OLD REPUBLIC INSURANCE COMPANY
MISCELLANEOUS PROFESSIONAL LIABILITY

This Supplement should be submitted to:

Chicago Underwriting Group, Inc.
191 N. Wacker Drive
Chicago, IL 60606
(312) 750-8800

THIRD PARTY ADMINISTRATOR SUPPLEMENT

1. Name of Applicant: _____

2. Indicate the following:

Number of plans administered:	_____
Number of accounts:	_____
Number of participants in plans administered:	_____
Number of employed accountants:	_____
Number of employed actuaries:	_____
Number of employed claims administration personnel:	_____
Number of employed data processing personnel:	_____
Number of employed insurance agents/brokers:	_____

3. Indicate which of the following types of clients the Applicant serves:

Single employer plans	___%	Taft-Hartley plans	___%
Multi-employer plans	___%	Public/government plans	___%
Multi-employer trusts (METs)	___%	Pension/profit sharing plans	___%
Multi-employer welfare arrangements (MEWAs)	___%	Corporate plans	___%
		Association plans	___%
Other (specify):	___%	**Total must equal:**	**100**%

4. Describe the Applicant's procedures to ensure the plans administered comply with ERISA:

_____
_____

5. Are actuarial certifications reviewed by a member of the Society of Actuaries or American Academy of Actuaries? ☐ Yes ☐ No

6. 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? ☐ Yes ☐ No
   If Yes, provide details:

_____

_____

7. Total annual contributions to self-insured plans administered: $_____

8. Total dollar amount of claims paid last year: $_____

9. Claim draft limit: $_____

10. List the Applicant's five largest accounts:

    _____

    _____

    _____

    _____

    _____

11. Total dollar amount of Applicant's fidelity bond: $_____

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

Name	Premium	% total premium volume	AM Best Rating
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Indicate the percentage of Applicant's fees derived from:

Administration of health plans	___%
Administration of pension plans	___%
Administration of self-insured workers comp	___%
Administration of other self-insured programs (attach details)	___%
Placement of stop loss or reinsurance products	___%
Placement of L/A&H insurance to fund plans administered by Applicant	___%
Placement of L/A&H insurance to other than above	___%
Placement of P&C insurance	___%
Loss control services (attach details)	___%
Consulting services (attach details)	___%
Actuarial services	___%
Utilization review	___%
Other (specify):	___%
Total must equal:	**100**%

14. Indicate the number of employees by job classification:

Job classification	No. Employees
_____	_____
_____	_____
_____	_____
_____	_____

It is understood and agreed that this supplemental application shall become part of the Application for the policy.

THIS APPLICATION MUST BE SIGNED BY AN OWNER, OFFICER OR PARTNER.

Signature: _____ Date: _____

Name and Title (Please Print): _____