

**SHAND MORAHAN**  
**MARKEL & COMPANY, INC.**  
 Ten Parkway North, Deerfield, IL 60015  
 (847) 572-6000 Fax (847) 572-6137  
 Underwriting Manager  
 A Markel Company

- o DEERFIELD INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
- o MARKEL INSURANCE COMPANY

**SUPPLEMENT FOR THIRD PARTY ADMINISTRATORS**

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: \_\_\_\_\_
2. Does the Applicant provide services to the following types of clients? If Yes, provide the percentage of total services provided.
 

(a) Single Employer Plans	_____%
(b) Multi-Employer Plans	_____%
(c) Multi-Employer Trusts (MET's)	_____%
(d) Multi-Employer Welfare Arrangements (MEWA's)	_____%
(e) Corporate Plans	_____%
(f) Taft-Hartley Plans	_____%
(g) Public/Government Plans	_____%
(h) Pension and/or Profit Sharing Plans	_____%
(i) Association Plans	_____%
(j) Other (specify) _____	_____%
3. Describe the procedures utilized by the Applicant to ensure that the plans administered comply with ERISA.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Are actuarial certifications reviewed by a member of the Society of Actuaries or American Academy of Actuaries?  
 [ ] Yes [ ] No
5. Does the Applicant or any of its principals or employees retain ownership interest in and/or act as a partner, director, officer or trustee for any clients or any plans? If Yes, provide complete details. [ ] Yes [ ] No  
 \_\_\_\_\_  
 \_\_\_\_\_
6. (a) Total annual contributions to self insured plans administered: \$ \_\_\_\_\_  
 (b) Total dollar amount of claims paid last year: \$ \_\_\_\_\_  
 (c) Claim draft limit: \$ \_\_\_\_\_
7. List the Applicant's five largest accounts:  
 (1) \_\_\_\_\_  
 (2) \_\_\_\_\_  
 (3) \_\_\_\_\_  
 (4) \_\_\_\_\_  
 (5) \_\_\_\_\_
8. Total dollar amount of Applicant's Fidelity Bond: \$ \_\_\_\_\_

9. List the top five insurance carriers through which the Applicant places business:

<u>Name</u>	<u>Premium</u>	<u>% of Total Premium Volume</u>	<u>A.M. Best Rating</u>
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
(4) _____	_____	_____	_____
(5) _____	_____	_____	_____

10. Provide the percentage of the Applicant's fees derived from:

- (a) Administration of health plans \$ \_\_\_\_\_
- (b) Administration of pension plans \$ \_\_\_\_\_
- (c) Administration of self insured Workers' Compensation \$ \_\_\_\_\_
- (d) Administration of other self insured programs - specify coverage \$ \_\_\_\_\_
- (e) Placement of stop loss or reinsurance products \$ \_\_\_\_\_
- (f) Placement of L/A&H Insurance to fund plans administered by Applicant \$ \_\_\_\_\_
- (g) Placement of L/A&H Insurance other than above \$ \_\_\_\_\_
- (h) Placement of P&C Insurance \$ \_\_\_\_\_
- (i) Loss control services (describe on separate attachment) \$ \_\_\_\_\_
- (j) Consulting services (describe on separate attachment) \$ \_\_\_\_\_
- (k) Actuarial Services \$ \_\_\_\_\_
- (l) Utilization Review \$ \_\_\_\_\_
- (m) Other (specify) \_\_\_\_\_ \$ \_\_\_\_\_

11. Provide the number of employees by job classification:

*Example: Employed Actuaries 2  
Claims Examiners 4*

<u>Job Classification</u>	<u>No. Employees</u>
_____	_____
_____	_____
_____	_____
_____	_____

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent (within 60 days of the proposed effective date).

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date