in business: _____

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 PERSONNEL

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: _____



REINSURANCE CLAIM ADMINISTRATION QUESTIONNAIRE

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 INSURANCE CARRIER

What reporting requirement(s) are currently in place: _____

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."



14755 North Outer 40 Drive · Suite 300 · Chesterfield, MO. 63017
Phone: 636.449.7000 · Toll Free: 877.975.2667 · Facsimile: 636.449.7199 · www.mwecc.com

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.						
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