Proposal for

City of Salinas

General Liability and Automobile Claims Administration
Request for Proposals (RFP)

Submitted by:

Jon Lord
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YORK

8855 Haven Ave.
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Due Date: July 12, 2017

Proposal for

City of Salinas

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YORK

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Cover Letter

July, 12 2017

Michael Mutalipassi
City Attorney
City of Salinas
200 Lincoln Avenue
Salinas, CA 93901

Re: York's Response to Request for Proposals for General Liability and Automobile Claims Administration

Dear Mr. Mutalipassi and the City of Salinas Evaluation Committee:

York Risk Services Group, Inc. ("York") appreciates the opportunity to submit our proposal to provide the City of Salinas ("City") General Liability and Automobile Claims Administration services. We are proposing an innovative and customized team approach that leverages our experience with public entities similar to the City to offer the best possible service model designed with the City's needs in mind.

There are several reasons why York should be the City's choice to provide General Liability and Automobile Claims Administration services:

Customized Service Model
York's customized program approach centers around one key component– communication. In order to provide exceptional customer service, all parties must work together to ensure timely and accurate exchange of information. In line with this philosophy, we are proposing a service model with Cynthia Gordon, Unit Manager and Chris Shaffer, Senior Account Executive, to oversee the claims handling and program for the City.

Niche Expertise in California Public Entities
York occupies a significant presence as a claims administrator within the California public entity community, supported by our 30 years of experience providing similar services to those requested in the RFP. Our focus is not only on claims administration for self-insured entities in the areas of liability, property, auto liability, and medical malpractice—we have special expertise and focus on claims administration for California public entities with a dedicated Public Entity division and a liability team with extensive history partnering with governmental agencies.

State-of-the-Art RMIS
York's state-of-the-art risk management information system, FOCUS, is a paperless environment that offers the City a single platform for managing your liability program. The system is capable of filtering a number of data fields, which will allow the City to not only trend losses but also run customized reports. This will enable the City to analyze a variety of information that will assist in the targeted reduction of overall claim frequency and severity. Additionally, our system

empowers York's Adjusters to operate more efficiently, allowing them to devote their time to proactive claims management and cost control.

We will be a strong partner in working to solve issues as they arise and we will dedicate ourselves to providing the City with unsurpassed service. Upon review of our proposal, if any questions should arise, please contact Jon Lord, Managing Vice President, Public Entity, at Jon.lord@yorkrsg.com or via telephone at (714) 620-1375.

Jon Lord
Managing Vice President of Sales

Jody A. Moses, Senior Vice President
Jody is legally authorized to bind York to the RFP.

Section I

Proposer's Questionnaire

Please furnish the following information, please complete your responses on this form and use an additional page only if necessary.

1. Name of Firm: **York Risk Services Group, Inc.**

   Corporate Address: **One Upper Pond Road, Building F, 4th Floor, Parsippany, NJ 07054**

   Telephone: **(973) 404-1200**

2. Date Established: **1961**

3. Branch office address and phone that would provide service to the City

   York's Concord office located at 1390 Willow Pass Rd., Suite 1030, Concord, CA 94520, Phone: (925) 349-3880 would provide services to the City.

4. Furnish a listing of the account team proposed to provide TPA services to the City — include: 1. name, 2. designations, 3. whether they hold a Self-Insurance Certificate, 4. level of expertise and summary of their background, 5. percentage of time allocated to service the City's program.

Proposed Account Team			
Name	**Self-Insurance Certification (Y/N)**	**Designations, Level of Expertise & Summary of Background**	**Percentage of Time Allocated to Service the City**
Tom Baber Vice President, Specialized Loss Adjusting Division	Not Applicable	Tom has more than 35 years of experience in the insurance claims industry and more than 28 years of experience managing and administering liability claims for self-insured California public agencies. During his tenure with York he served as the Liability Claims Manager for the City of Sacramento's dedicated claims unit, Regional Liability Claims Manager, and Vice President of Liability. In 2008, Tom was appointed to his current position as Vice President, in which he oversees York's public entity casualty claims administration operation in California.	5%
Mike Berndt Assistant Vice President, Casualty Claims	Not Applicable	Mike has more than 35 years of experience in the claims industry, serving in various capacities including Adjuster, Supervisor, Manager, and Vice President. Mike has more than 25 years of experience handling claims for public entities, including the cities of San Leandro, Oakland, and Fremont as well as Mt. Diablo, Hayward	10%

		and Berkeley Unified School Districts.	
Cynthia Gordon Unit Manager	Not Applicable	Business experience spanning the past 30 years has included, most recently, working in the capacity of Unit Manager for York Risk Services Group, managing the claims handling and litigation management needs of a number of self-insured city entity clients. This experience has included claims handling and litigation management for general and auto liability claim matters, police excessive force, pursuit and constitutional/1983 claims, Jail practices and medical malpractice claims, ADA claims and more.	35%
Jeff Rogers Designated Senior Adjuster	Not Applicable	Jeff has more than 20 years of industry experience including more than 10 years of California public entity claims handling experience.	50%

5. Describe your staffing, caseload parameters and quality control measures. How often are your claims reviewed by supervisory staff? What is the experience level of your staff?

Staffing

York is proposing the appointment of Jeff Rogers, designated Senior Claims Adjuster, who will be overseen by Cynthia Gordon, Unit Manager. Jeff and Cynthia will be supported by a designated Claims Assistant for clerical support and the Executive Linguist company in the event a Spanish interpreter is needed.

Cynthia will directly supervise Jeff by providing specific direction and insight on individual claims, including reserves and litigation management, as needed. Cynthia will approve reserve changes and payments above Adjuster authority, review new claims ten days post-assignment, assign her follow-up review dates as necessary, and conduct Claim reviews at the City's request.

Additionally, this position and the designated Senior Account Executive will be responsible for the Contract and for ensuring that York exceeds the City's expectations. They will offer training, reporting, and resolve issues as they arise.

Caseload Parameters

The average caseload for our liability Adjusters will not exceed 150 claims per Adjuster for general liability claims; Auto liability claims target caseloads are not to exceed 150 claims and the property liability claims average caseload is not to exceed 80 claims. Caseloads of a reasonable number allow the adjuster to conduct a more thorough investigation and to develop rapport with the claimant, resulting in shorter claim duration and, thereby, cost savings. Supervisor does not carry a caseload.

Quality Control Measures

Available as an option to the City, York has an internal Quality Assurance and Audit Team, York PLUS, whose sole responsibility is to measure claim staff performance against a number of key corporate and industry metrics. Each branch office conducts internal audits

on two closed claims per month for each adjuster and the York PLUS team audits adjusters, supervisors and managers on a quarterly basis. This is driven by a three-tier audit process designed to measure those desktop behaviors of the claim professional that tend to drive outcomes and impact the overall quality of the claims handled for our clients. The York PLUS audit team places greater emphasis on the —quality of the activities than on the mere completion of a task and is responsible for all internal claim performance evaluations (CPEs).

Adjusters are also audited monthly by the Claims Supervisor to verify that expected performance objectives are met or exceeded.

We are flexible to meet the needs of our clients and are willing to modify our procedures to meet your needs.

Supervisory Reviews

Effective use of diary to monitor all case activity is an integral part of claim management. Adjusters are required to use diary to track and coordinate planned activity as well as acting on prioritized diary types. Diary should be set as facts warrant. At time of diary review, the Plan of Action (POA) items shall be updated and addressed, as appropriate. Supervisors establish their own diary according to the current adjuster POA and the exposure presented by the claim. In other words, the Supervisor diary will allow him/her to monitor adjuster activity to make certain the adjuster keeps the POA moving forward through proactive involvement.

Experience Level of Claims Staff

Liability Claims Team	
Position	**Description of Responsibilities**
Unit Manager	Required Experience • BS / BA or Equivalent Work Experience • Minimum 7 years of experience The Unit Manager for the liability team supervises the team of claims professionals in meeting departmental performance standards and provides guidance, direction and coaching to ensure productive and efficient processing of work. Additional responsibilities include: • Supervise administrative and technical functions of the liability team and ensure attainment of objectives including cost containment, productivity, adherence to company policies and procedures, and fulfillment of customer service expectations. • Review and assign claims to staff, noting areas of concern, according to dollar impact and complexity of claims • Provide guidance to staff as needed; assist in solving work-related problems; and suggest investigative avenues as needed. Assist adjusters in handling claims that exceed their own authority. • Thorough file audits, review of diary material, employee appraisals or other avenues, monitor conformance of claims adjusting unit to company and industry standards, procedures and objectives.

	• Identify problem areas related to procedural, technical or personnel issues; develop and implement solutions, or recommend improvements to senior management. • Manage personnel-related matters including performance planning and appraisal, salary administration, hiring, orientation and training, discipline, and communication, according to company policy and procedure guidelines; resolve personnel related problems. • Keep the client and other involved parties advised of file status and other matters as required. • Participate as required in meetings or visits to the client and other involved parties, and participation in large account matters. Communicate information on new products, coverage, court decisions, industry trends, company policies and other new or revised material to company staff. • Other activities as assigned by management
Senior Liability Adjuster	Required Experience • Bachelor's degree in related field from four-year college or university preferred • General Adjuster's license • Extensive knowledge of investigation management including, but not limited to, taking and using recorded statements, determining coverage and application of coverage to claims, delivering case value and negotiation and resolution of claims. • Minimum of 5 to 7 years of industry experience in Property and Casualty Claims • The role of the Senior Liability Adjuster is to investigate, evaluate and adjust liability claims. Assigned claims typically consists of medium to complex non-litigated and litigated general liability claims. Responsibilities of the Senior Liability Adjuster include: • Evaluate insurance coverage based on claim report, the insurance policy, applicable statutes and case law to determine if a claim can be accepted as within coverage. • Comply with all statutory and regulatory requirements in all applicable jurisdictions. • Obtain and review medical records. • Interview, telephone, and/or correspond with claimant and witnesses; obtains and reviews police hospital records, Reports to client as required by contractual account instructions; varying method of investigation according to type of coverage • Identify key issues and investigation required. • Meet detailed quality assurance standards of performance • Obtain and maintain all required licenses and certifications and meet all continuous training and certification requirements. • Determine extent of the client's financial exposure with respect to claims; set case reserves for use by clients and regulatory authorities • Revise case reserves based on developments in the course of adjusting the claim • Settle claims within assigned levels of authority as set forth in complex, detailed client account instructions • Handle complex litigated claims with limited input from the Unit Manager and/or AVP • Effectuate prompt payment (with client's funds) to claimants and service providers • Select and manage defense and coverage counsel • Select and manage experts

	• Work with and provide claim-specific guidance to Field Adjusters • Be alert to insurance fraud and implement special procedures if fraud is suspected. • Involve client in decision-making as appropriate and/or follow client-specific requirements for escalation when client decision-making and/or notification is required. • Interact successfully with co-workers • Other duties as assigned
Claims Assistant	Required Experience • BS / BA or Equivalent Work Experience • 2 to 5 years of experience The Claims Assistant assists Claims Adjusters by providing clerical support, data entry, reporting, record keeping, liaison, ordering & involvement in client programs. This individual's duties and responsibilities include: • Setting up new claims within one day, preparing required letters and data integrity in claims system • Payment of all indemnity payments and responsibility for ongoing payment as needed, along with creating required State notices. • Completing all clerical tasks assigned, such as file and serve documents to attorneys, doctors, employees and employers, bill objection letters, litigation referrals, scheduling doctor appointments, requesting records, etc.; Processing payment of in house bills timely • Fosters a teamwork attitude in the department to include maintaining good relationships with Adjusters and supervisor, initiative to learn workers comp and offering assistants when daily work has been completed.

6. Identify outside firms in our local area that you would use to defend the City's claims. Describe the claims procedures you have in place for each of the following:

A) Liability/Damage Investigation **York performs investigation services in-house.**

B) Sub-rosa investigation **York performs sub-rosa investigation services in-house.**

7. Identify and describe your in-house services and the expertise of your firm to provide liability investigation, injury/damage assessment and, litigation management Please identify any other cost containment programs you are able to provide.

York will represent the City in all matters related to the set-up, investigation, adjustment, processing, negotiation and resolution of liability claims against the City.

Initial Reporting

York provides the flexibility to report losses through a variety of means, whichever best fits your needs. This includes web, fax, email, and reporting via the US Mail. York establishes a new file within 24 hours of our receipt of the claim submitted by, or on behalf of, the claimant. In cases where a file is to be established without a claim having been submitted, we request the following information: Date and time of Incident; Claimant name; Claimant

address; Claimant phone number; Client contact; Client phone number; Location of incident; and Description of incident. It is our recommendation that all incidents and claims be reported to us as soon as possible to allow us to timely begin our investigation.

Our after-hours emergency number and home telephone numbers of our staff will also be provided as *we provide 24-hour claims service.* Our experience is that our control of the claim from the onset can substantially reduce our client's liability claims costs. After receiving a report of a claim or incident report, we create the claim file and enter the data, including reserves, into the claims information system. We also acknowledge receipt via e-mail, advising the client of the claim number and the Adjuster assigned. We will provide our initial evaluation to the City within five (5) working days. This includes:

- An outline of details of the loss
- Claimant data, including name(s) of claimant(s)
- Initial Reserve recommendation
- Recommended plan of future activity, including governmental tort claim action required; e.g. Notice of Late Claim, Notice of Insufficiency, Notice of Rejection, or no action, if strategy so suggests

This is our normal procedure, *but we are flexible to meet the needs of the City and are willing to modify this procedure.* The City will be provided with a log-in name and password, which allows the City to view Adjuster notes, claims financials, including reserve history and payment details. The City can run custom queries, view standard reports and maintain their own personalized diaries.

Within 30 days of receipt of the claim, we provide our client with a comprehensive written report that contains the following captions:

- *Tort Claim* – Outlines our recommendation for response to the tort claim and the current procedural status.
- *Facts* – Detailed review of the facts of the claim as determined through field investigation (scene inspection, photograph, diagrams, etc.) statements of the parties and witnesses, official reports, internal reports, etc.
- *Injuries and Property Damage* – Review of the claimed injuries and damages for each claimant and discussion of the value of those damages based on documentation and the law.
- *Liability* – Assessment of the client's legal liability based on the information available at that time.
- *Evaluation* – Preliminary assessment of the value of each claim based on verified damages, legal liability, other responsible parties, indemnity/defense rights, additional insured status, Medicare Liens, immunities, and other related factors. This will also include Reserve recommendations.
- *Subrogation/Recovery/Contribution* – Identification of the potential for recovery from other responsible parties for damages sustained by the client and the plan to secure recovery.
- *Excess Reporting* – Confirmation as to whether the loss is reportable to the client's excess pool or carrier(s), the status of such reporting and any coverage issues.

- *Further Activity* - **A clear plan of action that moves the file toward resolution. This will include strategies for negotiations and alternative dispute resolution.**

Ongoing Status Reports

Throughout the pendency of the claim, we provide written status reports that update significant events in the file, particularly those that impact the value and assessment of the claim. Each status report will provide comment and an update of the plan of action. It is our practice to provide status reports every 30 days; however, the frequency and format of these reports can be modified to best meet the RTA's needs.

Closing Report

At the conclusion of each claim, we provide the City with a written report that confirms the basis on which the claim was closed; e.g. tolling of the statute of limitations, settlement, defense verdict, etc. This report also provides a summary of the payments made on the claim and any releases or other closing documents.

Proactive Investigation

York's prompt contact (within 24 hours), with the claimant(s) or claimant's(s') attorney and concise initial investigations can significantly influence future settlement. This also represents our commitment to providing quality customer service. During the first five days after receiving a new claim, our investigation would also include contact with the City's personnel and any witnesses, documented with statements, if possible. We obtain all possible reports, photographs and diagrams of the scene, and even use video when appropriate. We promptly identify indemnity and defense rights owed to the City through contracts and additional insured endorsement and aggressively pursue tenders on their behalf. We report all injury claims to the Index Bureau and have them re-indexed once or twice a year while the claim remains open.

Property damage claims are inspected promptly and the damages evaluated and assessed. Our adjusters are always alert to subrogation and will work with City staff to aggressively pursue recovery from responsible third parties on the City's behalf.

Our adjusters independently verify the facts via statements from involved parties and witnesses. Claims for injury or property damage are evaluated for appropriateness and as required by law.

Tort Claims

York carefully reviews all new claims to assure compliance with the California Tort Claims Act and asserts all available defenses.

- *Gov. Code Section 900 et seq – Tort Claim Filing Procedures* – **We have developed a system for evaluating and processing government tort claims pursuant to Gov. Code Section 900 et seq.**
- *Gov. Code Section 830 et seq. – Tort Claim Immunities* – **All timely claims are evaluated for legal liability and applicable immunities pursuant to the California Government Code, and in particular sections 830 et seq.**

Legal liability for claims arising out of traffic collisions would be assessed pursuant to general principles of tort and/or the California Vehicle Code. Claims arising out of real property owned, designed and/or maintained by the RTA would be assessed for liability and applicable immunities pursuant to Gov. Code section 835 et seq. Claims for which there was no actual or constructive notice, or arising out of trivial defects, would likely be denied. Claims relating to design defects would be evaluated pursuant to the "design immunities" afforded in this section.

Overall, our extensive experience, in this field, provides a holistic approach where we are focused on protecting the City's rights under the Government Claims Act and Government Codes sections 810-996.6 while generating a full and complete assessment of the facts of any claim, based on competent investigation, so all decisions made and information conveyed is grounded in sound judgment coupled with an interpretation of the factual evidence available.

Litigation Management

Litigation Management does not mean "hire an attorney and wait for their bills." Rather, we are actively involved in the process, beginning with "litigation prevention," pro-actively investigating, evaluating, and resolving claims, obviating the need for litigation.

Upon service of the Complaint, and following our referral to defense counsel, within 45 days following assignment, we ensure that defense counsel has submitted a preliminary evaluation of the lawsuit including a litigation plan and budget. We ensure that defense counsel submits status reports no later than every 90 days to include new developments only. We discourage routine submission of repetitive, non-substantive status reports.

We coordinate with defense counsel to properly follow up on investigation/discovery requests, to assist in obtaining expert witness opinions, to complete field investigation, and to notify relevant employees of status and their potential involvement in the discovery process. We ensure that all defense expenses, including, but not limited to, depositions, motions, and discovery, have been approved by the member. We ensure that, no later than 30 days before trial, defense counsel has submitted a report which includes:

- **An assessment of the member's liability exposure.**
- **An assessment of the plaintiff's damages.**
- **An assessment of the legal defenses and probability of prevailing, including significant arguments of each party and expected counter arguments.**
- **Unique characteristics of the jurisdiction, presiding judge and opposing counsel.**
- **The verdict value assuming full liability.**
- **Settlement value, considering defendant's liability exposure and chances**

8. List all existing municipal or other public sector clients in the State of California including names, addresses and phone numbers along with the number of employees served in each organization. (Please attach a separate page with this information)

York administers services for 23 public sector clients in the State of California. Our 23 public entity contracts equate to 110 separate public entity clients, being that they are

members of pools that we service. York does not track the number of employees served in each organization for our general liability clients.

California GL Client List	
Association of Bay Area Governments PLAN	County of Yuba
Calaveras County	East Side Union H.S.D.
California Transit Indemnity Pool	Golden Empire Transit
Capitol Area Development Auth.	Northern California Cities Self Insurance Fund
City of Bakersfield	Small Cities Organized Risk Effort
City of Chico	Ventura County Schools Self Insurance Fund Authority (VCSSFA)
City of Hanford	Riverside Transit Agency
City of Lancaster	County of Yuba
City of Modesto	East Side Union H.S.D.
City of Montebello	Golden Empire Transit
City of Oxnard	Northern California Cities Self Insurance Fund
City of Sacramento	Small Cities Organized Risk Effort
City of San Leandro	Ventura County Schools Self Insurance Fund Authority (VCSSFA)
City of San Mateo	Riverside Transit Agency
City of Vacaville	County of Yuba
County of Sutter	East Side Union H.S.D.
Golden Empire Transit	

9. What philosophy is used by your staff to calculate reserves on open claims? What criteria is used to make reserve changes?

Reserves are based on available facts and probable ultimate cost/exposure of the claim. Reserves are reevaluated and adjusted upon completion of the investigation and/or as material changes occur. Reserves are always reviewed on Adjuster and/or supervisor diary. Initial reserve is established within the first seven (7) days of receipt of the claim. The following factors are to be taken into account when setting a reserve:

- **Liability**
- **Damages**
- **Venue**
- **Facts**
- **Recent Verdict Values**
- **Claimant Legal Representation.**

We establish the applicable reserve within seven (7) days of assignment based on investigation completed to that time. Reserves for loss and expenses, including legal fees and costs, are evaluated and maintained separately in our claims management information system. We set a more precise reserve at the time our full captioned report is due (typically

30 days after assignment) and our investigation is largely complete. Subsequent reserve changes are adjusted within 14 days upon receipt of material changes.

We have a number of reports to offer the City, including our standard Reserve Change Report reflects all claims that have incurred a change in the total incurred reserve value from the previous month. The change, whether increase or decrease, is shown. It states the reserve from the prior month, the change and the new reserve.

10. Supply a sample of your computerized Detail Loss Run, management summaries, and escrow account reconciliation. Please attach any other detailed reports that will illustrate your Risk Management Information System capabilities.

York's RMIS, FOCUS, puts real time reports at the City's fingertips. The system provides the capability to select from a number of reports based on different filters, such as department, type of assignment, and can include billing and claim volume information.

The requested reports can be viewed on screen or printed. There is also an export function that allows the City to do ad hoc queries and export query results to an Excel spreadsheet for manipulation and analysis. Even better, your Account Executive, Chris Shaffer, will assist in report creation and scheduling reports to be sent to the City at your specific intervals.

Our standard package of reports includes, but is not limited to, the following:

- **Reserve History Report – Closed with Payments**
- **Reserve History Report – Open Claims**
- **General or Auto Liability Loss Reports**
- **Losses with transactions within specified period**
- **Transaction Detail Report**
- **"No Loss" Loss Report**
- **Detail Loss Analysis**
- **Check Register by Client**

For samples of Detail Loss Run, Management Summaries, Escrow Account Reconciliation, and many more, please refer to Attachment A: Sample Reports.

11. Describe any additional services your firm can provide that were not previously mentioned in the questionnaire that you feel would improve the City's program:

FOCUS **Just as we have a claims management system designed for our claims professionals, York offers the City a front end system, FOCUS, designed specifically for risk management personnel. FOCUS, is a powerful yet easy-to-use customer interface that will gives users instant access to the risk management information, analytics and reports you want, exactly the way you want to see it. FOCUS contains 100% of the information in our claims system, but it offers a view designed specifically for risk managers.**

With just a click or two, FOCUS helps you:

- **View critical risk management information at a glance**
- **Choose custom dashboards for lines of business or specialized functions such as Finance, Risk Management or Safety**

Let York help you FOCUS on the information you need to manage your risk effectively.

11. Upon selection, the successful bidder will be expected to enter into a contract for services with the City of Salinas. In order to do so, you should indicate your ability to comply with the following conditions:

A) Workers' Compensation Insurance will be maintained for all employees of the Administrator and any employees of any subcontractor who directly or indirectly provides services to the City. Workers' compensation as required by law and employer's liability in amounts of $1,000,000/$1,000,000/$1,000,000, covering Administrator's employees.

York agrees to comply.

B) Comprehensive commercial general liability on a form equivalent to a current ISO CG 00 01 10, in a minimum amount of $1,000,000 each occurrence and covering the City as an additional insured.

York agrees to comply.

C) Commercial automobile liability, covering all autos Administrators use in performing services, in a minimum amount of $1,000,000 each accident and covering the City as an additional insured.

York agrees to comply.

D) Professional Liability, Errors & Omissions Insurance in a minimum amount of $5,000,000 each claim, with a retroactive date no later than the date of this RFP. The professional liability coverage must be continually maintained during the term of service and for at least a year thereafter. If coverage is cancelled, allowed to lapse or replaced with coverage having a later retroactive date, Administrator will purchase an extended reporting period.

York agrees to comply.

E) All required insurance shall be placed with insurance carriers rated at least A VIII by A.M. Best. All policies shall provide that the City will receive at least 30 days prior notice before the coverage is cancelled, but 10 days in the event of cancellation for non-payment of premium is acceptable. Endorsements will be required naming the City as Additional Insured on all Liability insurance policies, except professional liability

York agrees to comply and will agree to name the City as Additional Insured on all liability insurance policies, except professional liability.

F) Fidelity Coverage with a minimum limit of $1,000,000 naming the City as Additional Insured and covering loss to third party property due to Administrator's employees' dishonesty and naming the City as a loss payee. (Note: This is optional, but would be required if the City converts to a self-insured program.)

We will address this in the event the City converts to a self-insured program.

G) All subcontractors or subconsultants hired by Administrator for the performance of the work shall carry at a minimum workers' compensation, commercial general liability,

commercial auto liability and professional liability as required above or as approved by the City.

York agrees to comply.

12. Upon selection the proposer will be expected to enter into a contract for services. Upon the award of business, a Certificate of Insurance shall be furnished, confirming the above minimum requirements.

York agrees and will comply.

Section II

Cost Proposal

(1) We are asking all responders to provide a quote for an Annual Proposed Fee based on an average of 82 claims per year. The Annual Proposed Fee is to be guaranteed for a period of three (3) years, commencing 8/1/17 and ending 7/31/2020 with an option to extend it another two (2) years subject to the approval of the City Council.

Thank you for allowing York Risk Services Group Inc. the opportunity to provide a flat annual fee based on the average number of claims detailed in the RFP and Addendum 1. York agrees that the proposed flat annual fees noted below will be guaranteed for a period of three (3) years, commencing on 8/ 1/17 and ending 7/31/2020 with an option to extend it another two (2) years, as mutually agreed upon.

Term	Flat Annual Fee
Year 1	**$80,169**
Year 2	**$81,772**
Year 3	**$83,407**
Optional Years: Pricing for optional year's four (4) and five (5) will be subject to a 2% increase.	

(2) What is your per Claim fee for:
1 year handling: **Not applicable.**
2 years handling: **Not applicable.**
Life of Claim: **Not applicable.**

(3) Proposed terms of billing (quarterly, monthly) **Monthly**

(4) A statement that the proposed fees will be guaranteed for a 12 month term, with options for additional 12 months periods, as mutually agreed upon (Please Attach)

The proposed fees will be guaranteed for 12 month term, with options for additional 12 month periods, as mutually agreed upon.

REMINDER: COST MUST BE ON A FLAT FEE OR PER CLAIM BASIS. FEES ON A TIME AND EXPENSE BASIS WILL NOT BE CONSIDERED.

Authorized Representative

Please refer to the following pages for York's complete cost proposal.

Definitions:

Annual Fee: York's Annual Fee quotation is a guaranteed flat annual fee and applies to claims administration services provided during the 12 month contract term. Any additional administration beyond the initial 12 month contract term will be subject to an additional negotiated flat annual fee or other mutually agreed upon rate structure. If there is a significant increase in claims volume, York may propose additional charges. If client agrees to such additional charges, the fees will be adjusted accordingly. If client does not agree to such charges, York will have the right to terminate services on 60 days' notice.

Services of the Account Manager, along with telephonic claim reviews, are provided at no additional charge.

General Fees, Services, Terms and Conditions

- Outside Activity/Field Investigations will be billed at $93.00 per hour.
- MMSEA Reporting: $8.75 per claim.
- FOCUS (RMIS) License: 1 license included.
- Billing: York will issue an electronic invoice monthly, via e-mail. Payments shall be due and payable no later than thirty days from the invoice date.
- Pricing has been developed based on provided loss data. In the event that the loss data is erroneous or otherwise incorrect both parties agree to discuss an equitable adjustment of service fees.
- The City may request that the services York performs be rendered in a particular or different way or additional services be provided, and York will make all reasonable efforts to comply. If such request increases York's cost of providing the services, York shall be entitled to an equitable adjustment in its compensation.
- Claims and Allocated Loss Adjustment Expenses (ALAE) may be handled in two ways:
  1. The City may elect to fund an account established and maintained by York. In this case, the City will maintain and provide timely replenishment of funds to pay all Claims and ALAE and to avoid penalties and late payments. York will electronically provide a monthly recap of all deposits as well as Claims and ALAE payments. The City will be responsible for bank fees with respect to the account.
  2. The City may elect to maintain and fund a client-owned account from which York will issue all Claim and ALAE payments. In this case, the City will provide York with the facsimile signature of an officer, director, partner or employee of the City to print digitally on the checks. The City will be responsible for bank fees with respect to the account.

Additionally, the City may elect to make claim payments directly to claimants but will be required to send York the payment records promptly for proper inclusion in the York claim system.

- York's proposed fees will remain in effect for 90 days from the date of this proposal.
- This proposal contemplates that York will be entering into a direct contract with the City. Should York be required to contract with any other party, different terms may apply.

Allocated Loss Adjustment Expenses

York will arrange for various services and other costs as agent for our client. These costs are referred to as Allocated Loss Adjustment Expenses (ALAE). A list of these expenses follows. Payment of ALAE is the responsibility of the City. York's fees do not cover ALAE, and York is under no obligation to pay ALAE with its own funds.

- Fees of outside counsel for claims in suit, coverage opinions and litigation and for representation at hearings or pretrial conferences
- Fees of court reporters
- All court costs, court fees and court expenses
- Fees for service of process
- Costs of undercover operatives and detectives
- Costs for employing experts for the preparation of maps, professional photographs, accounting, chemical or physical analysis, diagrams
- Costs for employing experts for the advice, opinions or testimony concerning claims under investigation or in litigation or for which a declaratory judgment is sought
- Costs for independent medical examination or evaluation for rehabilitation
- Costs of legal transcripts of testimony taken at coroner's inquests, criminal or civil proceeding
- Costs for copies of any public records or medical records
- Costs of depositions and court reported or recorded statements
- Costs and expenses of subrogation
- Costs of engineers, handwriting experts or any other type of expert used in the preparation of litigation or used on a one-time basis to resolve disputes
- Witness fees and travel expenses
- Costs of photographers and photocopy services
- Costs of appraisal fees and expenses (not included in flat fee or performed by others)
- Costs of indexing claimants
- Services performed outside York's normal geographical regions
- Costs of outside investigation, signed or recorded statements
- Out of the ordinary expenses incurred in connection with an individual claim or requiring meeting with the City
- Any other extraordinary services performed by York at the City's request
- Investigation of possible fraud including SIU services and related expenses
- Any other similar cost, fee or expense reasonably chargeable to the investigation, negotiation, settlement or defense of a claim or loss or to the protection or perfection of the subrogation rights of the City.

York may, but need not, elect to utilize its own staff or affiliated entities to perform any of these services.

Section III

Attachments

Attachment A: Sample Reports

Attachment B: General Liability Claims Best Practices

Attachment A

Sample Reports

FOCUS

SAMPLE REPORTS

AND

SCREENSHOTS

YORK

FOCUS CLIENT - 12345

Sample Quarterly Closure Analysis

	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013
Count of Open Claims at Beginning	5018	5077	5127	5182	5233	5293	228	153
Outstanding at Beginning	0	0	0	0	0	0	492,941	1,530,177
Count of Open at Beginning but Closed During	0	0	0	0	0	5102	106	33
Count of Claims Reported During Quarter and Still Open	59	50	55	50	61	37	26	44
Count of Claims Reported and Closed During Quarter	0	0	0	0	0	14	78	70
Count of Claims Open at End of Quarter	5077	5127	5182	5233	5293	228	153	174
Outstanding at End of Quarter	0	0	0	0	0	492,941	1,530,177	1,525,882
Percent Change of Open Claims Beginning to End of Quarter	*1.16%*	*0.98%*	*1.06%*	*0.97%*	*1.13%*	*-2,221.49%*	*-49.02%*	*12.07%*
Percent Change of Outstanding from Beginning to End of Quarter	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*100.00%*	*67.79%*	*-0.28%*
Total Count of Reported During Quarter	59	50	55	50	61	51	104	114
Total Count of Closed During Quarter	0	0	0	0	0	5116	184	103
Count of Claims Available to Close During Quarter	5077	5127	5182	5232	5294	5344	332	267
Closure % as Available to Close	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*95.73%*	*55.42%*	*38.58%*

FOCUS

Sample Triangle

Refresh Data | Export Spreadsheet

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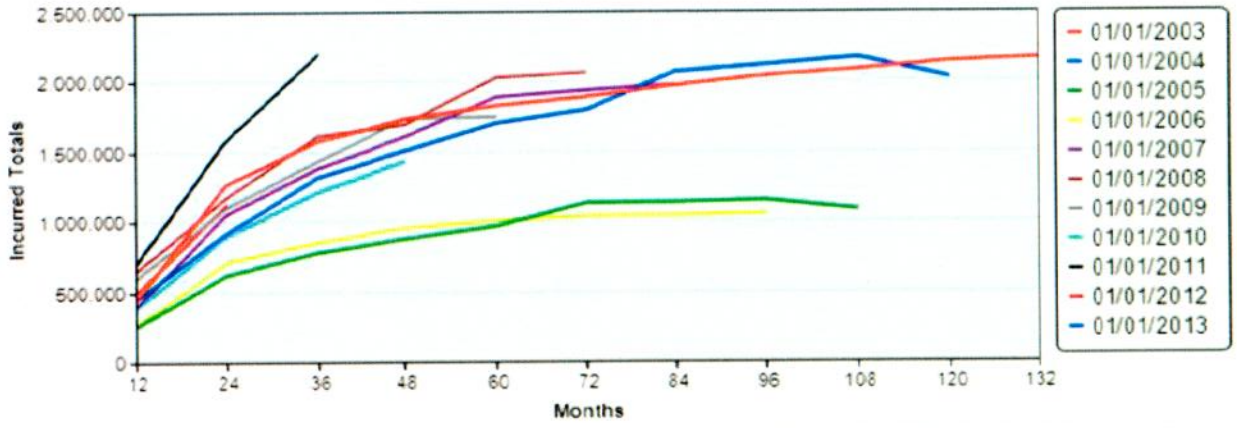
Grand Totals

	12 Months	24 Months	36 Months	48 Months	60 Months	72 Months	84 Months	96 Months	108 Months
12/31/2003	440,393	1,266,980	1,574,538	1,730,998	1,823,835	1,885,483	1,966,636	2,035,759	2,079,421
12/31/2004	445,155	910,706	1,312,344	1,503,130	1,698,834	1,791,844	2,062,599	2,113,087	2,166,381
12/31/2005	251,901	614,898	775,584	871,922	962,916	1,128,613	1,131,697	1,147,353	1,079,550
12/31/2006	263,338	709,943	853,705	954,881	1,005,803	1,037,121	1,042,962	1,055,314	
12/31/2007	391,008	1,050,631	1,378,836	1,605,511	1,885,117	1,932,512	1,971,551		
12/31/2008	647,291	1,172,568	1,611,161	1,693,739	2,026,763	2,061,037			
12/31/2009	593,309	1,097,988	1,430,961	1,734,600	1,745,085				
12/31/2010	381,114	892,292	1,208,423	1,426,867					
12/31/2011	695,667	1,580,200	2,189,602						
12/31/2012	491,892	1,118,797							
12/31/2013	575,546								
	2.32961	1.31969	1.13701	1.10262	1.05564	1.04454	1.02133	99586	98090
	2.26361	1.32690	1.13564	1.10437	1.04608	1.05143	1.02379	1.00550	97993
	2.32595	1.31910	1.13877	1.10313	1.03621	1.02296	1.01916	1.02145	98090



Browse Triangles

This triangle report has no

Projections*
- (•) No projections
- ( ) Use Straight Avg
- ( ) Use Weighted Avg
- ( ) Use Olympic Avg

Triangle Display*
- ( ) Show all
- (•) Incurred totals and char
- ( ) Paid totals and chart
- ( ) Claim counts and chart

Apply Options

FOCUS

Claims >

Preston, Madaline (4502046)

More

Claim Number	4502046
Occurrence Number	0
Claimant	Preston, Madaline
Line of Business	General Liability
Line of Coverage	Commercial General Liability Coverage - Occurrence (CG 00 01)
Line of Sub Coverage	Liability - Bodily Injury
Status	Reopened
Controverted Claim	No
Date of Loss	05/13/2010
Loss Time	12:00 AM
Day of Week	Thursday
Date Reported	05/13/2010
Date Opened	05/13/2010
Date Last Closed	03/27/2013
Date First Closed	03/04/2011
Date Last Reopened	07/30/2014
Event Location	4132 S San Pedro St
State of Accident	Iowa
Loss Description	Hit In Head With A Coffee Pot.

Full Details

Current Financials

Prior Valuation | Show Graph

	Reserves	Paid	Outstanding	Incurred
+ Bodily Injury	7,500.00	7,500.00	0.00	7,500.00
+ Expense	0.00	0.00	0.00	0.00
+ Property Damage	0.00	0.00	0.00	0.00
+ Legal	0.00	0.00	0.00	0.00
Risk Finance	0.00	0.00	0.00	0.00
- Recovery	0.00	0.00	0.00	0.00
- Subrogation	0.00	0.00	0.00	0.00
Net Incurred	**7,500.00**	**7,500.00**	**0.00**	**7,500.00**

Recent Notes

All Notes

Closure Claim has been settled for $7,500. Closing claim.
Julie Krebs on 01/24/2014

Communication with/from Plaintiff's Counsel Settlement agreed at $7,500
Julie Krebs on 01/24/2014

Communication with/from Plaintiff's Counsel Ageed to meet to discuss medical and settlement.
Julie Krebs on 01/24/2014

Action Plan After reviewing the medicals and the witness statement I believe it would be in the best interest of the insured to settle the claim.
Julie Krebs on 01/24/2014

Communication with/from Plaintiff's Counsel Received call from Claimant Attorney. Claimant wishes to settle claim. Asking for $10,000.
Julie Krebs on 01/24/2014

Files

All Files

- Initial Reserves
- Witness Statements.
- 5/13/10 Medical Record

FOCUS CLIENT - 12345

Incurred\Paid Change Last Year

Line of Business	01/01/2013 Claim Count	01/01/2013 Incurred Paid	12/31/2013 Claim Count	12/31/2013 Incurred Paid	Difference Incurred Paid	% Change Incurred Paid
		5,097,445		5,810,188	712,742	13.98%
Auto Liability	1,245	5,080,711	1,350	5,233,108	152,397	3.00%
		1,411,376		2,080,305	668,929	47.40%
General Liability	1,624	1,332,350	1,680	1,599,650	267,300	20.06%
		11,890		41,791	29,901	251.48%
Professional Liability	2	5,945	2	11,232	5,287	88.93%
		21,515		21,515	0	0.00%
Property	200	21,515	202	21,515	0	0.00%
		32,124,769		34,534,174	2,409,405	7.50%
Workers Compensation	5,293	32,115,182	5,642	32,587,320	472,138	1.47%
		38,666,995		**42,487,972**	**3,820,977**	**9.88%**
Grand Totals:	**8,364**	**38,555,703**	**8,876**	**39,452,824**	**897,121**	**2.33%**

FOCUS

FOCUS CLIENT - 12345

Summary by Coverage

3 - Year Summary (10/01/2007 - 09/30/2010)

Line of Business	Claim Count	Total Incurred	Total Paid	Total Outstanding	Avg Incurred	Max Incurred
Auto Liability	244	1,123,934	912,017	211,917	4,606	250,000
General Liability	249	932,514	701,185	231,329	3,745	224,232
Property	46	11,615	11,615	0	252	11,615
Workers Compensation	781	5,154,837	4,952,068	202,769	6,600	329,667
Grand Totals	**1,320**	**7,222,899**	**6,576,885**	**646,015**	**5,472**	**329,667**

FOCUS

YORK

YORK FOR *(Client Name)* - CLIENT # XXX
CLIENT BANK ACCOUNT # xxxxxxxxxxx
BANK RECONCILIATION
FOR THE PERIOD ENDED 0X/31/20XX

	LEDGER	BANK	DIFFERENCE
BEGINNING BALANCE AT 0X/01/2015 - PRIOR MONTH O/S	($798,611.80)	($797,674.95)	**($936.85)**
Add			
Deposit - **PAID CHECKS**	$2,126,278.00	$2,126,278.00	0.00
Less			
CHECK ISSUES - Current Month	($2,290,483.94)	($2,290,483.94)	$0.00
Voids of Current Month - CANCELS	$76,873.11	$76,378.34	$494.77
	($2,213,610.83)		
BALANCE BEFORE ADJUSTMENT	**($885,944.63)**	**(885,502.55)**	
Reconciling Items - Adjustments			
Check # 399283 voided on 0X/XX/15, but showing as cancelled in XXXXX'15 bank statement.		($442.08)	$442.08
	$0.00	($442.08)	
Balancing			
Current month Issues + Cancels	($2,213,610.83)		
Prior Month O/S Less Current Month O/S	$87,332.83		
Less Reconciling Items	$0.00		
Equals Paid Checks	($2,126,278.00)		

Current month voids	$76,873.11	76,378.34	
Check # 356470 voided in books on 0X/0X/15, but showing as cancelled in XXXXX '15 bank statement.		99.00	
Check # 366946 voided in books on 0X/0X/15, but showing as cancelled in XXXXX '15 bank statement.		7.85	
Check # 384695 voided in books on 0X/0X/15, but showing as cancelled in XXXXX '15 bank statement.		460.00	
Check # 407136 voided in books on 0X/0X/15, but showing as cancelled in XXXXX'15 bank statement.		370.00	
Check # 399283 voided on 0X/01/15, but showing as cancelled in XXXXX '15 bank statement.		(442.08)	
Equals Adjusted Voids	76,873.11	76,873.11	
ADJUSTED ENDING BALANCE AT 0X/31/2015	($885,944.63)	($885,944.63)	**$0.00**

Prepared By:	***xxxxx xxxxx, Accountant, (909) xxx-xxxx***
Approved By:	***xxxx xxxx, Accounting Manager, (909) xxx-xxxx***

Attachment B

General Liability Claims Best Practices

YORK™
Risk Services Group

BEST PRACTICE GUIDELINES

CASUALTY CLAIMS

York PLUS
Confidential and Proprietary
York Risk Services Group – August 20, 2015

File Management/Reporting

Initial Contact:

To meet and/or exceed expectations, the claim should reflect that the insured and claimant (or their representative) have been contacted by end of next business day (from date of adjuster's receipt). The contact person to whom the claim handler spoke should be identified and information obtained from each contact thoroughly documented. Sufficient information must be documented in the claim file to determine what issues are present that are relevant. If initial contact can not be completed by end of next business day the claim shall be documented as to the specific reasons why the contact could not be completed or was not necessary. Therefore, initial investigation contacts must be completed by end of next business day after adjuster notification. If 2 attempted contacts were unsuccessful, contact letter must be sent by the end of the next business day.

Contact: Transferred File

To meet or exceed expectations, the file should reflect that the insured, client, claimant, and vendors have been notified of change in adjuster. Use of reassignment template called "File transfer Contact letter" found in York Claims Expert is acceptable. Notice must be provided within 14 calendar days.

CMRs Accurate and Timely:

Claims Management Reviews (CMR) are to be completed by the 30th day if the loss is reported to the client/carrier. On claims that are not reported and fall within York's office authority a "CMR" must be completed by the 90th day of the file. The CMRs are also required when the indemnity reserve reaches the $50,000 level on all bodily injury &/or general liability property PD claims. Subsequent CMRs are to be completed every 90 days. The CMRs must be timely, thorough and accurately reflect current claim circumstances including any significant changes that have occurred since the previous review. The plan of action must be proactive and provide a rationale for claim resolution. The CMR should be grammatically correct with proper spelling and reflect a logical thought process.

CMRS are not necessary when:

- The client wishes their own form to be completed in lieu of the CMR
- CMRs are not required on collision, comprehensive, med-pay, PIP/No Fault and third party auto PD losses unless they are reportable to the client/carrier.

Reportables - Accurate and Timely:

Claims may be reportable (to client, excess, carrier, etc) because of defined "triggers". Reports are to be sent within fourteen (14) calendar days of recognizing any reportable trigger and thereafter as specified by account instructions or those we are reporting to. Claims will meet expectations if the reporting is timely, complies with required format and contains information that accurately reflects changing claim circumstances. Failure to recognize reportable triggers, and/or send an initial report within 45 days of recognizing the trigger, will be considered **unacceptable** and will automatically result in failure of the entire File Management category.

Accurate and Timely Communication:

Appropriate action must be taken on all written communication (mail, email, fax, etc), including supervisory instructions, within 5 business days and a response to any telephonic communication or time sensitive correspondence is required by the end of the next business day. Responses are professional in both content and format. Reporting has complied with jurisdictional requirements in those states which require notification/reporting. Documentation of communication should be summarized, not copied and pasted into file notes.

File Notes Timely and Appropriate:

Best Practices require that documented activity is clear and made at regular intervals based on claim activity. Incoming documents are to be properly annotated in the claim within five business (5) days of receipt (time sensitive material by the end of the next business day). File notes should support when claim reviewed and reflect current plan of action. File notes should be clear, concise, properly categorized, and reflect changing claim dynamics. Proper grammar, and spelling, should be utilized. Acronyms and abbreviations should be limited. File notes should not be based on emotion or opinions but factually supported, nor any comments related to race, religion, etc that are not pertinent to the investigation. A clear rationale for decisions made that affect claim resolution should be evident.

Effective Use of Hot List/Diary:

Effective use of diary to monitor all case activity is an integral part of claim management. Adjusters are required to use diary to track and coordinate planned activity as well as acting on prioritized diary types. Diary should be set as facts warrant. At time of diary review, the Plan of Action items shall be updated and addressed, as appropriate. Therefore, diaries are completed/appropriate actions taken within 7 days of effective due date.

Claims System Data Accurate and Timely/Proper Coding:

Data integrity relies on up-to-date coding within the claim file. Coding should be complete and updated upon receipt of appropriate information. Proper coding includes but is not limited to: cause, coverage, litigation log, recovery tab, and loss description coding along with marking the third party deductible box. It is also imperative that the initial fields pertaining to Medicare (Social Security or HICN, Gender, DOB, First and Last Name) are completed timely and accurately on ALL Bodily Injury claims. Claims found "Medicare Eligible = YES" have appropriate subsequent coding completed in a timely and accurate manner, consistent with Best Practices. If the claim is not subject to Medicare reporting, the file must contain documentation as to why.

Adherence to Special Account Instructions:

Claim supports that special client specific account instructions were followed. This includes adherence to assignment requests, client instructions, and billing guidelines. Therefore, claim documentation reflects compliance with client specific instructions.

Public Entity Compliance:

Proper application of public entity claim filing requirements and defined liability dictated by applicable government code. This includes, but is not limited to claims filing, immunities, defense obligations for public employees, judgment offsets, risk transfer, etc. Application of the claim requirements and various defenses will help avoid exposure to the government entity, including increased monetary exposure.

State Specific Compliance*:

Proper understanding and application of State laws and Department of Insurance regulations to meet our local obligations in each state is reflected in the file documentation. This includes, but is not limited to proper application of claim requirements and various defenses in the claim venue.

*Please refer to the California Fair Claims Settlement Practices Regulations, attached.

Coverage

Timely and Accurate Verification:

File contains evidence that a valid policy/MOC was in force and the date of loss was within policy period. File notes document how coverage was confirmed. A complete copy of policy is attached to the claim file. Applicable coverage details are documented in the claim. Coverage was confirmed within 7 days of receipt of loss. When confirmation within 7 days is not possible, file notes contain a clear explanation as to what is being done to confirm coverage. Where claim is subject to MOC, the examiner is responsible to identify any potential coverage issues and refer to management within 7 day of receipt of facts that indicate a coverage issue. All coverage issues and actions are to be clearly documented. When a claim is reassigned from one adjuster to another, the new adjuster must document in the file notes, within 7 days that coverage has been reviewed and enter a plan of action if there are any coverage issues. If the prior adjuster did not adequately document coverage, the new adjuster must document a detailed analysis.

Coverage Investigation:

Necessary investigation was done to determine that insured was a covered party/entity and all applicable endorsements were evaluated. All coverage issues are clarified and addressed.

Coverage Correctly Analyzed and Applied:

There is a clear and concise review of the policy and proper application to the facts of the loss and parties involved. Coverage is correctly evaluated and applied, or a plan is laid out as to what will be done to obtain missing information.

Coverage Approvals:

Coverage situations that require management or client approval show evidence that necessary authority was requested with timely follow up, and was obtained in a timely manner.

Coverage Letters:

All necessary letters, such as Reservation of Rights, denials, or tenders, were sent to applicable parties timely and contained requisite language. Preapproval was obtained and documented where required. Letters were sent certified where required by jurisdiction or client instructions. .Letters state all pertinent information in a concise and accurate manner.

Investigation

Investigation Plan Timely and Appropriate:

Investigation needed is explained in claim documentation and the Plan of Action (POA) clearly states how this will be achieved. All investigations should reflect plan of action as to the issues to be investigated; i.e. the appropriate individuals to be interviewed, and the information to be obtained (signed statements, personnel records, medical records/permits, contracts, tenders to/from third parties, etc.) The investigation required should reflect proactive attempts to complete in-house; or if warranted, referral to field investigation. If referral is necessary, approval is documented from the client. Therefore, all key issues are addressed in POA and POA is completed within 3 days.

Investigation Thorough – Planned and Executed:

The claim is documented as to the progress and results of the investigation per the plan of action and identifies further activity necessary. Investigation addresses all issues identified in the plan of action. Also, there is adherence to timelines set in POA/assignment instructions.

SIU/Surveillance Utilized Appropriately:

When investigation reveals factual discrepancies or "red flags" are identified, referral for an SIU and/or surveillance investigation is made. A budget is obtained and followed. SIU and/or surveillance investigation results are followed up timely and applied. When necessary, client approval is obtained and evident in the claim. The action should be initiated within 5 working days and the SIU investigation results are utilized appropriately.

Statement was Timely and on Point:

In those circumstances where need for a recorded or written statement is identified, the statement should be completed as soon as the need is identified. A recorded statement summary should reflect that mandated legal disclosures were made to the party being interviewed, the statement covers all pertinent issues raised by the claim, and the claim is documented as to what further issues need to be addressed. If not taken by the claim examiner, reason for additional assistance is documented.

Appropriate Management of Field Services/Expense Control:

Clear instructions were given with field assignments. There is evidence of follow up with and control of the vendor (York or external), and the work product submitted by the vendor has been thoroughly reviewed. All assignment issues were appropriately addressed. The vendor's service invoice was proper.

Evaluation

Timely and Appropriate Liability Analysis:

Claim reflects a timely and accurate liability analysis. The elements of negligence are addressed and all pertinent statutes are discussed. Any liability defenses are also addressed.

Timely Damage Verification and Analysis:

All specials received have been verified and analyzed. This includes documentation that specials have been reviewed and any unrelated portions have been recognized. There is a clear plan of action to address any gaps in documentation and information received is properly summarized. Mitigating and Aggravating factors are addressed.

Collateral Source/Liens Considered:

All liens are documented and addressed in a timely matter, especially Medicare/Medicaid eligibility. Any potential collateral sources are addressed and if jurisdiction has a collateral source rule or lien requirements, they are explained.

Exposure Analysis:

The analysis of coverage, liability, and damages is combined in a clear evaluation of exposure. Reserves should reflect resulting analysis. For claims with a reserve over $25,000, a Reserve and Settlement Evaluation worksheet is required. When not required, the evaluation of damages must be clearly explained in claim notes. The exposure analysis is detailed and logical. It is supported by details from earlier evaluations and is utilized in establishing timely reserves.

Reserving Section

Timely Reserving of Exposure:

Reserves were based on available facts and probable ultimate cost/exposure of the claim. Reserves will be re-evaluated and adjusted as material changes occur. Reserves should always be reviewed on adjuster and/or supervisor diary. Initial reserve will be established within the first five (5) days of receipt of the claim. Subsequent reserve changes are to be adjusted within 14 days upon receipt of material changes. Any deviation is documented in the claim file. Evidence of stair stepping reserves to cover payments is considered unacceptable.

Reserve Rationale:

A reserve worksheet shall be completed on all files where a CMR is required. When a CMR is not required, documentation in the file notes must clearly justify the amounts for both indemnity and expense reserves. Documentation is clear and accurate and justifies amounts held in reserve for probable ultimate cost/exposure.

Negotiation

Negotiation Plan Timely and Appropriate:

There is evidence that a negotiation plan is in place, supported by the exposure analysis. Negotiations are the responsibility of the adjuster. Any delegation must be clearly documented. If no current plan is in place, notes explain what is necessary to develop it. The negotiation plan is being followed and when circumstances warrant, the plan is adapted to address any changes. Authority is obtained where necessary.

Timely Initiation of Negotiations:

Claim indicates that negotiations are initiated and responded to timely. This includes making offers, responding to demands, addressing counteroffers, etc. Negotiations may be initiated before all damages are documented as long as the negotiations are based only on documentation that have been analyzed and confirmed.

Proper Documentation of Settlement Demands and Offers:

Claim documents what demands and offers have been made – when, by whom, and what was done as a result. When case is settled, proper documentation is attached. Settlement process is done timely.

Case Negotiated Effectively and Within Authority:

Claim demonstrates that negotiation plan was followed. Any authority required to settle case was obtained timely and settlement was within authority.

Litigation

Appropriate litigation referral:

Lawsuit is reviewed for coverage issues. Such issues are identified and addressed before referral to defense counsel. Before referral, settlement and/or stipulation was considered. Claim documentation identifies the need for litigation referral. Litigation is assigned to approved counsel. Written referral to counsel includes clear instructions is completed within 5 working days and includes vendor referral letter (York Claims Expert template) advising client will be responsible for payment of service invoices. Litigation log is complete.

Appropriate Documentation of Defense Strategy and Budget:

Once counsel has been assigned, claim should reflect that adjuster discussed claim with counsel **and agreed** on litigation strategy. The adjuster will oversee counsel's litigation reporting to ensure that counsel complies with the agreed plan and stays within the submitted budget. Discussions are evident with defense counsel and reports are received timely or the claim supports efforts to obtain the report. Claim reflects appropriate evaluation and summary of agreed strategy and budget.

On-going Direction from Adjuster to Defense Counsel:

The claim file will reflect that there is proactive communication with defense counsel on development of a viable litigation strategy to resolve the claim. There is confirmation that the agreed strategy is followed and effectively implemented. If not, has client been advised?

Legal Bills Reviewed for Accuracy and Appropriateness:

Upon receipt of billing invoices, the claim should reflect that the adjuster has reviewed them for accuracy, client guidelines, excessive and/or duplicative billing, and compliance with budget plan. Appropriate corrective action has been taken with counsel when billing inconsistencies are discovered. The claim documents that the bills were reviewed within 5 days of receipt. Inconsistencies are addressed with counsel.

Litigation Date Management:

The claim should contain documentation that all upcoming mediations, arbitrations, hearings, and trial dates have been addressed. If needed, client authority and notification is documented in the claim file.

Recovery

Contribution Potential Identified and Pursued:

The claim documentation shall reflect that potential contribution (incl. other coverage, excess, reinsurance, etc) has been identified and responsible parties placed on notice of their exposure. Claim documentation will state the percentage of allocation and reflect aggressive pursuit for contribution.

Subrogation Potential Recognized and Pursued*:

All potential third parties and their potential insurance is identified, put on notice at first knowledge, and pursued within the statute of limitations. Claim documentation will reflect aggressive pursuit. Recovery tab is completed.

Timely Reporting of Recovery Potential to Specialist:

The claim is referred within five (5) days of sending notice to any potential third party, to the appropriate specialist.

Salvage Properly Handled and Identified:

Salvage is identified and plans to address its disposal are clear. Effort to leave salvage with owner and apply credit is attempted. If vendor is used for disposal, claim indicates location of salvage, plans for disposal, and any associated costs.

Recovery of Third Party Deductibles pursued:

There is evidence in the claim as to whether a third party deductible applies. Necessary and timely (5 days) notification was sent so that deductible could be recovered. In cases where adjuster is required to make recovery, there is evidence that the deductible was recovered and processed appropriately.

Supervision

1. **Did the Supervisor review and provide initial direction when appropriate?**
   - Was initial file direction given when necessary? Was it file specific or generic?
   - If issues were apparent initially that called for specific instructions, were they given?
   - Given the complexity of the case and the experience level of the claim professional, if guidance was needed, was it provided?

2. **Was appropriate follow-up guidance provided?**
   - Given the complexity of the case and the experience level of the claim professional, if guidance was needed, was it provided?
   - Notwithstanding case complexity and the experience level of the claim professional, did the direction and progress of the claim warrant Supervisor intervention?
   - Did the direction provided address outstanding issues and/or any deficiencies in the file? This would include a review of the adjusters reserving practices and rationale.
   - Did supervisor approve necessary reports, reserve changes forms etc.
   - Was the frequency of direction appropriate based on the needs of the file?

3. **Is there evidence of effective supervision?**
   - If appropriate direction was provided but not responded to by the adjuster, is there evidence of the Supervisor taking appropriate action to follow-up and assure compliance over and above a repeat of the original request? Such actions could be discussing the issue with the adjuster, providing training or counseling reference the missed issue etc. (Note it is not appropriate to document adjuster performance improvement plans or HR issues in the claim file, however the claim file must show that the supervisor coordinated action on the file if the adjuster is not responsive to supervisory notes.)