

satisfactorily performed will be performed only when approved in advance and authorized by County.

4. **Payment.** The fees shall be calculated at the rates set forth in the attached Exhibit A. The Maximum Compensation for the performance of Services within the Scope of Services described in Exhibit A is Six Hundred Fifty-Seven Thousand Two Hundred Ninety-Six and 00/100 dollars (\$657,296.00) (first year compensation shall not exceed \$340,000). In no case shall the amount paid by County under this Agreement exceed the Maximum Compensation without an approved change order. CCMSI understands and agrees that the Maximum Compensation stated is an all-inclusive amount and no additional fee, cost or reimbursed expense shall be added whatsoever to the fees stated in the Exhibit(s). County will pay CCMSI based on the following procedures: Upon completion of the tasks identified in the Scope of Services, CCMSI shall submit to County one (1) original copies of invoices showing the amounts due for services performed in a form acceptable to County. Contractor may submit electronically via: apauditor@fortbendcountytexas.gov. County shall review such invoices and approve them within 30 calendar days with such modifications as are consistent with this Agreement and forward same to the Auditor for processing. County shall pay each such approved invoice within thirty (30) calendar days. County reserves the right to withhold payment pending verification of satisfactory work performed.
5. **Limit of Appropriation.** CCMSI clearly understands and agrees, such understanding and agreement being of the absolute essence of this Agreement, that County shall have available the total maximum sum of Six Hundred Fifty-Seven Thousand Two Hundred Ninety-Six and 00/100 dollars (\$657,296.00) (first year compensation shall not exceed \$340,000), specifically allocated to fully discharge any and all liabilities County may incur. CCMSI does further understand and agree, said understanding and agreement also being of the absolute essence of this Agreement, that the total maximum compensation that CCMSI may become entitled to and the total maximum sum that County may become liable to pay to CCMSI shall not under any conditions, circumstances, or interpretations thereof exceed Six Hundred Fifty-Seven Thousand Two Hundred Ninety-Six and 00/100 dollars (\$657,296.00) (first year compensation shall not exceed \$340,000). In no event will the amount paid by the County for all Services under this Agreement exceed this Limit of Appropriation without an amendment executed by the parties. In no event shall said termination of this Agreement or County's failure to appropriate said funds be deemed a breach or default of this Agreement or create a debt by County in any amount(s) in excess of those previously funded.
6. **Public Information Act and Open Meetings Act.** CCMSI expressly acknowledges that County is subject to the Texas Public Information Act, TEX. GOV'T CODE ANN. §§ 552.001 *et seq.*, as amended, and notwithstanding any provision in the Agreement to the contrary, County will make any information related to the Agreement, or otherwise, available to third parties in accordance with the Texas Public Information Act. Any proprietary or confidential information marked as such provided to County by CCMSI shall not be disclosed to any third party, except as directed by the Texas Attorney General in response to a request for such under the Texas Public Information Act, which provides for notice to the owner of such marked information and the opportunity for the owner of such information to notify the

Attorney General of the reasons why such information should not be disclosed. The terms and conditions of the Agreement are not proprietary or confidential information.

CCMSI expressly acknowledges that County is subject to the Texas Open Meetings Act, TEX. GOV'T CODE ANN. §§ 551.001 *et seq.*, as amended, and notwithstanding any provision in the Agreement to the contrary, County will comply with the provisions of the Texas Open Meetings Act in relation to the Agreement.

7. **Indemnity.** The parties agree that under the Constitution and laws of the State of Texas, County cannot enter into an agreement whereby County agrees to indemnify or hold harmless another party; therefore, all references of any kind to County defending, indemnifying, holding or saving harmless CCMSI for any reason are hereby deleted. CCMSI shall indemnify and defend County against all losses, liabilities, claims, causes of action, and other expenses, including reasonable attorney's fees, arising from activities of CCMSI, its agents, servants or employees, performed under this agreement that result from the negligent act, error, or omission of CCMSI or any of CCMSI's agents, servants or employees.
8. **Applicable Law; Arbitration; Attorney Fees; Record Retention.** The laws of the State of Texas govern all disputes arising out of or relating to this Agreement. The parties hereto acknowledge that venue is proper in Fort Bend County, Texas, for all legal actions or proceedings arising out of or relating to this Agreement and waive the right to sue or be sued elsewhere. Nothing in the Agreement shall be construed to waive the County's sovereign immunity. County does not agree to submit disputes arising out of the Agreement to binding arbitration. Therefore, any references to binding arbitration or the waiver of a right to litigate a dispute are hereby deleted. County does not agree to pay any and/or all attorney fees incurred by CCMSI in any way associated with the Agreement. Nothing in this Agreement will be construed to waive the requirements of any record retention laws applicable to County.
9. **No Waiver of Jury Trial.** The County does not agree that all disputes (including any claims or counterclaims) arising from or related to this Agreement shall be resolved without a jury. Therefore, any references to waiver of jury trial are hereby deleted.
10. **Certain State Law Requirements for Contracts.** The contents of this Section are required by Texas Law and are included by County regardless of content. For purposes of Sections 2252.152, 2271.002, and 2274.002, Texas Government Code, as amended, CCMSI hereby verifies that CCMSI and any parent company, wholly owned subsidiary, majority-owned subsidiary, and affiliate:
 - a. Unless affirmatively declared by the United States government to be excluded from its federal sanctions regime relating to Sudan or Iran or any federal sanctions regime relating to a foreign terrorist organization, is not identified on a list prepared and maintained by the Texas Comptroller of Public Accounts under Section 806.051, 807.051, or 2252.153 of the Texas Government Code.
 - b. If employing ten (10) or more full-time employees and this Agreement has a value of \$100,000.00 or more, CCMSI does not boycott Israel and is authorized to agree in such

contracts not to boycott Israel during the term of such contracts. "Boycott Israel" has the meaning provided in § 808.001 of the Texas Government Code.

- c. If employing ten (10) or more full-time employees and this Agreement has a value of \$100,000.00 or more, CCMSI does not boycott energy companies and is authorized to agree in such contracts not to boycott energy companies during the term of such contracts. "Boycott energy company" has the meaning provided in § 809.001 of the Texas Government Code.
- d. If employing ten (10) or more full-time employees and this Agreement has a value of \$100,000.00 or more, CCMSI does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association and is authorized to agree in such contracts not to discriminate against a firearm entity or firearm trade association during the term of such contracts. "Discriminate against a firearm entity or firearm trade association" has the meaning provided in § 2274.001(3) of the Texas Government Code. "Firearm entity" and "firearm trade association" have the meanings provided in § 2274.001(6) and (7) of the Texas Government Code.

11. **Modifications and Waivers.** The parties may not amend or waive this Agreement, except by a written agreement executed by both parties. No failure or delay in exercising any right or remedy or requiring the satisfaction of any condition under this Agreement, and no course of dealing between the parties, operates as a waiver or estoppel of any right, remedy, or condition. The rights and remedies of the parties set forth in this Agreement are not exclusive of, but are cumulative to, any rights or remedies now or subsequently existing at law, in equity, or by statute.

12. **Human Trafficking.** BY ACCEPTANCE OF CONTRACT, CCMSI ACKNOWLEDGES THAT FORT BEND COUNTY IS OPPOSED TO HUMAN TRAFFICKING AND THAT NO COUNTY FUNDS WILL BE USED IN SUPPORT OF SERVICES OR ACTIVITIES THAT VIOLATE HUMAN TRAFFICKING LAWS.

13. **Use of Customer Name.** CCMSI may use County's name without County's prior written consent only in any of CCMSI's customer lists, any other use must be approved in advance by County.

14. **Performance Warranty.** CCMSI warrants to County that CCMSI has the skill and knowledge ordinarily possessed by well-informed members of its trade or profession practicing in the greater Houston metropolitan area and CCMSI will apply that skill and knowledge with care and diligence to ensure that the Services provided hereunder will be performed and delivered in accordance with the highest professional standards.

CCMSI warrants to County that the Services will be free from material errors and will materially conform to all requirements and specifications contained in the attached Exhibit A, and the requirements and specifications of TIPS Cooperative Contract No. 230103.

15. **Conflict.** In the event there is a conflict between this Addendum and the Agreement, this Addendum controls. In the event there is a conflict between this Addendum and the terms

and conditions of TIPS Cooperative Contract No. 230103, then the terms and conditions of TIPS Cooperative Contract No. 230103 controls to the extent of the conflict.

16. **Understanding, Fair Construction.** By execution of this Addendum, the parties acknowledge that they have read and understood each provision, term and obligation contained in this Addendum. This Addendum, although drawn by one party, shall be construed fairly and reasonably and not more strictly against the drafting party than the nondrafting party.
17. **Captions.** The section captions used in this Agreement are for convenience of reference only and do not affect the interpretation or construction of this Agreement.
18. **Electronic and Digital Signatures.** The parties to this Agreement agree that any electronic and/or digital signatures of the parties included in this Agreement are intended to authenticate this writing and to have the same force and effect as the use of manual signatures.
19. **Assignment and Delegation.**
 - 19.1. Neither party may assign any of its rights under this Agreement, except with the prior written consent of the other party. That party shall not unreasonably withhold its consent. All assignments of rights are prohibited under this subsection, whether they are voluntarily or involuntarily, by merger, consolidation, dissolution, operation of law, or any other manner.
 - 19.2. Neither party may delegate any performance under this Agreement.
 - 19.3. Any purported assignment of rights or delegation of performance in violation of this Section is void.
 - 19.4. Nothing herein shall be construed as creating any personal liability on the part of any officer or agent of the County.
20. **Successors and Assigns.** County and CCMSI bind themselves and their successors, executors, administrators and assigns to the other party of this Agreement and to the successors, executors, administrators and assigns of the other party, in respect to all covenants of this Agreement.
21. **Personnel.** CCMSI represents that it presently has, or is able to obtain, adequate qualified personnel in its employment for the timely performance of the Services required under this Agreement and that CCMSI shall furnish and maintain, at its own expense, adequate and sufficient personnel, in the opinion of County, to perform the Services when and as required and without delays.

All employees of CCMSI shall have such knowledge and experience as will enable them to perform the duties assigned to them. Any employee of CCMSI or agent of CCMSI who, in the opinion of County, is incompetent or by his conduct becomes detrimental to providing Services pursuant to this Agreement shall, upon request of County, immediately be removed from association with the Services required under this Agreement.

When performing Services on-site at the County, CCMSI shall comply with, and ensure that all CCMSI Personnel comply with, all rules, regulations and policies of County that are communicated to CCMSI in writing, such as building security procedures, including the restriction of access by County to certain areas of its premises or systems for security reasons, and general health and safety practices and procedures.

22. **Compliance with Laws.** CCMSI shall comply with all federal, state, and local laws, statutes, ordinances, rules and regulations, and the orders and decrees of any courts or administrative bodies or tribunals in any matter affecting the performance of this Agreement, including, without limitation, Worker's Compensation laws, minimum and maximum salary and wage statutes and regulations, licensing laws and regulations. When required by County, CCMSI shall furnish County with certification of compliance with said laws, statutes, ordinances, rules, regulations, orders, and decrees above specified.
23. **Confidential Information.** CCMSI acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Agreement, be exposed to or acquire information that is confidential to County. Any and all information of any form obtained by CCMSI or its employees or agents from County in the performance of this Agreement shall be deemed to be confidential information of County ("Confidential Information"). Any reports or other documents or items (including software) that result from the use of the Confidential Information by CCMSI shall be treated with respect to confidentiality in the same manner as the Confidential Information. Confidential Information shall be deemed not to include information that (a) is or becomes (other than by disclosure by CCMSI) publicly known or is contained in a publicly available document; (b) is rightfully in CCMSI's possession without the obligation of nondisclosure prior to the time of its disclosure under this Agreement; or (c) is independently developed by employees or agents of CCMSI who can be shown to have had no access to the Confidential Information.

CCMSI agrees to hold Confidential Information in strict confidence, using at least the same degree of care that CCMSI uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties or use Confidential Information for any purposes whatsoever other than the provision of Services to County hereunder, and to advise each of its employees and agents of their obligations to keep Confidential Information confidential. CCMSI shall use its best efforts to assist County in identifying and preventing any unauthorized use or disclosure of any Confidential Information. Without limitation of the foregoing, CCMSI shall advise County immediately in the event CCMSI learns or has reason to believe that any person who has had access to Confidential Information has violated or intends to violate the terms of this Agreement and CCMSI will at its expense cooperate with County in seeking injunctive or other equitable relief in the name of County or CCMSI against any such person. CCMSI agrees that, except as directed by County, CCMSI will not at any time during or after the term of this Agreement disclose, directly or indirectly, any Confidential Information to any person, and that upon termination of this Agreement or at County's request, CCMSI

will promptly turn over to County all documents, papers, and other matter in CCMSI's possession which embody Confidential Information.

CCMSI acknowledges that a breach of this Section, including disclosure of any Confidential Information, or disclosure of other information that, at law or in equity, ought to remain confidential, will give rise to irreparable injury to County that is inadequately compensable in damages. Accordingly, County may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies that may be available. CCMSI acknowledges and agrees that the covenants contained herein are necessary for the protection of the legitimate business interest of County and are reasonable in scope and content.

CCMSI in providing all Services hereunder agrees to abide by the provisions of any applicable Federal or State Data Privacy Act.

24. Termination.

24.1. Termination for Convenience. County may terminate this Agreement at any time upon thirty (30) days written notice.

24.2. Termination for Default. County may terminate the whole or any part of this Agreement for cause in the following circumstances:

(a). If CCMSI fails to timely perform Services pursuant to this Agreement or any extension thereof granted by the County in writing;

(b). If CCMSI materially breaches any of the covenants or terms and conditions set forth in this Agreement or fails to perform any of the other provisions of this Agreement or so fails to make progress as to endanger performance of this Agreement in accordance with its terms, and in any of these circumstances does not cure such breach or failure to County's reasonable satisfaction within a period of ten (10) calendar days after receipt of notice from County specifying such breach or failure.

24.3. If, after termination, it is determined for any reason whatsoever that CCMSI was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the County in accordance with § 24.1 above.

24.4. Upon termination of this Agreement, County shall compensate CCMSI in accordance with § 4, above, for those Services which were provided under this Agreement prior to its termination and which have not been previously invoiced to County. CCMSI's final invoice for said Services will be presented to and paid by County in the same manner set forth in § 4 above.

- 24.5. If County terminates this Agreement as provided in this Section, no fees of any type, other than fees due and payable at the Termination Date, shall thereafter be paid to CCMSI.
- 24.6. If County terminates this Agreement prior to the termination date, County shall not be subject to any early termination fee or other penalty.
- 24.7. Upon termination of this Agreement for any reason, if CCMSI has any property in its possession belonging to County, CCMSI will account for the same, and dispose of it in the manner the County directs.
25. **Independent Contractor.** In the performance of work or services hereunder, CCMSI shall be deemed an independent contractor, and any of its agents, employees, officers, or volunteers performing work required hereunder shall be deemed solely as employees of CCMSI or, where permitted, of its subcontractors. CCMSI and its agents, employees, officers, or volunteers shall not, by performing work pursuant to this Agreement, be deemed to be employees, agents, or servants of County and shall not be entitled to any of the privileges or benefits of County employment.
26. **Further Assurances.** Each party further agrees that it shall take any and all necessary steps and sign and execute any and all necessary documents or agreements required to implement the terms of the Agreement of the parties contained in this contract, and each party agrees to refrain from taking any action, either expressly or impliedly, which would have the effect to prohibiting or hindering the performance of the other party to this Agreement.
27. **Severability.** If any provision of this Agreement is determined to be invalid, illegal, or unenforceable, the remaining provisions remain in full force, if the essential terms and conditions of this Agreement for each party remain valid, binding, and enforceable.
28. **Dispute Resolution.**
- 28.1. The parties shall attempt in good faith to resolve promptly any dispute arising out of or relating to this Agreement by negotiation between the parties. In the event the dispute cannot be settled through negotiation, the parties agree to submit the dispute to non-binding mediation.
- 28.2. The party requesting mediation shall notify the other party in writing of the dispute desired to be mediated. If the parties are unable to resolve their differences within ten (10) days of the receipt of such notice, such dispute shall be submitted for mediation.
- 28.3. Each party shall be responsible for its own costs associated with the mediation.
- 28.4. The requirement to seek mediation shall be a condition required before filing an action at law or in equity, unless to do so would prevent either party from

seeking relief in a court of law or equity under any applicable statute of limitations.

29. Insurance.

A. At contract execution, contractor shall furnish County with properly executed certificates of insurance, which shall evidence all insurance required and provide that such insurance shall not be canceled, except on 30 days prior written notice to County. Contractor shall provide certified copies of insurance endorsements and/or policies if requested by County. Contractor shall maintain such insurance coverage from the time Services commence until Services are completed and provide replacement certificates, policies and/or endorsements for any such insurance expiring prior to completion of Services. Contractor shall obtain such insurance written on an Occurrence form (or a Claims Made form for Professional Liability insurance) from such companies having Best's rating of A/VII or better, licensed or approved to transact business in the State of Texas, and shall obtain such insurance of the following types and minimum limits:

1. Workers' Compensation insurance. Substitutes to genuine Workers' Compensation Insurance will not be allowed.
2. Employers' Liability insurance with limits of not less than \$1,000,000 per injury by accident, \$1,000,000 per injury by disease, and \$1,000,000 per bodily injury by disease.
3. Commercial general liability insurance with a limit of not less than \$1,000,000 each occurrence and \$2,000,000 in the annual aggregate. Policy shall cover liability for bodily injury, personal injury, and property damage and products/completed operations arising out of the business operations of the policyholder.
4. Professional Liability (Errors & Omissions) Insurance with limits of not less than \$1,000,000 each occurrence, \$2,000,000 aggregate. Such insurance will cover all Work performed by or on behalf of Contractor and its subcontractors under this Agreement. No Professional Liability policy written on an occurrence form will include a sunset or similar clause that limits coverage unless such clause provides coverage for at least twenty-four (24) months after the expiration or termination of this Agreement for any reason.

B. County and the members of Commissioners Court shall be named as additional insured on a Primary and Non-Contributory basis to all required coverage except for Workers' Compensation and Professional Liability (Medical Malpractice) Insurance. All Liability policies including Workers' Compensation written on behalf of contractor, shall contain a waiver of subrogation in favor of County and members of Commissioners Court.

C. If required coverage is written on a claims-made basis, contractor warrants that any

retroactive date applicable to coverage under the policy precedes the effective date of the contract; and that continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning from the time that work under the agreement is completed.

- D. CCMSI shall not commence any portion of the work under this Contract until it has obtained the insurance required herein and certificates of such insurance have been filed with and approved by Fort Bend County.
- E. No cancellation of or changes to the certificates, or the policies, may be made without thirty (30) days prior, written notification to Fort Bend County.
- F. Approval of the insurance by Fort Bend County shall not relieve or decrease the liability of CCMSI.

30. Notices.

- 30.1. Each party giving any notice or making any request, demand, or other communication (each, a "Notice") pursuant to this Agreement shall do so in writing and shall use one of the following methods of delivery, each of which, for purposes of this Agreement, is a writing: personal delivery, registered or certified mail (in each case, return receipt requested and postage prepaid), or nationally recognized overnight courier (with all fees prepaid).
- 30.2. Each party giving a Notice shall address the Notice to the receiving party at the address listed below or to another address designated by a party in a Notice pursuant to this Section:

County: Fort Bend County County Judge
401 Jackson Street
Richmond, Texas 77469

With a copy to: Attn: Fort Bend County Risk Management
301 Jackson Street, Suite 224
Richmond, Texas 77469

Contractor: Cannon Cochran Management Services, Inc.
Attn: Sharada Rogers
2 East Main Street
Town Centre Building
Danville, Illinois 61832-5852

- 30.3. A Notice is effective only if the party giving or making the Notice has complied with subsections 30.1 and 30.2 and if the addressee has received the Notice. A Notice is deemed received as follows:

30.3.1. If the Notice is delivered in person, or sent by registered or certified mail or a nationally recognized overnight courier, upon receipt as indicated by the date on the signed receipt.

30.3.2. If the addressee rejects or otherwise refuses to accept the Notice, or if the Notice cannot be delivered because of a change in address for which no Notice was given, then upon the rejection, refusal, or inability to deliver.

(Execution Page Follows)

(Remainder of Page Intentionally Left Blank)

IN WITNESS WHEREOF, this Addendum is signed, accepted, and agreed to by all parties by and through the parties or their agents or authorized representatives. All parties hereby acknowledge that they have read and understood this Addendum and the attachments and exhibits hereto. All parties further acknowledge that they have executed this legal document voluntarily and of their own free will.

FORT BEND COUNTY

CANNON COCHRAN MANAGEMENT SERVICES, INC.

John E. Kluth II

[John E. Kluth II \(Jan 9, 2026 10:47:24 CST\)](#)

KP George, County Judge

Authorized Agent – Signature

John E. Kluth II

Date

Authorized Agent- Printed Name

Chief Financial Officer

ATTEST:

Title

01/09/2026

Laura Richard, County Clerk

Date

AUDITOR’S CERTIFICATE

I hereby certify that funds in the amount of \$_____ are available to pay the obligation of Fort Bend County within the foregoing Agreement.

Robert Ed Sturdivant, County Auditor

Exhibit A: CCMSI’s Proposal and Service Agreement

Exhibit B: RFP 26-001

Exhibit A

PROPOSAL TO:



**Property and Casualty Claims
Third Party Administration Services
RFP 26-001**

SEPTEMBER 2025



PREPARED BY
SHARADA ROGERS
STATE DIRECTOR

Office: 713.268.7812 | Cell: 254.733.8988
srogers@ccmsi.com



CCMSI®

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- **Proof of Insurance**
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- **Completed W9 form**
- **Completed debt form**

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1. *Client Service Team Biographies*
2. *Audited Financial Statements*
3. *Internal Auditing Guidelines & Worksheets*
4. *Corporate Claims Handling Best Practices*
5. *Banking Options*
6. *Implementation Overview & Plan*
7. *Texas Licenses*
8. *Standard Service Agreement*

All data and information contained herein and provided by CCMSI in response to a PROSPECTIVE CLIENT'S RFP is considered confidential and proprietary. The data and information contained herein may not be reproduced, published or distributed to, or for, any third parties without the express prior written consent of CCMSI.



CCMSI

Executive Summary



Wednesday, September 17, 2025

Fort Bend County
Purchasing Department
Travis Annex
301 Jackson, Suite 201
Richmond, TX 77469

RE: Property and Casualty Claims Third Party Administration Services - RFP 26-001

To whom it may concern:

Cannon Cochran Management Services, Inc. (CCMSI) was the third-party administrator (TPA) of Fort Bend County's workers' compensation and liability programs from January 1, 2020, to January 31, 2024. It is with great appreciation that we are afforded the opportunity to pursue another contract with the County.

Since 1978, CCMSI has been at the forefront of the third-party claims administration industry, offering unmatched expertise, professionalism, and innovative technology. We believe exceptional service is the key to earning recognition as a superior claims administrator—that's why we prioritize client satisfaction by ensuring they receive support and personalized attention at every step.

CCMSI will have two primary goals as the County's claims administration firm of choice:

1. Serve as an extension of your Risk Management department by providing technical and strategic claims insight, superior claims management technology and systems, and seamless administrative support.
2. Reduce your overall cost of risk.

CCMSI is a leader and trusted advisor in third-party claims administration known for our expert teams, cutting-edge technology, and unwavering focus on client satisfaction. We offer a comprehensive range of services that set us apart from the competition, including:

- Aggressive investigations, Fraud Identification Recovery Edge (FIRE) fraud program, and Claim Risk Assessment (CRA);
- Transparent communication in person, over the phone, and via adjuster claim file log notes;
- Best Practices for reserving, settlement, subrogation, and related concerns;
- Comp MC managed care program;
- Comprehensive Legal Expense Analysis & Review (CLEAR) legal bill review program;
- Financial data tracking (e.g., reserves, settlements, expenses, and medical costs) via Internet Claims Edge (iCE), our proprietary, web-based, user-friendly, and accessible RMIS—a powerful tool that clearly illustrates our clients' quantifiable savings;



- Equipping your staff with real-time access to iCE and training them to electronically file initial claim reports, which produce meaningful risk and financial reports for management, and engaging other risk management functions;
- SOC 1 and SOC 2 credentialing and additional data security policies;
- Providing designated adjusters to manage the County's account; and
- Conducting quarterly claim and stewardship meetings to ensure we meet your goals.

Our team, from claim examiners to your dedicated account manager, is committed to understanding and aligning with Fort Bend County's unique goals and program needs. Once we establish your objectives and protocols, we will develop a tailored Quality Service Plan to ensure clear communication and adherence. Notably, we empower our teams to proactively address and resolve any issues that arise, ensuring we always meet your expectations.

CCMSI understands that a smooth, seamless transition is crucial to your decision. With our extensive experience, detailed Implementation Plan, and dedicated team, we guarantee a streamlined process that ensures success from day one.

Thank you for considering us as a partner in managing this important responsibility. We look forward to presenting our program to interested parties in Fort Bend's administration.

Please direct communication concerning this request for proposal to:

Sharada Rogers, ARM
State Director | Texas
PO Box 802082 | Dallas, TX 75380
Office: 713.268.7812 | Cell: 254.733.8988
srogers@ccmsi.com

Sincerely,

Sharada Rogers

Sharada Rogers, ARM
State Director

ATTACHMENT 1: GENERAL QUESTIONNAIRE

A. Location and Personnel

1. List the location of your firm's main office and the locations of offices in the State of Texas. Provide the address of the office location that will service the County.

CCMSI | Corporate Headquarters

2 East Main Street
Danville, IL 61832

Houston, Texas

1500 CityWest, Suite 120
Houston, TX 77042

Dallas, Texas

Providence Towers
5001 Spring Valley Rd, Suite 750 W
Dallas, TX 75244

Our Houston office, with support from our Dallas office, will provide services to Fort Bend County.

2. Identify the person directly responsible as the Account Coordinator on behalf of the County and provide contact information for that person and include a brief description of the representative's background, experience and qualification, as well as an explanation of the representative's role and responsibilities for the firm.

a. What are the responsibilities of this position?

Princess Lott, who previously served as Fort Bend's account manager, will proactively manage every aspect of the County's claims program as its proposed account manager and single point of contact. With a focus on understanding your unique business, goals, and desired outcomes, she will tailor strategies to meet your objectives and ensure seamless execution. Princess will meticulously oversee every detail and coordinate with our team, leveraging all available resources to drive results that exceed expectations and support the County's long-term success. In addition, the state director will oversee the program from a senior corporate level.

Sharada Rogers, Texas State Director

State director responsibilities:

- Senior corporate-level management and oversight.
- Manage and deploy critical corporate resources to ensure service excellence.
- Select and oversee the Client Service team.
- Design the optimum service model in collaboration with the County.
- Client communication and service issue resolution.

Princess Lott, Account Manager | princess.lott@ccmsi.com | (713) 268-7827

Account manager responsibilities:

- Manage the County's transition from its current third-party administrator.

- Coordinate and select the team of professionals assigned to your Client Service team.
- Serve as your singular point of contact for all technical and administrative questions.
- Establish client-specific account handling instructions (Quality Service Plan [QSP]).
- Deliver and train the Client Service team on the County's QSP.
- Conduct quarterly claim reviews and annual stewardship meetings. We will provide the County with agendas in advance.
- Coordinate iCE system training for the County's users. We will schedule an educational session for all system users.
- Coordinate banking arrangements.
- Produce loss runs and other necessary monthly reporting and analytics.
- Facilitate audit requests.
- Manage the billing process for our service fees.
- Work with our claims office to ensure data integrity.
- Provide other communication and services as the County deems necessary.

Please refer to Ms. Lott's biography in our response to 2f below and in [Exhibit 1](#).

b. What additional duties may be required of this individual besides that of account coordinator?

Ms. Lott was the former account manager for Fort Bend County. She is currently the account manager Bexar County, Texas, Darling Ingredients, Inc., G&A Outsourcing, Inc., and Hard Rock International USA, Inc.

c. What authority does this individual have to affect action and changes on behalf of the County?

Ms. Lott will have the complete authority to effect action and change (with the County's approval). Texas State Director Sharada Rogers will provide senior corporate-level oversight for your program.

d. How is the account coordinator monitored and evaluated? By whom and how frequently?

Our quality-focused performance metrics align account manager evaluations with quality and customer-centric service. Key metrics for accountability, including client audit scores, internal compliance audits, timely state filings, client scorecard results, closing ratios, and file close duration, drive their success and ensure top-tier results.

Account managers undergo annual performance evaluations by the state director and regional vice president, who review audit scores and performance, with compensation raises linked to these results. We also recognize exceptional service throughout the year with spot awards.

e. Is the account coordinator's compensation related to performance?

Yes. Please reference our response above (question 2d).

f. Please provide a resume of the Account Coordinator recommended for the County’s program. Please include prior experience in this position.



Princess Lott

Account Manager – Houston, TX

Biographical Information

Professional Experience

With over twenty years of workers’ compensation industry experience for carriers and third-party administrators, Ms. Lott joined Cannon Cochran Management Services, Inc. (CCMSI) as an account manager in May 2022. She brings a wealth of experience to CCMSI from working with various sectors, including small businesses, national corporations, sports leagues, public entities, and municipalities.

As a workers’ compensation and risk management expert, she skillfully executes complex initiatives on time and under budget. Ms. Lott has a proven track record of being an engaging communicator focused on building positive relationships with peers, direct reports, and customers, which ensures operational excellence.

She began her workers’ compensation career in 2001 with leading carriers in the industry. Throughout her career, she has exemplified the heart of a teacher and strength of a leader in various roles, including adjuster level 2 with The Travelers; claim plus team lead adjuster for multimillion-dollar accounts at The Hartford; and senior adjuster, trainer, and project manager at Texas Mutual. She began her transition into the TPA world in 2015 as a claims supervisor, where she incorporated her knowledge and comprehensive experience with the core values associated with the industry.

Ms. Lott has extensive experience managing workers’ compensation compliance for multiple jurisdictions, including Texas, Louisiana, Arkansas, and Oklahoma, specializing in operations management, risk management, process improvements, and training and development. However, her passion is helping her clients by removing confusion regarding their risk program while defining and driving successful strategic initiatives.

Education and Professional Training

Ms. Lott holds a Texas All-Lines license and Workers’ Compensation licenses in Oklahoma, Louisiana, and Arkansas. She completed business and physical therapy courses at San Jacinto College and obtained her Real Estate license at the Champions School of Real Estate.

g. From which office is this person based?

Princess is based in our Houston office.

B. Designated Adjusters

1. If you designate an adjuster, or a team, will this person handle more than one jurisdiction? If so, how many jurisdictions and which ones?

The County's assigned team will handle Texas claims only.

2. What training or development is provided to adjusters who manage claims for multiple jurisdictions?

Claim representatives participate in first-level training at the state director level and ongoing, personalized sessions at each local CCMSI office. These sessions are held monthly or as needed to address changes in state laws, corporate updates, or client requests, ensuring our team stays informed and responsive. In addition to adjuster meetings, training sessions are held at each office that provide general updates or address urgent matters, such as:

- CSA/MSAs
- Case Law Updates
- Definition of Injury
- Dental Claims
- FCE/Permanent Restrictions/Vocational Rehabilitation
- File Closures
- New Claim Packets
- Administrative Denials
- Physical Therapy vs. Chiropractic Treatment
- Utilization Review
- Causation vs. Medical Necessity
- Preparing for IMEs
- Bill Review
- Reconsiderations

CCMSI additionally develops, promotes, and finances the following industry training programs and initiatives for employees:

- Attendance at industry conferences, workshops, and seminars (e.g., RIMS, PRIMA, ASHRM, Self-Insurers Associations);
- Periodic legislative and legal updates from law firms (lunch and learns);
- Participation in professional education programs (e.g., AIC, SCLA, CPCU, ARM, RPA);
- In-house, online training programs for claim professionals;
- Participation in industry tutorial programs;
- Claim system training: hands-on and written training material to manage claims in CCMSI's claims system;
- Best Practices: CCMSI claim professionals are trained on our Best Practices and audited for compliance;
- In-house training: CCMSI's internal training committee identifies and coordinates technical training sessions for various staff levels, with topics including all components of the claims management process;
- Qualified personnel from the medical community provide ongoing training related to developments in medical advancements and prescription drugs; and
- Performance reviews: CCMSI adjusters' performance reviews are tied to their compliance with client expectations and claim management criteria (Best Practices).

CCMSI's Corporate Training program, held regularly at our corporate office in Danville, Illinois, connects claim representatives, supervisors, and managers with at least six months of experience, allowing them to exchange ideas and for CCMSI to develop and retain talent. Designed to ensure a consistent approach to training, the program reinforces Best Practices across CCMSI, boosting client satisfaction, improving audit scores, and driving better business outcomes and financial results.

Our Corporate Training Program provides direction and leadership for CCMSI's training initiatives, organizing focused annual sessions for adjusters, supervisors, and account managers. With a state-of-the-art technology center for hands-on learning and on-site sessions coordinated by our corporate trainer, we ensure our staff receive the most effective and relevant training to excel in their roles.

Monthly online training, such as Security Awareness, demonstrates CCMSI's commitment to enforcing mandatory training. To ensure compliance, employees are locked out of the system if they fail to complete it.

LevelUP Career Pathway Program

At CCMSI, we foster talented claim professional development through our on-the-job LevelUP Career Pathway Program, which prepares participants for advancement to workers' compensation and liability claim adjuster roles. Our internal training program provides developmental tools, resources, and on-the-job learning through personal study, e-courses, work shadowing seasoned adjusters, and planned experiences. Continuous feedback and assessments ensure participants' success in applying their skills.

The LevelUP Career Development program follows a structured timeline, typically completed in one year, though we recognize that progress may vary for each individual.

3. Please provide resumes of the adjusters who are recommended to be assigned to the County account. Please include the jurisdictions with which they currently work and length of experience with each jurisdiction.

CCMSI's service model fosters a collaborative team approach, ensuring the County's adjusters work collectively with the rest of the client service team to gain in-depth insight into your specific service requirements. With a supervisor-to-adjuster ratio of one to five, we provide personalized oversight and a tailored claims experience.

The County's designated team will perform the following functions:

- State Director: Corporate oversight and supervision.
- Account Manager: Translates the County's specific needs into operational processes and ensures we consistently meet them.
- Claim Supervisors: Supervise and handle high-exposure claims.
- Liability Claim Adjusters: Handle liability, contested, and litigated claims.
- Indemnity Claim Adjusters: Handle lost-time, contested, and litigated claims.
- Medical Only Claim Adjusters: Handle claims requiring only medical treatment.
- Claim Assistants: Enter claim information and administratively support the team.

Management Team

Regional Vice President: Rich Cangiolosi
 Texas State Director: Sharada Rogers
 Account Manager: Princess Lott

Liability Team

Liability Supervisor: Devin Carter
 Liability Adjuster: Stacy Culberson
 Liability Adjuster: Tanya Francis

Workers' Compensation Team

Workers' Compensation Supervisor: Melissa Aires
 Indemnity Adjuster: Latasha Harris
 Medical Only Adjuster: Sylvia Ibanez

Biographies may be referenced in Exhibit 1.

4. What are adjuster turnover rates, nationally and by branch?

National 2024

- Managers: 0.7%
- Supervisors: 1.2%
- Claim Staff (0-5 years with CCMSI): 12.08%
- Claim Staff (5+ years with CCMSI): 1.8%

Texas 2024

- Managers: 0%
- Supervisors: 5%
- Claim Staff (0-5 years with CCMSI): 12.3%
- Claim Staff (5+ years with CCMSI): 0%

5. What are adjuster caseloads, nationally and by branch?

We carefully assign caseloads based on jurisdiction, experience level, and coverage lines, among other factors, including the total number of claims, number of new claims received monthly, number of claims closed monthly, claim severity/complexity, and the client's claim handling/reporting requirements. Our average caseloads are as follows:

Workers' compensation claim representatives

National:

- Indemnity: 125 on average | 150 maximum
- Medical-only: 250 on average | 275 maximum

Texas:

- Indemnity: 100 on average | 110 maximum
- Medical-only: 175 on average | 200 maximum

Liability claim representatives

- Property damage liability: 100-125 on average | 125 maximum
- Bodily injury liability: 90-110 on average | 125 maximum

CCMSI recognizes that a commitment to manageable caseloads is vital to client service and customer satisfaction. Account managers run caseload reports monthly to verify that claim representatives are not consistently above the average caseload standard. If an adjuster's caseload is too high, we will reassign files and add client service team members as needed.

6. What is the maximum adjuster caseload allowed?

Please refer to the previous question.

7. Will adjusters work from a company office or from home?

All adjusters assigned to the County's account will work in an office, hybrid, or remote.

C. Firm Overview

1. Provide an overview of the firm, including the full legal name of the institution, state of organization and supervisory and regulatory authorities that oversee the institution.

Since 1978, **Cannon Cochran Management Services, Inc. (CCMSI)** has set the gold standard as the leading boutique third-party administrator for property and casualty programs. Specializing in workers' compensation, liability, and property claims management, we attract top industry talent and prioritize meeting each client's needs, goals, and expectations with innovative solutions, advanced technology, and tailored approaches to claim services, loss control, managed care, internet claims analysis, and reporting services.

As a privately held, **100% employee-owned company** and Delaware-registered S corporation, CCMSI is accountable to our clients, not insurance carriers, brokers, or private equity funds, empowering our team to make client-centric decisions and focus on long-term client value creation versus short-term financial performance. Our commitment to transparency, exceptional client satisfaction, and delivering superior results with integrity has earned us the trust and respect of clients and partners nationwide.

At CCMSI, we don't believe in a one-size-fits-all approach and recognize that each client has unique needs. Through close collaboration with our clients, we deliver customized, strategic solutions that exceed expectations while maximizing cost savings. With a **98% client retention rate**, our client-focused approach has established us as the industry's quality standard, proudly partnering with self-insured groups and employers across diverse sectors, including government, retail, healthcare, manufacturing, gaming, construction, transportation, and higher education.

For the eighth consecutive year, CCMSI has earned certification as a Great Place to Work®—a testament to our commitment to fostering a positive and supportive work environment. This culture is vital to our success and growth, helping us attract and retain top talent and maintain the lowest industry turnover. By investing in our greatest asset—our people—we ensure continuity and deliver exceptional, consistent service to our clients. Without our dedicated staff, we could not successfully *deliver what matters most* to our clients. See the results here: <https://www.greatplacetowork.com/certified->



company/7010279.

CCMSI provides a wide range of risk management services, offering comprehensive coverage and administrative efficiencies. Services include:

- Client-specific third-party claims administration
- Self-insured group administration: Accounting, underwriting, marketing, and excess placement
- Loss control: Industry-specific loss control programs
- iCE: Web-based claims analysis and reporting tool
- Comp MC: Private label managed care program
- FIRE: Special Investigation Unit program
- CLEAR: Legal bill review program



CCMSI generates an annual revenue of \$225 million and employs over 1,600 people across thirty-two offices. We provide services to more than five hundred individual employers, ten-plus captives, forty-plus primary insurance companies, and fifty-plus self-insurance groups.



CCMSI completes annual SOC 1 and SOC 2 audits, which validate that our internal financial, technology, and security controls are properly designed and operate effectively. These audits cover customer information security, including confidentiality and access management.

2. Provide a summary of the ownership and management of the firm. Describe any significant changes in the management and/or structure of your firm, including mergers that have occurred during the past three years. Does your firm foresee or anticipate any organizational changes in the next 24 months?

Cannon Cochran Management Services, Inc. (CCMSI) is a Delaware-registered, 100% employee-owned S corporation.

CCMSI's officers include:

- G. Bryan Thomas, Chief Executive Officer/President
- John Kluth II, Chief Financial Officer
- James Benham, Acting Chief Technology Officer
- Jerry Armatis, Executive Vice President

There have been no changes to CCMSI within the past three years or anticipated in the next twenty-four months.

3. Provide an annual report or other information describing your business, its scope, size and structure.

[Please see Exhibit 2 for our most recent audited financial statement.](#)

4. When was your business started and how long has it provided claims administration services?

CCMSI has provided claims administration services since its inception on February 15, 1978.

5. How many clients do you support and what is the average size of the clients business?

CCMSI provides services to more than five hundred individual employers, ten-plus captives, forty-plus primary insurance companies, and fifty-plus self-insurance groups. Our clients' average business size varies.

6. Does your firm carry Errors and Omissions coverage for its staff? Who is covered?

Yes, which covers all employees.

D. Claim Office Structure

1. What is the structure of each claim office?

CCMSI operates thirty-two offices nationwide, organized into three regions, each led by a regional vice president (RVP) who reports to the vice president Mid-America region. Every office is led by a branch manager or state director, who reports to the RVP. Dedicated teams comprising administrative assistants, claim assistants, adjusters, and supervisors (who report to the branch manager) support each office. Clients are assigned an account manager, who reports to the state director or, on larger accounts, the RVP or vice president Mid-America region.

Our flat organizational structure empowers local teams to make swift decisions and customize services to meet client needs, with resources and support available at the branch level. This approach guarantees agility, efficient communication, and the highest level of customer service.

2. What is the supervisor to adjuster ratio? What are the specific supervisory duties and responsibilities? Do supervisors supervise any staff other than adjusters?

The supervisor-to-adjuster ratio is one to five, with supervisor responsibilities including oversight of claim assistants and claims staff to ensure compliance with Best Practices and client service instructions.

3. Do supervisors manage claims? If so, what is their caseload?

As a general rule, Texas workers' compensation supervisors do not carry caseloads. Liability supervisors can carry minimal caseloads of no more than fifty claims; however, this depends on the number of staff they supervise.

4. How are supervisors monitored and evaluated, how frequently and by whom? Is compensation related to performance?

Supervisors undergo annual performance evaluations by their managers that review audit scores and performance, with compensation raises linked to these results. We also recognize exceptional service throughout the year with spot awards.

5. What internal audit functions does your company perform, either at the home office or claim office level?

Quality Control Team: This team develops and provides training at all locations on compliance with our Corporate Claims Handling Best Practices and conducts regular claim audits, which tie to performance evaluations, ensuring ongoing quality control. [See Exhibit 3 – Internal Auditing Guidelines & Worksheets.](#)

Audit Team Goals

- Ensure compliance with Best Practices, client handling instructions, and carrier requirements;
- Provide an objective audit with constructive feedback;
- Help management and claims staff proactively identify areas for improvement;
- Work with our claims staff to provide solutions to any areas identified as needing improvement;
- Foster understanding of our Mission to all claims staff;
- Streamline processes to ensure timely service delivery to our clients; and
- Ensure quality service and value to our clients.

New Hire Audits: CCMSI audits all new hires ninety days after their hire date, allowing us to identify and correct any noted deficiencies. The Quality Assurance team and local management will review results with each adjuster and provide additional coaching and training as needed.

Annual Corporate Audits: CCMSI conducts annual audits on a sample of claims handled by each adjuster, following a standardized process understood by all claims staff. After each audit, we hold feedback sessions with the individual office and applicable claim personnel. If needed, that office's management and the Audit team (if requested) implement action plans to address any areas that need improvement. Our audits review key competencies and adherence to CCMSI Best Practices and client-specific handling instructions outlined in the QSP. Offices with an audit score below 86% must develop a corrective action plan signed off by the state director, regional vice president, and lead auditor.

E. Volume of Business.

1. Provide a summary of the firm’s claim volume for each of the past three years by the following categories: commercial property, general liability, commercial umbrella and commercial automobile, public official liability and bond, and workers’ compensation.

- Commercial Property – 5,806
- General Liability – 106,501
- Commercial Umbrella – 1
- Commercial Automobile – 113,877
- Public Office Liability – 477
- Bond – 2
- Workers’ Compensation – 393,531

2. If the office that will service the County’s account is a branch or subsidiary of a national or regional firm, the above information should be provided for both the office providing services to the County and the entire firm.

- Commercial Property – 0
- General Liability – 1,656
- Commercial Umbrella – 0
- Commercial Automobile – 968
- Public Office Liability – 11
- Bond – 0
- Workers’ Compensation – 26,417

F. References.

1. Provide a list of at least three clients with insurance adjusting needs similar to the County which may include public schools, city, county or state governmental entities.

University of Texas System
 210 W. 7th Street
 Austin, TX 78701
 Contact: JoAnn Anderson
 Phone: 512-499-4645
joanderson@utsystem.edu

Houston Independent School District (HISD)
 4400 West 18th Street
 Houston, TX 77092
 Contact: Donna Fernandez
 Phone: 713-556-6676
donna.fernandez@houstonisd.org

Bexar County
 101 W. Nueva St., Suite 901
 San Antonio, TX 78205
 Contact: Veronica Guevara
 Phone: 210-335-2559
veronica.guevara@bexar.org

2. Describe your firm’s specific experience providing services to each of those clients.

The University of Texas System: Client since 11/1/2013. We provide workers’ compensation and liability claims management services.

Bexar County: Client since 8/1/2019. We provide workers’ compensation and liability claims management services.

Houston Independent School District: Client since 11/1/2014. We provide workers’ compensation and liability claims management services and oversight of the District’s 504 Network Provider Panel.

3. Describe your experience, if any, providing third party claims administration services to counties in the State of Texas

CCMSI has extensive experience with the following Texas governmental clients:

CLIENT PRIMARY NAME	CLIENT SINCE DATE
BEXAR COUNTY MGMT. & FINANCE	8/1/2019
CITY OF PEARLAND, TX	10/1/2020
CITY OF WICHITA FALLS	2/1/2019
HOUSTON INDEPENDENT SCHOOL DISTRICT	11/1/2014
THE UNIVERSITY OF TEXAS SYSTEM	12/1/2013

4. Describe any issues or problems that have impacted any of the client accounts described in this section.

No issues or problems have impacted any of these accounts; however, below are a few items that impact our clients in general:

- Higher exposure to catastrophic events (e.g., natural disasters, mass casualty incidents, large liability cases).
- Wide variety of risks (workers’ compensation, general liability, auto liability, law enforcement liability, school claims, etc.).
- Limited flexibility in allocating funds between risk management, claims handling, and operational priorities.
- Exposure to penalties or fines when deadlines or compliance standards are not met.
- Changes in elected leadership shift priorities mid-program (e.g., reallocation of funds, restructuring contracts).

5. Identify ways in which you added unique value or problem solving to any of the client accounts.

Houston Independent School District (HISD)

- Implemented a 504 network.
- HR feed: Facilitate filing first reports, reducing employer’s lag.

- Since all payments must be client-approved, CCMSI modified payment workflows, which satisfy their unique banking and wire procedures.
- Modified internal protocols to ensure all referrals comply with Outside Referral Form (OSF).
- Triage Desk: Since all incidents are reported, CCMSI implemented a triage desk that identifies and processes record-only, medical-only, and indemnity claims.
- Cleaned up and merged conversion data from the prior twenty years, enabling HISD to evaluate its complete financial history.

University of Texas System

- Customized hierarchy based on the needs of fourteen different members (institutions), facilitating an evaluation of the individual program’s performance based on their unique needs.
- Converted over twenty years of zero-pay explanation of benefits (EOB) historical data into standardized forms.

Bexar County

- Hierarchy modification to integrate cost centers to implement a charge-back model.
- Developed and implemented a 504 Network in collaboration with vendor partners.

All Clients

- Extensive reporting capability: Daily, weekly, monthly, and quarterly reports are scheduled to assist clients, adjusters, and managers in tracking the program’s performance from a high-level or a close-up perspective for in-depth monitoring of claim costs, processes, or loss control needs.

6. Provide contact information to enable the County to contact those accounts as references.

See contact information above in our response to F1.

7. Identify any new accounts for governmental entities obtained in the past three years and any such accounts that the firm has lost. Provide an explanation for the lost accounts.

CCMSI has not obtained any new Texas governmental entities in the past three years. However, we have secured the following new accounts in other jurisdictions:

Client Primary Name	Client Since Date	Client Profile State
Center Line Public Schools	7/1/2022	Michigan
City Of Aurora	4/15/2024	Illinois
City Of Dekalb	12/1/2023	Illinois
City Of Hammond	5/1/2022	Louisiana
City Of Kingsport	7/1/2022	Tennessee
City Of Longmont	5/1/2022	Colorado
City Of Markham G1	12/1/2023	Illinois
City Of Park Ridge	9/1/2023	Illinois
City Of Thornton, Colorado	9/26/2024	Colorado
Dona Ana County New Mexico	7/1/2024	New Mexico
Las Vegas Valley Water District	12/1/2024	Nevada

Mississippi School Boards Association - Liability	6/1/2025	Mississippi
Mississippi School Boards Association - Property	6/1/2025	Mississippi
Rutherford County Government & Board Of Education	7/1/2023	Tennessee
St. Bernard Parish Government	2/1/2022	Louisiana
St. Charles Parish	5/1/2024	Louisiana
State Of Colorado	7/1/2025	Colorado
State Of New Mexico	7/1/2024	New Mexico
Town Of Oak Bluffs	8/1/2025	Massachusetts
Town Of Silver City	7/1/2023	New Mexico
Village Of Lombard	1/1/2023	Illinois
Village Of Wheeling	12/31/2022	Illinois

CCMSI has not lost any governmental entity accounts obtained in the past three years.

G. Customer Support.

1. Describe and discuss your staff available to support the County.

CCMSI’s team of experts, comprising your assigned account manager and claim specialists, the Texas state director, sales executive, IT staff, compliance, operations, and the Implementation team, will support the County.

2. How much of that staff is located in the state of Texas?

All of the County’s claims staff will be located in Texas. Several Client Service team members will be in other CCMSI offices.

3. How many dedicated claims support staff does the firm maintain?

There is one claims support staff for every five adjusters.

4. What portion of the claims support staff is located in the state of Texas?

There are five claims support staff members in Texas.

5. How many claims support staff are located in the office that will service the County?

There are more than four claims support staff members in the Dallas and Houston offices.

6. Identify the average number of claims support staff per customer account and the average number of claims handled by each claims support staff member each year.

The average claim support staff per account would be one (three if you include office support [e.g., mail, front desk]). Claims support staff handle an average of six hundred claims per year.

7. Identify any technology or related tools available from your firm and describe the advantages those tools offer the County.

Internet Claims Edge (iCE), CCMSI's innovative Risk Management Information System, is designed to be flexible, user-friendly, and accessible. Fully customizable to meet client needs, iCE allows real-time, 24/7 access to claims via a web-based, mobile-friendly platform. Through user-defined filters, including claim type and date of loss, clients can view their claims, complete with adjuster notes and bill images, in as much or as little detail as they wish.

- **Initial reporting:** Create initial report forms online in iCE or submit claims via web service or custom interfaces. Benefit from industry-specific custom reporting, such as accident reports for transportation clients.
- **Executive Summary dashboard:** Customize a high-level risk management analysis overview for quick insights.
- **Claims Analysis:** A flexible tool that lets clients explore claims in-depth or at a high level.
- **MyReports:** CCMSI's robust reporting engine delivers countless customizable data combinations. Export to PDF or Excel, schedule automatic email reports, or post to iCE.
- **Comp MC:** Through MyReports, run managed care reports for CCMSI's Comp MC program, such as PPO penetration and location-specific savings.
- **OSHA reporting:** Simplify OSHA compliance by auto-generating 300 (Log), 300-A (Summary), and 301 (Incident Report) forms using claims data from the Initial Report. Print at any time for any location.
- **Claim Risk Assessment:** Predictive modeling that identifies potential high-risk claims, enabling early intervention for better outcomes.
- **iCE mobile app:** Access and report claims data anytime, anywhere on Android and Apple devices.
- **ClaimView:** A mobile-friendly claimant portal for injured workers to view lost-time payments, upload documents, and communicate with their adjuster.
- **Stewardship and benchmarking:** Leveraging historical trends and industry benchmarks (such as WCRI and IDS), we regularly analyze and evaluate our performance to drive successful claims management programs.
- **Automated outbound text and email:** A customizable feature offering workers' compensation claimants a personalized welcome message, key claim details, resources, and their claim representative's contact info. Opt-in claimants receive real-time notifications on indemnity payments, including amounts, issue dates, and service dates.

Reporting Features

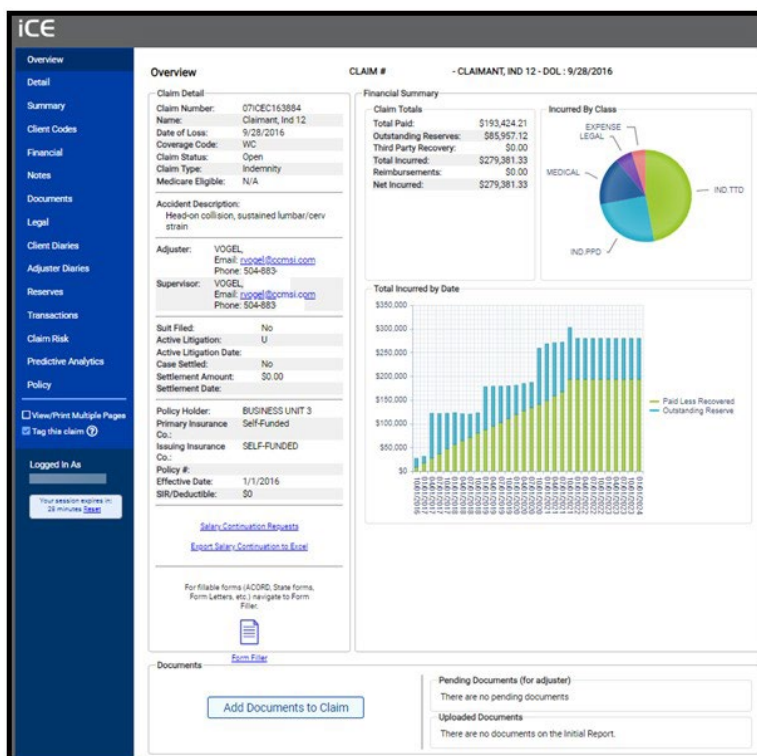
- **Report access:** Instant online access to standard monthly reports for the past twenty-four months.
- **Executive portal:** A personalized portal displaying key data at login for quick insights.
- **Customizable dashboard:** Tailored to fit each client's needs.
- **Ad hoc reporting:** Create custom reports covering financial, claims detail, and loss control data.
- **Multi-level reporting:** View summary and detailed claim reporting with drill-down capabilities for deeper analyses.
- **Analytical tools:** Compare historical and current data with various graphical presentations.
- **Cost-containment reporting:** Track savings and fees with comprehensive cost-containment reports.

Additional features

- **Data integration:** Seamlessly receive data from multiple sources for comprehensive insights.
- **Security:** Password protection with customizable security access levels for enhanced protection.
- **Hierarchical tracking:** Track data across twenty-five levels, including by state, department, and more.
- **Custom user fields:** Modify the system to meet specific needs by creating personalized user fields.
- **Adjuster notes:** Easily view adjuster notes by category (summary, medical, litigation, reserves, etc.).
- **State-specific reports:** Generate state-specific First Reports of Injury and other forms in PDF.
- **Document upload:** Clients can upload documents directly to the claim file or adjuster.
- **Medical bills and reports:** Access medical bills and reports online.
- **Predictive analytics:** Utilize AI-driven insights to predict risk drivers, future treatments, and financial forecasts.

Access and Reporting Overview

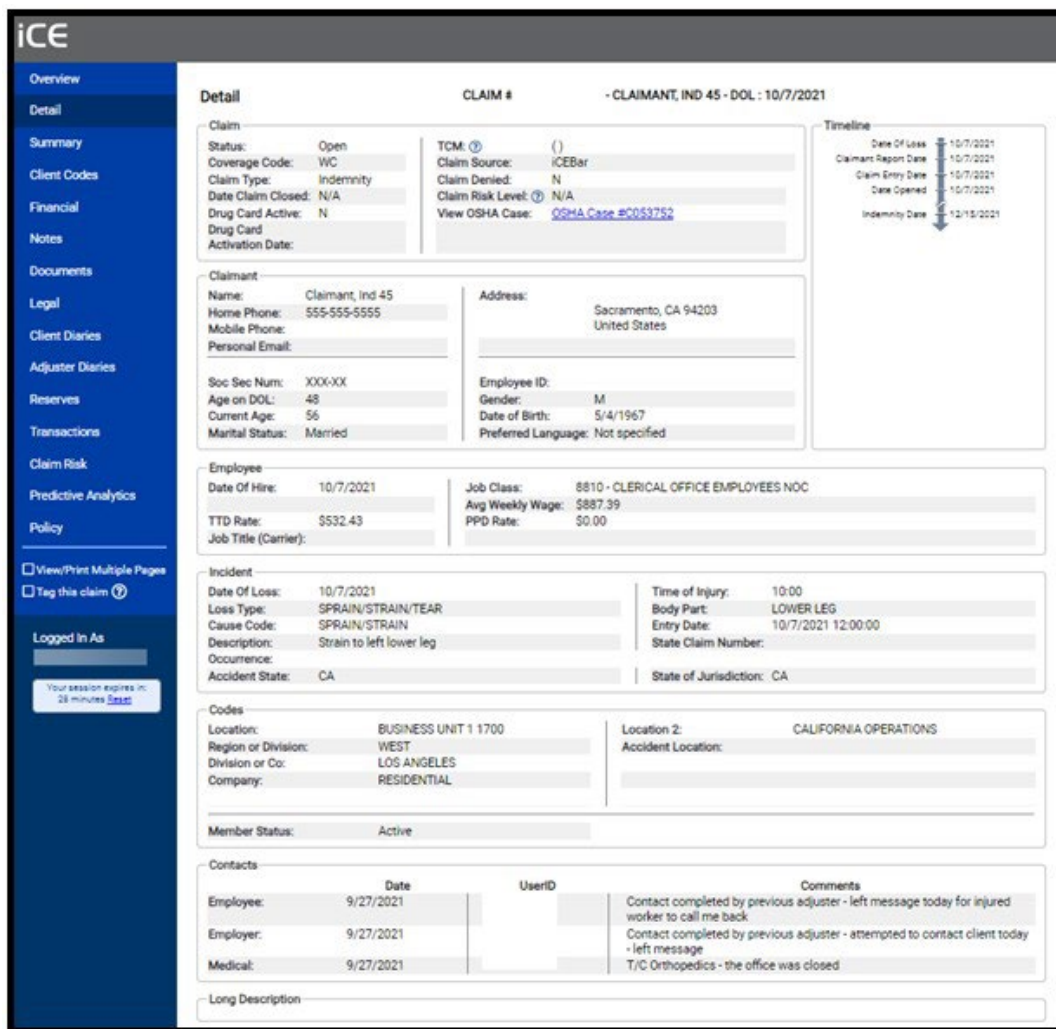
We can assign varying levels of access to our clients' designated employees, allowing them to review every aspect of the claim file based on a selected group (e.g., department or division), time frame, or the entire organization. Client-specific reports, including loss, financial, and summary reports; monthly check registers; and monthly vendor payments, are posted to the iCE Report tab and maintained in PDF format for a rolling twelve-month period.



Financial transaction screens provide a comprehensive list of all payments made on a claim, including detailed information and links to scanned images of medical bills and reports with added commentary. Additionally, our system offers as-of-date financial data with a simple calendar selector, enabling users to

view information from a previous date for complete transparency and control.

The following screenshot displays claim file categories and a navigational sidebar containing other vital data for client review.



CCMSI clients can easily filter claim information by various data fields, such as date of loss, claimant name or Social Security Number, claims denied, and total incurred over a specific dollar amount. Once they locate the desired claim, clients can view and download details, including claim status (i.e., open, closed, pending), a detailed claim summary, employment information (e.g., average weekly wage and PPD, etc.) and all adjuster notes, such as action plans, settlement evaluations, and medical treatment summaries.

Clients also have quick access to financial transactions and analyses, including payment details, medical invoices, and charts, offering a clear, visual breakdown of claim reserves and reserve development.

CCMSI Claim Risk Assessment (CRA) and Gradient AI Daily Claim Scorecard

Understanding that early identification and intervention in potential high-risk claims can lead to significant

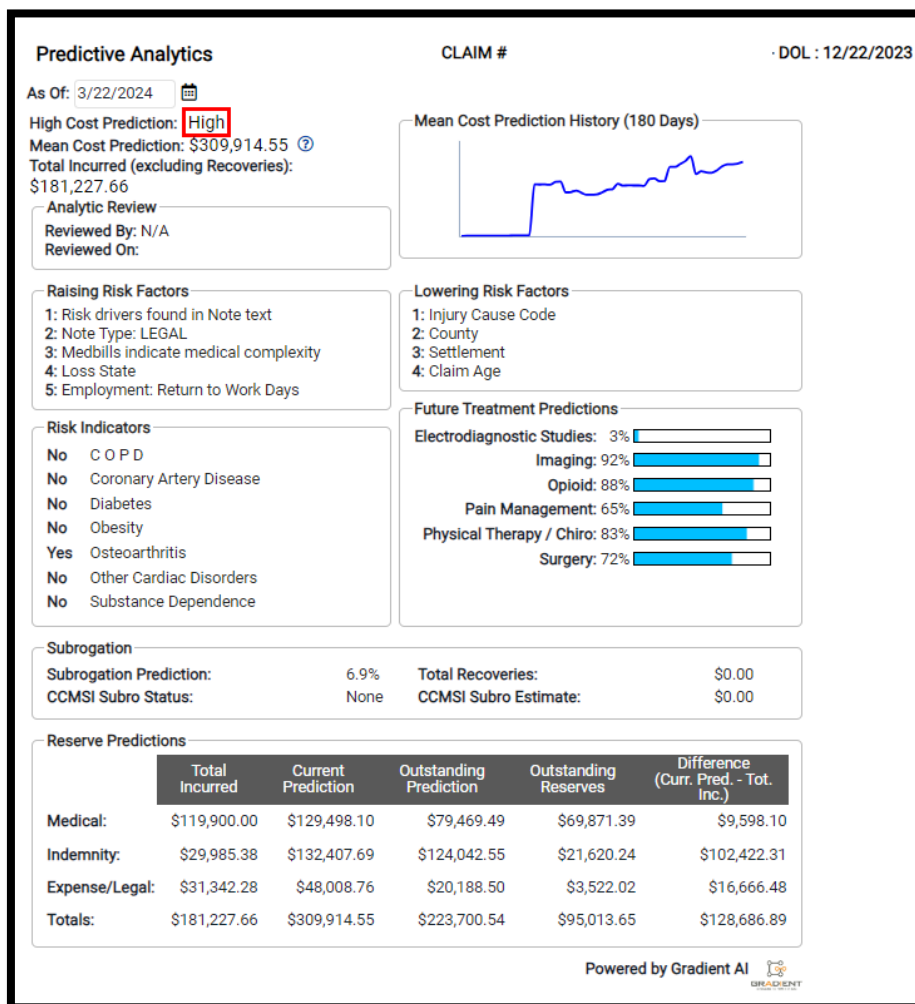
cost savings, CCMSI has utilized our customized Claim Risk Assessment (CRA) adjuster tool to classify indemnity claims as potential high, moderate, or low risk since 2015. This scoring system analyzes seventy-five data fields, such as comorbidities, proximity to medical care, and the claimant’s likelihood of returning to work, helping to identify potential issues before they escalate. (A complete list of data fields is available upon request.)

Since partnering with Gradient AI in the First Quarter of 2019, CCMSI has leveraged AI to score all indemnity and medical-only claims nightly. Using over forty million workers’ compensation claims and additional third-party data, Gradient AI performs daily analyses to identify key claim drivers and costs early on, significantly improving our ability to manage claims effectively and proactively.

Each evening, CCMSI transmits all claims data fields in our system to Gradient AI, including transactions, adjuster notes, medical bills, prescriptions, and Claim Risk Assessment fields. Gradient then scores the claims and provides CCMSI with the following information:

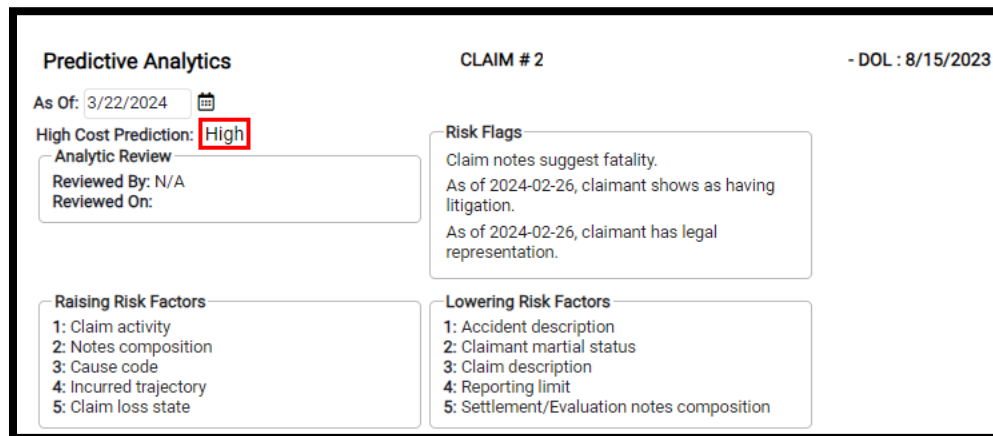
- Risk classification of High, Medium, or Low of a claim being high cost
- Total incurred predication through generative artificial intelligence (GAI) models versus the current CCMSI adjuster incurred value
- Treatment predictions (e.g., surgery, PT, imaging, opioids, electrodiagnostics, pain management)
- List of all comorbidities
- List of factors impacting the claim cost (e.g., legal, return to work, future medical)

The screenshot to the right shows how the adjuster iCEBAR system and client iCE portal display these analytics.



The iCE client portal presents liability analytics in a format similar to our workers’ compensation model.

The screenshot below previews the available data guidance presented to adjusters.

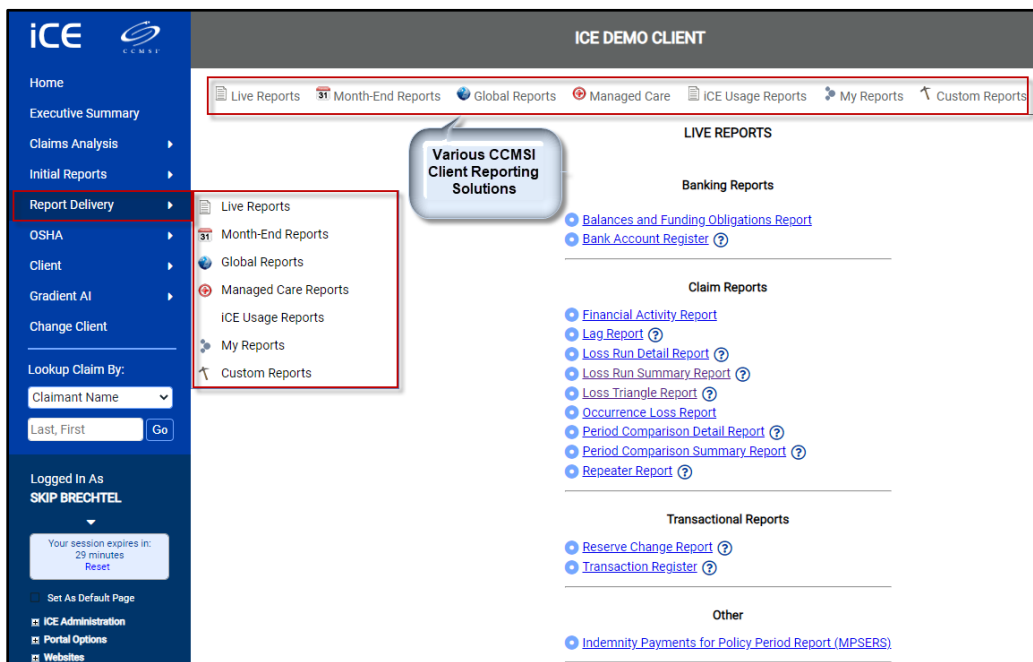


CCMSI adjusters, supervisors, and account managers use this tool to support claim evaluations and facilitate discussions with our clients.

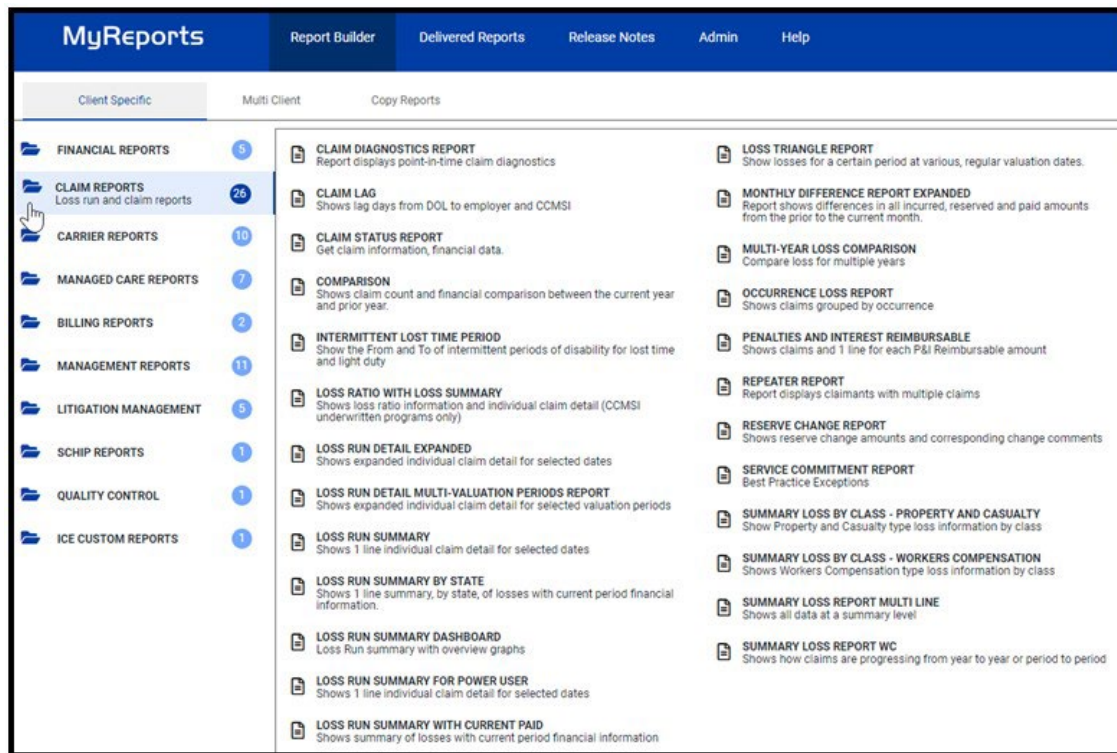
Reports

iCE delivers timely, accurate, and comprehensive data. Users can easily access standard and custom online reports, offering the flexibility to view claims and loss control data at a high level or in greater detail.

- **Standard reports:** CCMSI has developed a catalog of over four hundred reports based on specific client requirements, including detailed claim information, summary (at various reporting levels), check and payment registers, and loss ratio (by desired operating levels). These static reports are posted online within five business days and are available 24/7 within iCE.
- **Ad hoc reporting:** Clients can generate diverse ad hoc reports with the ability to sort and categorize by various fields and data. Analytics, including charts and graphs, are available for deeper insights and easy data visualization.
- **Special customized reports:** If our standard and ad hoc reporting options don't fully meet our client's needs, we offer custom report design and development to fit exact specifications. While we typically bill custom reports at a standard hourly rate, we will likely provide most minimal requests at no additional charge.
- **Live reports:** This feature provides our thirteen most commonly used reports, including detail and summary loss runs, comparative periods, loss triangles, and reserve change reports. Users can generate these reports with user-selected periods and as-of dates.



➤ **MyReports:** Clients can build a customized loss run using over three hundred data fields, which can be scheduled to run automatically and delivered via email in PDF or Excel or posted directly to iCE. Our customer service team is available to assist with creating and tailoring these reports.



8. What are your internal quality assurance processes? Please provide your company's service standards or best practices?

CCMSI's rigorous Quality Control program ensures strict adherence to CCMSI Best Practices and, most importantly, to the Quality Service Plan—our client's definition of quality. Our Quality Assurance team of experts, with comprehensive experience in claims management, auditing, and system and management training, has developed resources for CCMSI to provide consistent, quality, and aggressive claims management.

Quality Control Team: This team develops and provides training at all locations on compliance with our Corporate Claims Handling Best Practices and conducts regular claim audits, which tie to performance evaluations, ensuring ongoing quality control. Please reference our Internal Auditing Guidelines & Worksheets in Exhibit 3 and Exhibit 4 for our Corporate Claims Handling Best Practices.

Audit Team Goals

- Ensure compliance with Best Practices, client handling instructions, and carrier requirements;
- Provide an objective audit with constructive feedback;
- Help management and claims staff proactively identify areas for improvement;
- Work with our claims staff to provide solutions to any areas identified as needing improvement;
- Foster understanding of our Mission to all claims staff;
- Streamline processes to ensure timely service delivery to our clients; and
- Ensure quality service and value to our clients.

New Hire Audits: CCMSI audits all new hires ninety days after their hire date, allowing us to identify and correct any noted deficiencies. The Quality Assurance team and local management will review results with each adjuster and provide additional coaching and training as needed.

Annual Corporate Audits: CCMSI conducts annual audits on a sample of claims handled by each adjuster, following a standardized process understood by all claims staff. After each audit, we hold feedback sessions with the individual office and applicable claim personnel. If needed, that office's management and the Audit team (if requested) implement action plans to address any areas that need improvement. Our audits review key competencies and adherence to CCMSI Best Practices and client-specific handling instructions outlined in the QSP. Offices with an audit score below 86% must develop a corrective action plan signed off by the state director, regional vice president, and lead auditor.

Quality Service Plan: We design each client's program to meet their exact specifications by creating custom, detailed handling instructions and working closely with them to ensure continuous and consistent compliance.

Intake Procedures: Supervisors review all claims upon intake to ensure proper adjuster assignment based on case complexity and the adjuster's experience and skill level. Once claim data and timelines are entered, the assigned adjuster verifies and tracks for accuracy and ensures compliance.

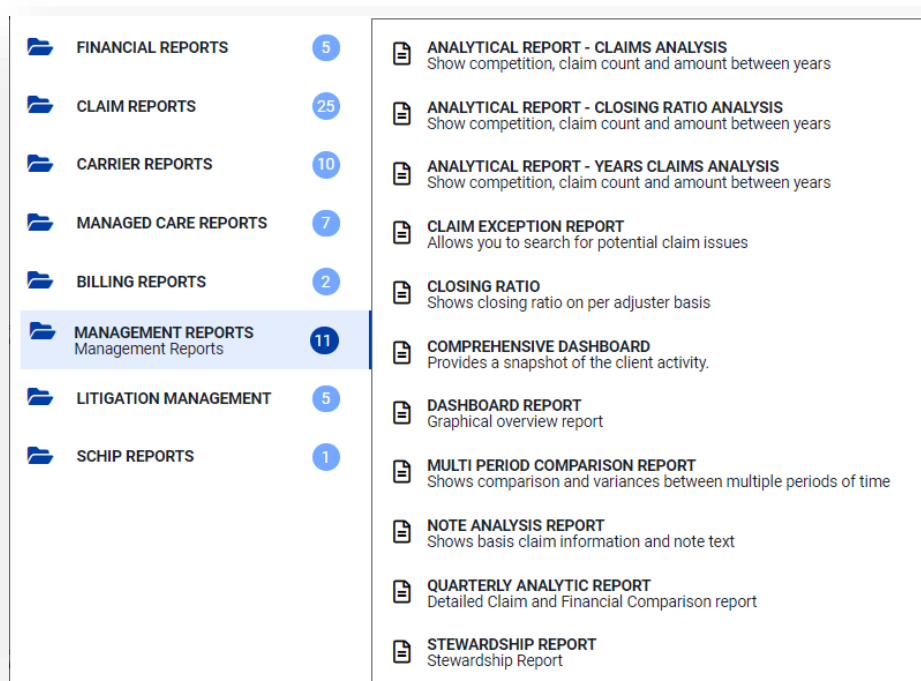
Supervisor Reviews: We conduct thorough reviews using a detailed checklist to ensure compliance with internal Best Practices and the client’s Quality Service Plan. Supervisors review claims at intake and again within thirty to ninety days, depending on claim complexity. Supervisors will not simply check off best practice compliance but diligently push proactive and aggressive claims handling to drive rapid file closure.

Supervisor Audits: Supervisors conduct monthly file audits on a designated number of files for each adjuster and client.

External Audits and File Reviews: CCMSI welcomes the opportunity to validate our processes, assess performance, and implement improvements by collaborating with clients, brokers, and excess insurers to coordinate audits and file reviews. Account managers facilitate auditor reviews and oversee the company’s written response and procedural action items.

SOC Reports: CCMSI completes annual SOC 1 and SOC 2 audits to demonstrate that our financial, technology, and security controls are properly designed and operate effectively regarding customer information confidentiality, integrity, and availability.

Monthly Report Review: Your account manager will utilize MyReports (illustrated below) to generate monthly Management reports that track data and claim trends. This regular analysis helps identify immediate areas for improvement, ensuring continuous performance enhancement.



Benchmarking: Utilizing historical trends and other benchmarking sources (such as WCRI), we perform regular and detailed performance analyses, providing clients with extensive metrics to drive their claims management program’s success.

Annual Stewardship Meetings: We hold annual stewardship meetings with our clients to comprehensively review the past year's performance, focusing on service quality, claim causes, and loss cost trends. Together, we develop and implement strategies to enhance program performance for the year ahead.

9. How are adjusters monitored and/or compensated to ensure compliance with your internal service standards or best practices with the County's client service instructions?

Our quality-focused performance metrics align adjuster evaluations with quality and customer-centric service. Adjusters are compensated based on their ability to provide excellent client service, effective file management, and loss cost reduction. Key metrics for accountability, including client audit scores, internal compliance audits, timely state filings, client scorecard results, closing ratios, and file close duration, drive their success and ensure top-tier results.

Adjusters undergo annual performance evaluations by their managers that review audit scores and performance, with compensation raises linked to these results. We also recognize exceptional service throughout the year with spot awards.

10. Describe your risk management information system (RMIS). What controls are in place to ensure data integrity?

SOC 1 Type 2 and SOC 2 Type 2: CCMSI conducts these annual audits to demonstrate that our internal financial, technology, and security controls are designed properly and operate effectively. These reports provide transparency and instill confidence in our customers and other stakeholders, demonstrating our commitment to safeguarding infrastructure, security, data handling, and customer information.

Our custom-developed, proprietary application systems leverage modern development tools, built on a web-based application rooted in Angular with a microservice architecture and Microsoft SQL Server for robust data management, enabling us to deliver seamless, efficient service. Our primary systems include:

VISION: A comprehensive policy management, carrier, and broker relationship database that captures essential carrier details, including policy information, coverage, effective date, and more.

iCEBAR: A dynamic property and casualty claims management software application integrated with VISION, designed to enhance adjuster workflow for greater accuracy and efficiency in claims handling within policy requirements.

iCE (Internet Claims Edge): A user-friendly, web-based RMIS tool providing clients 24/7 access to critical policy and claims data from VISION and iCEBAR. iCE enables online claims reporting, policy changes, loss control access, and numerous other features, such as detailed management reports and a summary dashboard of key performance indicators.

Controls Affecting CCMSI's Claims Administration Systems and Procedures

Policy management: Client and related coverage information is entered into the VISION policy management system and databases when clients contract with CCMSI for TPA services. The information systems database administrator performs the setup, and the designated CCMSI manager conducts verification.

Claim entry: We receive claims via mail, fax, email, internet (our RMIS iCE), and the 800 line. Due to its security, directness, and immediate availability, CCMSI encourages submission through iCE, which enforces entry of required information and ensures the use of valid codes and an active policy before it will be accepted and processed in iCEBAR. Notifications concerning receipt of claims are reported to state agencies if required by state statute or regulation.

Claim investigation: Claims entered and accepted for processing are routed to the appropriate claim personnel. All inquiries (including initial), documentation requests, and responses are logged in the respective claim's iCEBAR database records. Once entered, claim personnel cannot alter or change the activity after twenty-four hours. Clarifications or corrections can only be noted through the entry of additional file notes.

Check release: After the designated claim professional approves payment, it is forwarded for bill review/repricing or direct payment (as appropriate). The Medical Bill Processing unit then electronically or manually enters the payments into the system and electronically returns them to the designated claim personnel for review and final approval. Our custom claims system has built-in checks and balances, ensuring no single person can input, approve, and release payments.

Cash requirements and disbursement: Before printing checks, designated claim personnel confirm adequate funding is available for authorized payments. If funding is inadequate, we notify the client. Once funds are available and disbursement is approved, client funds are drawn upon to produce the checks. The transactions are released to the Information Systems Processing Unit, where the checks are processed and distributed. Electronic signatures applied during check generation are maintained in files protected by computer access security procedures.

Additional CCMSI application controls include the following:

- Payees require two independent parties to be set up in the system;
- The iCEBAR application enforces edits for duplicates;
- The system does not accept claims lacking complete information;
- Only payees set up in the system may be applied to claims;
- Claim personnel are trained on Best Practices;
- Designated CCMSI management reviews Management Reports;
- The system maintains a log of all activity against a claim;
- Claim reserves are based on the designated claim personnel's assessment of each claim; and
- Excess insurance carriers are informed of reportable losses.

11. Describe what type of access and training you will be offering the County to your RMIS

During your account transition, we will collaborate with your team to identify departments and individuals who need training. Your account manager, with support from our Corporate IT department, will provide the County's users with a comprehensive one-day, on-site training session covering all aspects of the iCE system's functionality, including:

- Internet claims reporting;
- How to access your claim representative's electronic claim files;
- How to access and download static, standard reports we provide monthly;
- How to access our report library and utilize/customize existing report templates; and
- How to write ad hoc reports that are specific to your needs.

H. Claim Notes

1. What information is required to be included in the claim notes?

CCMSI's general practices on adjuster notes are outlined below, providing the County with an understanding of the detail and functionality that will be available to them.

A summary of all highly sensitive correspondence, contacts (e.g., emails, faxes), or information that affects a claim's exposure will be logged in the claim notes and attached within two business days of receipt. Other relevant correspondence and information will be logged in claim notes and attached to the file within ten business days of receipt. All verbal contact must be handled/responded to appropriately and documented within two business days under the appropriate heading. All correspondence must be date-stamped and appropriately marked upon receipt.

The log note headings are as follows:

Action Plan/Diary Review Explain what your strategy will be going forward on the claim. Use this to convey what your current plan is, outlining the necessary steps to bring the file to a resolution. A routine look at the claim by the designated claim professional. The claim log notes should reflect what you have done when reviewing the claim.

Carrier Reporting Document any contact with the excess or deductible carrier, including first reports, updates, requests for information, etc.

Claimant Any contact with the claimant or a person near them (wife, child, etc.), which includes a summary of any recorded statement. This heading should also be used to document the request and receipt of medical authorization forms.

Client Any contact with the member/insured/client. It can also be used to document any contact with an agent for the insured/member/client. Many agents monitor the handling of the claims for the insured.

Client-External This heading is used by one external client who is entering notes to their claim files

directly. No internal CCMSI user should use this heading.

Contact Information Document-pertinent contact names, addresses, and phone numbers for a given file.
Note: *This log note can be modified after twenty-four hours.*

Coverage Analysis Document all coverage information and potential coverage issues under this heading. Documented coverage information should include, but is not limited to, carrier name, coverage type, policy effective dates, policy number, policy limits, deductibles, reporting level, replacement cost vs. actual cost value, and any applicable endorsements that apply.

Damages Document and analyze the property and/or casualty damages claimed in the loss. For medical malpractice, list the alleged condition that was caused by the alleged malpractice.

Denied/Disputed (Texas only) This heading is used for Texas claims only to outline each PLN1 (denials) and PLN11 (disputes) completed on the file to capture the exact language filed with the state. This heading will also be updated when the designated claim professional retracts a previously filed denial/dispute.

EDI This is used to document any EDI submission requests by claims staff to EDI Data Entry, which can be used as evidence of timely submissions. Automated responses from EDI Data Entry or acknowledgments from the state will be downloaded to this note heading. Do not use this note heading to document state form filings.

General This heading is used to communicate and provide direction to other internal team members working on a claim. This heading should be used when no other heading applies.

High Priority ICEBAR provides the capability of making notes high priority. Use this at the direction of the client/account manager to flag a note as a high priority. There are no required notes on which to use this per Best Practices.

Indemnity Payment This heading is used to document any indemnity payment created through the Indemnity Payments or Scheduled Payments screens. The payee name, amount, and time period will be recorded in a system-generated log note.

Index/Prior Claims Document ISO/index search results, follow-up activity (as necessary), and any prior injury results. This is not intended to document prior medical records.

Investigation Should be the initial note in the claim file summarizing the initial description of the injury or loss. All compensability/liability issues should be documented under this heading, as well as a summary of all fieldwork, scene photos, etc.

Legal Document any contact with the legal counsel or their office. This would be calls, emails, voicemails, letters, etc.

Liens This heading is used to document any potential lien information on a claim, including wage garnishments, attorney fees, child support liens, etc. *This does not include any CMS (Medicare, Medicaid, MAPS) or subrogation liens (subrogation, SIF, salvage).*

Medical Document when ordering records, writing to the doctor, speaking with the office and PT, logging medical notes, etc. into the claims system. Any information regarding IME appointments and results should be logged under this heading.

Medical Case Management Document any contact or correspondence received regarding the internal nurse/case manager, external case manager reports, etc. Internal case managers/telephonic case management nurses relaying their recommendations on the claim should use this heading. The Medical heading should be used whenever contact is made with the treating physician (when applicable).

Medicare Compliance This heading is to be used to document all issues that arise on a particular claim regarding SCHIP reporting, Medicare, and CMS. Examples of appropriate usage of this heading include a Medicare Set-Aside (MSA) evaluation or Claim Settlement Allocation (CSA) exposure by the claim professional (i.e., why an MSA/CSA is or is not required on the claim), documenting the decision to refer the claim to a vendor who will provide the MSA/CSA evaluation, summary of the MSA/CSA report, documentation pertaining to the submission of the MSA to CMS for approval, CMS liens, an acknowledgment of any claim reported under SCHIP requirements.

Pre-Cert/UR Document all precertification information, utilization review determinations, California Requests for Authorizations (RFA), case notes, and other activity pertaining to the role of the pre-certification or utilization review personnel. Do not use this note heading for medical case management or other claim adjuster notes.

Private Note ICEBAR provides the capability to make notes private. The private note is intended for communication and/or documentation only within CCMSI—**not** externally. It should be used with great care and discretion. When considering whether to make a note private, weigh your other options for communicating this message (e.g., phone call, email, memo, or verbal communication).

Provider Document any discussion with providers regarding bills: negotiated savings on bills, when negotiating a rate for services, or when negotiating a rate that varies from the state fee schedule or U&C rates should be logged under this heading. This heading should **not** be used to document medical information.

Provider Statement This heading is used when a statement is received from a provider. A statement is a bill that does not have enough information to qualify for payment (e.g., ICD-9 or CPT codes). *This heading is not for the claimant's recorded statement or interview summary.*

Reserves This heading is for the designated claim professional or supervisor to use when discussing the reasoning of the reserve levels set; i.e., reserve rationale.

Risk Assessment This heading is used for the system-generated note, including the Claim Risk Assessment, and to discuss any changes to the Risk Assessment and ninety-day reviews.

Rx/Prescription This heading is to be used to document all information related to Rx/prescription medication requests, utilization, alerts, billing, Rx reports, etc.

Settlement/Evaluation This heading is for the designated claim professional to use when analyzing and/or evaluating the case exposure and final results, or when logging receipt of approved contracts and/or legal settlement documents.

State Regular correspondence is required on claims in many states. This would be used when forms are sent to or received from the state. Example: when notifying the state of a claim, updating the state that TTD has started or ended, state-required employer filings, etc. Also, log any conversations with the state here. Do not use this note heading for any EDI submissions or acknowledgments.

Subro/Recovery/Salvage This heading is used to document whether or not there is potential subrogation/recovery, contribution vs. joint tortfeasor, and/or a risk transfer opportunity for claim defense and indemnification vs. contractual third-party indemnitors. It is also used to summarize anything related to subrogation/recovery and recovery investigation/contribution/risk transfer investigation, follow-up, etc. This heading would additionally be used to document if salvage was involved and how it was handled.

Supervisor This heading is for the supervisor to document the monthly or routine look at the claim. Log what you have done when reviewing the claim and any recommendations for future handling. It should also be used for the adjuster or supervisor to input the setup instructions into the claims system.

Surveillance Document surveillance results, background checks, and any contact with the surveillance company.

UB Itemization This heading is used for the itemization of a UB92 bill.

Vendors/Independent Adjuster This heading is used by property and casualty adjusters to document all assignments to independent adjusters, rental car companies, medical record copy vendors, and translation vendors, as well as receipt/payment of these bills. Continue to use the Investigation or Damages headings to document the results received.

Voc Rehab Any contact with a vocational rehabilitation person (e.g., reports and phone calls).

Wage Information This heading is used to attach wage statements and document the detailed wage rate calculations and summary of wage rates (AWW, TTD/CR, daily TTD, PPD).

Witness Document any contact with a witness or witness statements received on a file. This would be calls, emails, voicemails, letters, etc.

2. What are the supervisory file review criteria? What supervisory note documentation is required?

Supervisors review all claims upon intake to ensure proper adjuster assignment based on case complexity and the adjuster's experience and skill level. Potential complexities and necessary actions are identified and captured in the file notes.

Per our Corporate Claim Standards, all files must have an initial supervisor diary review within the first thirty days of receipt of a new claim. Supervisors are then responsible for maintaining subsequent diary reviews every thirty to ninety days, depending on the severity and activity of a claim.

Our system's automated diary process sends a diary notification to the supervisor upon setup and recurs until claim closure.

Below is what a supervisor looks at when reviewing/evaluating a diarized claim:

- **Coverage:** Was coverage verified and/or were coverage issues clearly documented in the system and appropriate follow-up actions taken.
- **Contact:** Was it documented clearly and in the timeframe established by our Corporate Claim Standards or the client. Was this contact meaningful and was there appropriate follow-up contact.
- **Investigation:** Was a full investigation completed or attempted within the timeframe established by our Corporate Claim Standards or by client-specific handling guidelines. Was the investigation thorough enough to support the compensability decision on the claim. Was the compensability rationale clearly documented in the log notes. Was subrogation, recovery, salvage, or SIF investigated and documented. Was the Index Bureau utilized properly and documented in the log notes in accordance with our Corporate Claim Standards. Is additional investigation necessary.
- **Reserves:** Were the initial reserves established within Corporate Claim Standard guidelines. Were the reserves reviewed and updated timely as developments occurred. Was the reserve rationale from the adjuster clearly documented in the log notes. Are the reserves adequate based on known exposures.
- **Medical & Disability Management:** Were pertinent medical records requested, received, and documented timely in the log notes. Were medical bills properly adjudicated within state specifications or within thirty days. The supervisor will also evaluate the appropriate use of IMEs, Medical Case Management, and Vocational Rehab professionals. Did the adjuster make every effort to return the injured employee to work at the earliest possible time.
- **Litigation Management:** Were all pertinent legal information/requests handled timely. Was the litigation plan and/or settlement strategy of the claim managed and directed by the claim professional, as well as clearly documented in the claim log notes.
- **Excess/Reinsurance:** If the claim met the reporting requirements, was prompt notice given and documented clearly in the claim log notes. Were timely follow-up reports provided to the carrier/client once the initial report was made.
- **File Documentation & Misc.:** Was a meaningful initial action plan developed/documented and updated timely to reflect important changes. Were log notes and the claim summary current, concise, and complete. Were client instructions followed. Was the claim file concluded effectively and timely.

Following the file review, supervisors will document their findings and recommendations for future handling in the file notes and continue monitoring to ensure their recommendations were executed.

3. Are medical case manager notes included?

Yes, all work products (including case manager notes) are integrated electronically into ICE, our claims processing system user interface. Through the ICE platform, nurses are provided a defined level of access to the claim files they manage, from which they can populate notes.

4. Who else enters claim notes?

Claim representatives and supervisors can enter claim notes into their assigned files.

I. Reserving Practices

1. What is your company's reserving philosophy?

One of the many things that sets CCMSI apart is our personalized approach to reserving. Unlike most TPAs, who apply standard reserve amounts to all claims, often leading to inaccurate reserves, we approach each on a case-specific basis. In addition to various guidelines, our claim professionals evaluate the merits of each claim and apply their knowledge and expertise to set reserves based on its anticipated financial outcome. They carefully examine key red flag indicators, such as age, health factors, occupation, retirement plans, workforce changes, and any disciplinary issues, to assess how these may affect an employee's ability or willingness to return to work.

When limited information is available, we establish a minimum reserve. Proper reserve analysis involves myriad variables, including all past and future lost income and medical treatment, any permanent disability, potential permanent total benefits, and expenses such as litigation, rehabilitative services, mileage, outside expert opinions, and possible settlement values.

2. When are initial reserves established?

CCMSI specializes in working with large self-insured and risk-sensitive programs, understanding the critical financial impact of setting accurate, timely reserves. Our proven processes ensure effective reserving, eliminating unnecessary adjustments or stair-stepping. Our goal is to instill confidence in clients and carriers that our reserving practices accurately reflect the current exposure of each claim.

We establish and review reserves as follows:

- Initial reserves are established and posted into the claims system within ten business days from receipt of loss.
- Reserves are re-evaluated every thirty to ninety days after that (depending on claim activity and severity).
- Claim supervisors review reserves within the first thirty days and at each adjuster and supervisor diary. Afterward, reserve reviews will depend on claim activity and severity, with log notes included regarding the rationale for any changes.

- Upon receiving new and pertinent claim documentation and/or information, adjusters re-evaluate reserves within ten days. We promptly request additional information if needed to evaluate the current exposure fully.

Title	Maximum Reserve Authority
Chief Operating Officer	\$3,000,000 & greater
V.P. Claims	\$3,000,000
Regional V.P.	\$1,000,000
Branch Manager/State Director	\$500,000
Account Manager/Claim Manager/National Account Manager	\$250,000
Sr. Claim Supervisor/Claim Supervisor/Claim Specialist	\$200,000
Claim Consultant	\$100,000
Claim Representative	\$50,000
Claim Associate	\$25,000
Medical Only Claim Representative	\$5,000
Claim Clerk	\$0

3. When and how do you communicate reserve information to the client?

The County will have 24/7 access to all reserve information via our RMIS, iCE. Adjusters must document their reserves and rationale in their notes. Within the system, clients can view the complete reserve history and adjuster reserve notes on specific claims, including reserve worksheets when warranted.

We will prepare reserve worksheets and attach them to the claim file to support reserve changes for claims that meet criteria based on the County’s desired preferences. In just a few easy steps, our clients can generate a reserve change report that shows all changes (or filtered amounts greater than a pre-defined threshold).

4. When do supervisors review initial reserves, reserve changes and conduct periodic reserve reviews?

Claim supervisors become involved from the moment a claim is received, providing adjusters with investigation recommendations and guidance (as needed) on evaluating the initial ongoing reserve.

Subsequently, supervisors review all files every thirty to ninety days, depending on the claim’s complexity; however, it is more frequent if the complexity and exposure warrant. Upon each review, supervisors thoroughly examine and evaluate reserves, providing direction for any necessary adjustments.

Our system automatically sets all supervisor diaries.

5. What subjective information and/or objective tools are used by your company to establish reserves?

CCMSI has developed a detailed reserving worksheet integrated into our proprietary RMIS and widely shared with major carriers, auditors, and workers' compensation governing bodies nationwide. We consistently receive positive feedback from industry experts, stating that it provides meaningful insights and detailed analysis of established reserves, including the adjuster's rationale.

Used by all adjusters, the worksheet links seamlessly to their software application (iCEBAR), allowing them to save reserve changes as a work in progress if they need to gather additional information to capture the reserve in a comprehensive and detailed format. The reserve worksheet ties directly to the claim file notes in CCMSI's claims system and iCE, allowing clients complete visibility into adjuster notes and the entire worksheet, ensuring transparency and insight into how our professionals develop reserves.

In addition to leveraging our claim professionals' experience and knowledge to establish case reserves, we have integrated predictive analytics and artificial intelligence (AI) into our claims management process. AI and machine learning help our adjusters quickly read, understand, and extract critical information from documents that impact claim outcomes. By providing adjusters with vital insights early in a claim's lifecycle, we empower them to be proactive, improve reserving accuracy, and drive better outcomes. By combining our adjusters' expertise with advanced technology, we consistently deliver optimal financial results for our clients.

CCMSI's predictive analytics program enhances claims management by identifying comorbidity flags and forecasting future treatment and costs. The model analyzes the entire claims database, finds those with similar attributes, and determines an average cost prediction. Additionally, it scores claims daily, updates cost predictions based on new data, and provides adjusters with rising and lowering risk factors. While adjusters do not rely solely on AI to establish reserves, they use it as one component in the total reserving evaluation process to ensure the most accurate and effective reserve evaluations.

6. Does your company use an automated reserving program to establish reserves?

No, please refer to our tailored reserving philosophy described in the responses above.

J. Diary System

1. What automatic system diary notices are provided, to whom and when?

iCEBAR, our proprietary claims system, automatically sets initial ten-day diaries for supervisors and claim professionals. Adjusters must maintain a minimum thirty-day diary for file review, including reserve adequacy. Additional diaries may be maintained for doctor visits, hearings, trials, etc.

Per iCEBAR rules, an open claim cannot exist without an open adjuster diary. When a claim is entered, diaries are automatically sent to the file owner and supervisor.

Once the initial review is complete, diaries can be established within one to thirty days, depending on the

severity and activity required. Supervisors maintain adequate review diaries based on the adjuster's experience level and the file's complexity and severity.

2. How frequently do supervisors monitor/review claims?

Per our Corporate Claim Standards, all claims undergo an initial supervisor diary review within thirty days of receipt, followed by regular reviews every thirty to ninety days, depending on the claim's severity and activity. Following the file review, supervisors document their findings and recommendations for future handling in the file notes and continue monitoring to ensure their recommendations are executed.

3. How frequently are adjusters expected to review a claim? Other diary notices.

Adjusters are required to maintain a minimum thirty-day diary for file review, including reserve adequacy. If indemnity benefits are being paid, the adjuster will review the file every fourteen days.

K. Subrogation

1. The County does not allow subrogation to be pursued without County approval.

CCMSI understands and will not pursue subrogation without the County's approval.

2. Describe your subrogation services. What criteria are used for exploring cases with potential subrogation? Do you use resources from outside your organization for this service? How does this affect pricing?

CCMSI significantly reduces claim costs by identifying and pursuing optimal recoveries, especially when third parties are involved. Our claim representatives are subrogation experts, actively investigating all claims with potential recovery opportunities, which ensures we maximize recoveries directly from third parties or their insurers whenever possible. Potential claim types that may involve subrogation include, but are not limited to:

- Animal bites
- Slips and falls (on or off insured premises)
- Aircraft, train, or boat accidents
- Motor vehicle accidents
- Construction site accidents
- Machinery accidents
- Product-related claims
- Losses involving an explosion or fire
- Lifting/loading/unloading accidents
- Inhalation/exposure claims
- Criminal interaction claims

When we identify a recovery opportunity, the claim representative consults with their supervisor first and then with the client to gain approval before proceeding. Upon authorization, we notify the third party of our right of recovery. We then create a detailed subrogation/recovery action plan (available in the claim notes) outlining the subrogation issues involved, recovery potential, the probable amount to be recovered, and the next steps. As with general action plans, we update the subrogation action plan accordingly as the claim evolves.

We maintain regular follow-ups with the third party, ensuring they remain informed of the nature and

extent of damages and claim progress. If the third party disputes accident facts regarding the claimant's injuries, our team works to negotiate a reasonable and timely settlement, pursuing legal remedies (i.e., mediation, suit) if necessary. Subrogation efforts continue until it is no longer viable or until the client directs us to discontinue.

3. Please discuss in detail any additional fees required for these services.

Please refer to the Pricing Tab for all costs.

L. Litigation Management Strategies

1. What are your litigation management practices?

CCMSI's litigation philosophy is as follows: *To provide the best and most appropriate defense for CCMSI, its clients, and insureds, and to vigorously defend non-meritorious claims, as well as claims where the demands are excessive.*

Equally important, we understand that the County has distinct needs and expectations and are prepared to meet with the appropriate parties to formalize the process. Highlights of CCMSI's litigation management philosophy include:

- Timely, quality communication/interaction with the client's designated individuals;
- Consultative recommendations regarding developing, implementing, and monitoring the litigation strategy for each case;
- Eliminating unnecessary, unproductive, and duplicate efforts by members of the litigation team;
- Monitoring defense counsel to ensure timely reports and budget adherence;
- Diary-driven monitoring and re-evaluating litigated claims and, as appropriate, modifying the disposition strategy;
- Concentrating legal expenditures on activities that mitigate the client's financial exposure; and
- Paying legal fees and associated expenses promptly as budgeted and approved by the client.

2. What is the procedure for assigning defense counsel to a claim?

Criteria considered when making a referral to legal counsel include the following:

- Cases in suit;
- Coverage opinion(s) needed if the carrier reserves their rights or disclaims coverage;
- Severe, catastrophic, or highly questionable claim;
- High-profile (e.g., media-sensitive) events;
- Disputed, high-dollar exposure cases that are heading toward litigation;
- Cases that involve third-party litigation, liens, or subrogation recoveries; and
- Any claim wherein staff suspect fraud.

Our litigation management objective is to provide our clients with an appropriate, cost-effective, and professional defense. CCMSI is committed to controlling legal expenditures and ensuring all expenses are consistent with the established litigation strategy. We insist that a prompt determination is made on the merits of every claim and that a plan is swiftly adopted to settle or proceed to a hearing.

3. What is the adjuster and supervisor involvement in a litigated claim?

Our claim professionals direct and monitor defense counsel activities and have ultimate accountability for all litigation matters. We maintain regular contact with the claimant's attorney to achieve swift claim resolution, and closely review legal bills before payment to confirm that the charges are reasonable and substantiated. Collaborating with defense counsel, we develop and adjust defense strategies as needed and establish defense budgets for costs and expenses (when appropriate). For qualifying cases, we utilize arbitration or mediation to reduce costs and achieve prompt settlements.

4. Describe your process for coordinating with County counsel.

The assigned claim adjuster will work with County counsel throughout the entire litigation process, providing continuous communication and updated reports. Please refer to the previous question for additional details.

5. Do you have an approved outside counsel list? Will you add our preferred attorneys to the list?

CCMSI does not have an approved outside counsel list, but works with several defense firms in Texas. We will work with the County's counsel of choice.

M. Allocated Loss Adjustment Expenses (ALAE)

1. What do you define as ALAE?

ALAE are charges for services provided in connection with specific claims by persons or firms eligible for claim expenses under the client's program. CCMSI will pay all ALAE with client funds at the market rate. Independent of this, ALAE will include all expenses incurred in connection with the investigation, adjustment, settlement, or client claim defense, even if CCMSI incurs such expenses, including, but not limited to, charges for:

- 1) Claimant independent medical examinations (IME);
- 2) Managed care expenses, which include the services provided by Comp MC™, CCMSI's proprietary managed care program. Examples of managed care expenses include state fee schedules, PPO networks, utilization reviews, nurse case management, medical bill audits, and medical bill reviews;
- 3) Fraud detection expenses, such as surveillance, which include the services provided by FIRE, CCMSI's proprietary Special Investigation Unit (SIU), and other related expenses associated with detecting, reporting, and prosecuting fraudulent claims, including legal fees;
- 4) Attorneys, experts, and special process servers;
- 5) Court costs, fees, interest, and expenses;
- 6) Depositions, court reporters, and recorded statements;
- 7) Independent adjusters and appraisers;
- 8) Index Bureau and Office of Foreign Assets Control (OFAC) charges;
- 9) MMSEA/SCHIP compliance charges;
- 10) Electronic data interchange (EDI) charges if required by state law;

- 11) CCMSI personnel at their customary rate or charge, but only concerning claims outside the state and only if such customary rate is communicated to the client before cost incurrence;
- 12) Actual reasonable expenses incurred by CCMSI employees outside the state for meals, travel, and lodging in conjunction with claims management;
- 13) Police, weather, and fire report charges that are related to claims administered under the client's program;
- 14) Charges associated with accident reconstruction, cause and origin investigations, etc.;
- 15) Charges for medical records, personnel documents, and other documents necessary for claims adjudication under the client's program;
- 16) Charges associated with Medicare Set-Aside allocations and other MSP-related services;
- 17) Legal bill review expenses, including services provided by CCMSI's proprietary legal bill review program, CLEAR, such as reviewing and auditing invoices submitted by County-approved law firms for compliance with the Client's Defense Counsel Billing Guidelines.
- 18) Other expenses that are normally recognized as ALAE by industry standards.

2. What are the adjuster's responsibilities?

When applicable, we will follow the County's client service instructions regarding the use of outside vendors, who must have the appropriate certificates of insurance. Before taking action, our staff will discuss the proposed use of these providers with you. Our goal is to engage service providers who help us investigate and adjudicate claims subject to state law.

As the assignor of services, the designated claim professional is responsible for:

- Documenting the rationale for referring to an outside vendor and a brief description of the assignment's scope.
- Obtaining an initial cost cap and monitoring expenses as needed.
- Ensuring the vendor stays aligned with the outlined strategy.
- Documenting the vendor's outcomes to assess if goals are being met.

N. Client Instructions

1. How are client service instructions made available to adjusters?

The County's account manager will email its client service instructions to adjusters and upload them to the County's account in our claims system.

2. Is there a gate-keeping system that will require the adjuster to complete or comply with all items of the client special handling instructions?

No, there is no automated gate system. Adherence to client instructions is reviewed during all supervisory audits and reviews.

3. How do supervisors ensure adjuster's compliance with client service instructions?

Compliance is reviewed during all supervisory audits and reviews.

4. Please confirm that TPA is agreeable to weekly call with FBC RM department personnel to verify claims are being setup and investigated properly.

CCMSI confirms.

5. Please confirm if TPA is agreeable to considering using Dean Pappas and Associates as a FBC preferred WC defense counsel for any hearing or litigation needs.

CCMSI confirms.

O. Claim Review Meetings

1. Claim review meetings will be conducted with the County on a quarterly basis.

CCMSI agrees.

2. What are your recommendations for scheduling and accomplishing the quarterly claim review meetings?

We encourage quarterly claims management meetings to ensure transparent communication with client risk management personnel and take an active leadership role in these reviews, guided by criteria set by the County, which we propose to hold via Microsoft Teams or in-person, if requested.

CCMSI will prepare and distribute agendas in advance to facilitate an efficient and productive meeting and allow for adequate preparation. Necessary members of the claims account team will attend, ready to discuss claims according to the agenda criteria, offer recommendations, and request settlement authority. The meetings will also address procedural matters and any service-related issues.

3. Please confirm that TPA has the ability to prepare detailed AL/GL/WC/Claim Status Reports prior to each Quarterly Claim Review (current status, financials and action plan going forward)

CCMSI confirms.

4. What fees are assessed for this service, if any?

These costs are included in our administration fees.

P. Claim Reporting Options

1. What options are available to the County for reporting new losses to your company?

CCMSI offers various intake options.

800 capability: We partner with Stratacare to provide this service and script intake questions to suit client needs. This service's 24/7 capability may be utilized at an additional fee.

Phone, email, and facsimile: Accepted by our local office during regular business hours (8:00 a.m. to 4:30 p.m. local standard time).

iCE Mobile App: Android- and Apple-compatible app for clients to report and view claims data.

Online: The County can report claims 24/7 via iCE, our proprietary state-of-the-art internet claims analysis and reporting tool. The Initial Report section of iCE allows users to create an Initial Report Form per state guidelines. Once submitted, the system immediately notifies the claim supervisor and automatically assigns a claim number that is viewable in iCE. The submitted data populates our proprietary claims system in real time, enabling our claim adjusters to begin working on your new claims immediately.

DataLoad2: A web-based service application programming interface (API) built for our clients to electronically transmit real-time new loss data, notes, and attachments securely via an Initial Reports interface.

Nurse Triage Service: We partner with Stratacare to offer this 24/7 licensed registered nurse triage hotline, quickly assessing an injury's severity, recommending the best course of action, and initiating the claims process.

2. How are new losses disbursed to claim offices? What is the guaranteed time frame?

Experienced claim professionals review and evaluate all First Notices of Loss (FNOL) daily and promptly assign them to the appropriate team members. Indemnity, complex, and questionable medical claims are entered and activated within one business day of the first report of injury; medical-only claims are processed and have claims management initiated within two business days of the first report of injury; and property and casualty claims are entered and activated within one business day of the first notice of claim, ensuring swift and efficient handling from the start.

3. What are the internal service standards for establishing a claim file for a new loss?

When claims are reported via iCE, the file sets up automatically and notifies the supervisor and handling adjuster immediately. When reported by phone, fax, etc., the claim file will be set up no later than twenty-four hours after receipt.

4. County currently has a proprietary incident reporting system. After September (2023) incident reporting will be available through Origami. Can County system or Origami interface with your RMIS to upload incident reports to you? Is there a cost for this service?

Yes, CCMSI's RMIS (iCE) can interface with the County's system and Origami to upload incident reports at no fee if the County uses our standard interface. There will be a \$150 hourly IT fee if the County would like a customized interface. We will provide an estimate of charges before any work is done. There are no claims reporting or incident-only claim fees for claims that are entered directly into our web-based RMIS. There is a \$25 per claim reporting fee for telephone, fax, and 1-800 claims reporting.

5. Please provide pricing options.

Please reference our previous response and the Pricing tab for all costs.

Q. Centralized Medical Only Claim Handling

1. Please provide a detailed description of your capabilities relative to the administration of medical only claims.

Please refer to Exhibit 4 – Corporate Claims Handling Best Practices.

2. If so, please provide details of locations, personnel, and best practices.

Yes, if requested by the County, we can manage its medical-only claims from one of our existing centralized medical-only units, which we can discuss during the implementation phase.

R. Billing/Funding

1. What billing options are available to the County? How are fees estimated if billed on a per-claim basis?

CCMSI can accommodate multiple claims payment funding options and works closely with our clients to determine specific banking needs during the account setup process. Please refer to Exhibit 5 - Banking Options.

2. What banking arrangements are available to the County?

Please refer to Exhibit 5 - Banking Options.

CCMSI's preferred escrow:

- Multi-employer account with all transactions uniquely identified to the client and all analysis and reporting at the client level.
- Account structured to ensure claim payments comply with timelines imposed by various state regulations. CCMSI is responsible for fines and penalties resulting from late payments.
- Account is with Bank of America; includes payee positive pay and overdraft protection.

- Account will have CCMSI's FEIN.
- Streamlined new client setup; no signature cards, test checks, etc.
- Account will be managed via online banking within CCMSI's Treasury department internal control structure.
- CCMSI prints and issues checks daily for approved claim payments.
- CCMSI prepares monthly bank reconciliation and assists with state escheatment requirements.
- Client will not incur bank charges (except wire fees) or receive interest earnings.
- Client is responsible for appropriate account funding.

3. How is the imprest/escrow fund determined?

- The initial escrow deposit (imprest) is calculated by Treasury funding based on 1.5 times the average paid claims, funding frequency (daily, weekly, monthly), and funding method (ACH, wire, check).
- Treasury funding will request advance funding for large settlements (\$50,000 or other amount specified by the client).
- Funding invoices will be invoiced in arrears based on check registers and are due prior to the end of the succeeding funding period. The client must maintain a good payment status. Failure to pay funding invoices promptly may necessitate an escrow deposit increase or a change in account type.
- Required escrow deposit will be reviewed annually or if the client's balance goes negative for more than three months. Adjustments to the escrow deposit will be included on the next funding invoice.
- ACH is the preferred method for funding. Each wire transfer will result in a \$9.45 fee to the client included on the monthly funding invoice, regardless of bank account type.

4. Please outline your internal procedures to ensure security of claim checks.

Segregation of Funds: Clients who elect the Preferred Escrow account structure are part of a multi-employer account at Bank of America, each with a unique subaccount and access to personalized analysis and reporting.

Positive Pay: To prevent fraud, all Preferred Escrow, Managed Escrow, and Insurance Carrier Escrow accounts are protected by Payee Positive Pay. The CCMSI claims system generates Positive Pay files daily, which are sent to the bank and reviewed by a CCMSI accountant (separate from the assigned funding accountant) for Positive Pay rejections.

Segregation of Duties: Clients are assigned a funding accountant who manages daily oversight of their account(s) and monthly reconciliations, while the treasury manager oversees the day-to-day functions of the funding accountants.

Deposits: The funding accounts receivable accountant monitors funding deposits obtained by CCMSI and posts all deposits collected, which are recorded in our accounts receivable and claim systems.

Disbursements: CCMSI's Treasury Check Printing team handles disbursements from the claim account and prints all checks and reports per the client's specifications.

Monthly Reconciliations: The assigned funding accountant reconciles all bank statements to the claims system transaction reports monthly, after which we provide a copy of the reconciliation to the client. The treasury manager reviews and approves all bank reconciliations and meets monthly with the corporate controller and chief financial officer to review the status of bank reconciliations and escheatment requirements.

Escheatment: CCMSI reviews outstanding checks each month. Claims staff investigate checks that remain uncashed after eight months and send due diligence letters to the payees. Based on the response, checks will be voided or voided/reissued and provided to the client to include in their due diligence filings.

5. Are benefit checks issued from the claim office or from a central facility?

Checks are issued from our corporate office in Danville, Illinois.

5. Carrier Protocols

1. How is claim data transferred to an excess insurance carrier? Is there a cost associated with this service?

Data will be transferred via an electronic interface. We set up interfaces with each carrier to ensure a seamless process. See the Pricing Tab for all costs.

2. How are claims with excess insurance potential identified?

CCMSI Corporate Best Practices include procedures to ensure that reporting on excess claims is compliant with policy, client, and CCMSI standards, which include but are not limited to:

- A fixed dollar amount or percentage of the insured retention level per occurrence;
- Permanent total disability (as defined by statute);
- Fatalities;
- Paraplegics and quadriplegics or spinal cord injury;
- Serious burns;
- Brain injury;
- Amputation of a major extremity; and
- Any occurrence that results in serious injury to two or more employees.

3. How are claims with excess insurance potential reported?

At the County's initial client setup, our Implementation team will verify and establish all reporting levels within CCMSI's policy management system and iCE, as determined by the guidelines, which allows the policy information and any special handling requirements to be accessible by the claim adjuster at any time during handling.

Our claims automation system monitors claim levels and notifies the adjuster and supervisor when a

claim reaches the reporting level specified in the policy through a system-automated diary (based on whether claim payments and reserves have arrived at the specific threshold). It can also monitor when the last reporting was completed and when the next is due.

Completed Edit screens indicate the first report date and follow-up reports. CCMSI can generate threshold reports to help monitor excess recovery, while iCE can produce reports that help facilitate excess file identification through the Claims Analysis report, which lists incurred cost thresholds. CCMSI transmits claim data each month to the carrier through an automated process.

CCMSI's centralized Carrier Reimbursement team, comprising individuals from the Underwriting department with expertise in policy language, finance, and accounting, oversees the reimbursement process for all carrier reimbursements. Their responsibilities include, but are not limited to:

- Automatically identifying and notifying all newly paid claims/occurrences exceeding retention;
- Evaluating corresponding policies with specific client guidelines for reimbursement determination;
- Reimbursement requests to the carrier with notifications to claim adjusters, supervisors, and/or clients;
- Reimbursement posting and file documentation; and
- Aggregate claim tracking and posting.

4. When, and how, is the client notified of these types of claims?

The policy language, issued by the carrier and accepted by the client, specifies excess carrier reporting requirements. Each policy has specific handling procedures that include levels of retention, levels of reporting, contacts for reporting, methods of reporting, and reporting criteria. These, and any additional requirements per the client's direction, are utilized to ensure each claim complies with the set guidelines.

At the County's initial client setup, our Implementation team will verify and establish all reporting levels within CCMSI's policy management system and iCE, as determined by the guidelines, which allows the policy information and any special handling requirements to be accessible by the claim adjuster at any time during handling.

5. The County is self-insured and has its' own RMIS for internally-handled claims, to review third party administered claims and to run combined reports of internally/externally handled claims. Does your system have the ability to interface with the County's RMIS (Origami) to include notes, reserves, financial transactions, photos, accident investigative reports, incident reports, etc.? Is there a cost for this interface or data transfer service? If so, please include pricing in your quote.

Yes. Our claims system will interface with Origami to include the above-mentioned reports and features. There is no fee for the interface.

T. Implementation Plan

1. Please provide a management plan and timeline for the implementation of the County's program.

[See Exhibit 6 – Implementation Overview & Plan.](#)

Changing your TPA is a critical decision, with the implementation process vital to a successful transition. At CCMSI, we've developed a seamless approach backed by years of experience onboarding complex programs and performing substantial data conversions. Our refined and proven process minimizes disruption and maximizes results. But don't just take our word for it—hear directly from our clients:

"We were reluctant to change TPAs due to the perceived hassle of the process but due to a servicing issue with our prior TPA, we had no choice but to move forward. It was scary for us since we didn't have weeks to make a decision, we had days. To say that it was seamless transition is an understatement! CCMSI was able to complete the conversion process without issue in a matter of a couple of days. We have now been with CCMSI for 10+ years and couldn't be happier. Their service has been superb. Highly recommend CCMSI."

Denise K. Evans | Director of Claims, Staffmark

A smooth TPA transition requires a strategic and comprehensive approach. We focus on key areas in our Implementation Plan to ensure a successful migration and seamless claims management execution. Below are some crucial steps we follow:

- **Assigning a Dedicated Implementation Manager:** This individual is the primary point of contact and oversees the transition process, ensuring we execute all steps efficiently.
- **Issuing Client and Incumbent TPA Information Request Forms:** Gathering necessary information from the client and the current TPA to identify any specific needs or challenges and understand the existing setup and requirements.
- **Understanding Expectations and Target Metrics:** Documenting the client's expectations and establishing clear, measurable goals (target metrics) for service.
- **Developing the Client Scorecard:** A tool to measure CCMSI's performance and the program's overall effectiveness against predefined metrics.
- **Developing Specific Client Service Instructions (Quality Service Plan [QSP]):** The QSP outlines how services should be delivered, ensuring they align with the client's expectations and industry standards.
- **Developing a Staffing Model:** Implementing a staffing plan that fits the client's needs, including identifying and hiring top talent (sometimes from the incumbent TPA) to work on the account.
- **Training and Assimilating Staff:** Ensuring all CCMSI and client staff are adequately trained and integrated into the new system and processes.
- **Establishing Database Structure and Hierarchy:** Setting up a logical and efficient system to store and manage data for easy access and reporting.
- **Capturing Data and Designing Reports:** Migrating existing data and creating custom reports to enhance information delivery and analysis.

- **Transferring Files:** Migrating and transferring all necessary electronic and physical files with minimal disruption to ongoing operations.
- **Internal Communication:** Conducting introductory meetings, training sessions, and site visits to ensure everyone is on the same page.
- **Excess Carrier Reporting:** Identifying excess carrier reporting requirements and establishing procedures to comply with these requirements.
- **Drafting and Completing the Contract:** Finalizing the agreement, which outlines the terms of the service, expectations, and responsibilities.
- **Loss Account and Funding Procedures:** Establishing procedures for managing losses and funding.
- **Setting Up Medical Cost Containment:** Implementing strategies and practices to control medical costs effectively.

By focusing on these critical areas, we provide a seamless transition, ensuring minimal disruption and enhancing our clients’ claims management experience. Clients who have transitioned to CCMSI see a **21.8% reduction in total incurred** on closed claims and a **44.66% reduction in expenses** twelve months after conversion on average.

Implementation Team

CCMSI has assembled the following Implementation team and requests that the County designate at least one internal implementation manager to coordinate all client resources for a smooth transition.

Implementation Team	
<i>Regional Vice President</i>	Rich Cangiolosi
<i>Texas State Director</i>	Sharada Rogers
<i>National Sales Executive</i>	William Beattie
<i>Implementation Manager</i>	Rachel Vogel
<i>Account Manager</i>	Princess Lott
<i>Director of Product Management</i>	Kristen Meeker
<i>Vice President of Human Resources</i>	Rhonda Stuebe
<i>Vice President of Compliance</i>	Craig Parten
<i>Data Migration Manager</i>	Kathy Elkin
<i>Vice President of Accounting</i>	Tiffany Tarter
<i>Vice President of Managed Care</i>	Sharon Elliott

Client Time Commitment

The following chart highlights the key implementation areas and the estimated time commitment from County staff, excluding any interface feeds.

<i>Client Personnel Required Activity</i>	<i>Required Time (hours)</i>
<i>Complete Client Information Request Form</i>	2
<i>Contract Preparation</i>	2
<i>Implementation Meetings (bi-weekly for four weeks)</i>	6
<i>RMIS Setup: Hierarchy, Reporting, User Access</i>	4

<i>RMIS Training</i>	4
<i>Call Center, Nurse Triage Process, and Script Design</i>	3
<i>Quality Service Plan: Design Meeting and Finalization Steps</i>	4
<i>Banking: Loss Fund Process Design, Setup</i>	2
<i>Internal Communications</i>	3
<i>Other</i>	5
Total	35

Claim Takeover Methodology

The key to a successful claims takeover lies in rapid file handling and seamless data migration. Professional and courteous collaboration with the former TPA is crucial to ensuring a smooth transition.

Rapid Claims Takeover Procedures

We work closely with the former TPA to set clear deadlines, ensuring a clean cutoff. We then provide a plan for delivering all open files to the designated CCMSI location and request reports to identify priority cases, including those with active time loss, to avoid payment delays. Each runoff claim will receive priority status and be thoroughly reviewed by a designated claim representative. We will develop a comprehensive overview of each file, including an action plan addressing the appropriate file strategy and an estimated timeline for closure.

The examiner will evaluate whether the reserves for each claim are appropriate and consult with the County on any necessary adjustments. Additionally, they will document all relevant developments in the file, maintaining a chronological log of updates and actions taken. Through iCE, your personnel will have 24/7 access to the examiner’s overview, action plan, and log notes. If defense counsel is involved, we’ll contact the attorney to discuss the claim’s status and strategy.

Data Migration/Interface

CCMSI utilizes a comprehensive and efficient data migration process that ensures accurate and timely data migration. With extensive experience developing data interfaces with clients, insurance carriers, and cost-containment vendors, we are fully equipped to handle all the County’s data and EDI needs. Our key processes for data migration and EDI development include:

1. Secure information below from the migrating data source:
 - a. type of database (e.g., Microsoft SQL, Oracle, Sybase, FoxPro, FileMaker Pro),
 - b. data formats available (e.g., tab-delimited, space-delimited, fixed-length),
 - c. database definition, including technical documentation with specific information about each field, field length, field type, etc.,
 - d. data definition, including documentation with specific information about each field, what data means, and if control codes are used,
 - e. control code definition, including documentation normally containing a numeric code and description of code,
 - f. custom code definitions, including customized client-defined data fields and codes, and
 - g. projected date for data availability, including extract of all data to date, if possible. *This will provide us with additional time to work on the more complicated details of the data conversion (data mapping to our tables and control code equivalents);*

2. Identify the receipt date final data set will be sent to us for conversion. Data will include control totals for post-conversion reconciliation of financial data;
 3. Effect transfer of raw data. *This can be accomplished via SFTP and/or external drive sent via UPS or FedEx;*
 4. Validate data received (i.e., check for data format, file corruption, number of tables, record length, etc.);
 5. Review documentation (i.e., check for completion, identification of key table and data fields, etc.);
 6. Transfer data to SQL;
 7. Validate transferred data and check for accuracy, including reconciliation to supplied control totals and loss run;
 8. Map data, including extract list of common fields and distinct data, matching to equivalent field in our database, and adding to MAP table;
 9. Control code definition and mapping, including extract list of distinct codes for appropriate fields, matching to equivalent code in our database, and adding to XREF table;
 10. Set up utilizing SQL server to include converting mapped data;
 11. Validate converted data, including reconciliation to supplied control totals and checking for data accuracy. Check for duplicates and repeat the previous step of the process;
 12. Transfer data to SQL server;
 13. Perform final data validation check, ensuring:
 - a. all codes embedded in converted data conform to iCEBAR (our front-end claims management software system) standards,
 - b. all payment files balance to each other by payment type and payment code, and
 - c. all reserve files balance to each other by reserve type and reserve code;
 14. Load conversion data in production iCEBAR database;
 15. Create a reserve database (if not received in source data);
 16. Update ancillary iCEBAR financial files;
 17. Identify and eliminate duplicate claims; and
 18. Resolve unforeseen minor conversion issues as they are identified.
2. Please firm that your RMIS is compatible with Origami (currently the FBC RMIS system).

CCMSI confirms.

3. Please indicate if your system and IT group are able to complete transfer of data between your system and Origami and to set up an ongoing interface to transfer claims file data within a 6-8 week setup and implementation period.

Yes.

4. Please include who will be responsible for each activity.

See above.

U. Cost Reduction Results

1. Please provide your average cost per claim for workers' compensation medical only and lost time

claims, auto liability bodily injury and general liability bodily injury claims.

Average cost of indemnity claims – \$13,362
 Average cost of medical only claims – \$1,030
 Average cost of ALB claims – \$5,266
 Average cost of GLB claims – \$1,366

2. Please provide the average number of days a workers' compensation medical only and lost time, auto liability bodily injury and general liability bodily injury claim is in an open status.

Average days open for indemnity claims – 202
 Average days open for medical only claims – 68
 Average days open for ALB claims – 279
 Average days open for GLB claims – 127

3. Please provide the average number of days your claimants are on temporary total disability.

97 days

4. Please provide details on your temporary transitional assignment (modified duty) process for compensable injured employees on workers compensation.

We evaluate each claim individually to assess return-to-work (RTW) potential. Our claim representatives work closely with clients to return injured workers to employment as quickly as possible, collaborating with treating physicians and managed care professionals (when necessary) to ensure an early or limited RTW, with or without restrictions. We will actively pursue transitional work opportunities in partnership with the County and medical providers, recognizing the significant cost savings and psychological benefits of returning injured workers to employment as early as possible, even in alternate positions.

By supporting alternative duty programs, we help clients control claim costs while maintaining contact with injured employees. These programs reduce lost workdays, minimize Temporary Total Disability (TTD) payments, and provide workers with critical psychological and economic support, helping maintain their standard of living.

CCMSI's expertise extends to navigating labor agreements and union collaboration to implement successful alternative duty programs. Our team works with clients to develop written policies, job descriptions, and options that accommodate common restrictions, such as no mobility, no lifting, or one-handed work. Additionally, we assess physical demands from an ergonomics perspective to ensure that alternative duties are safe and manageable for employees.

Managers, supervisors, and employees must establish and agree to alternative duty program parameters and goals. The program must be acknowledged by any existing employment contracts if employees are represented by collective bargaining agreements. Possible program elements/goals include:

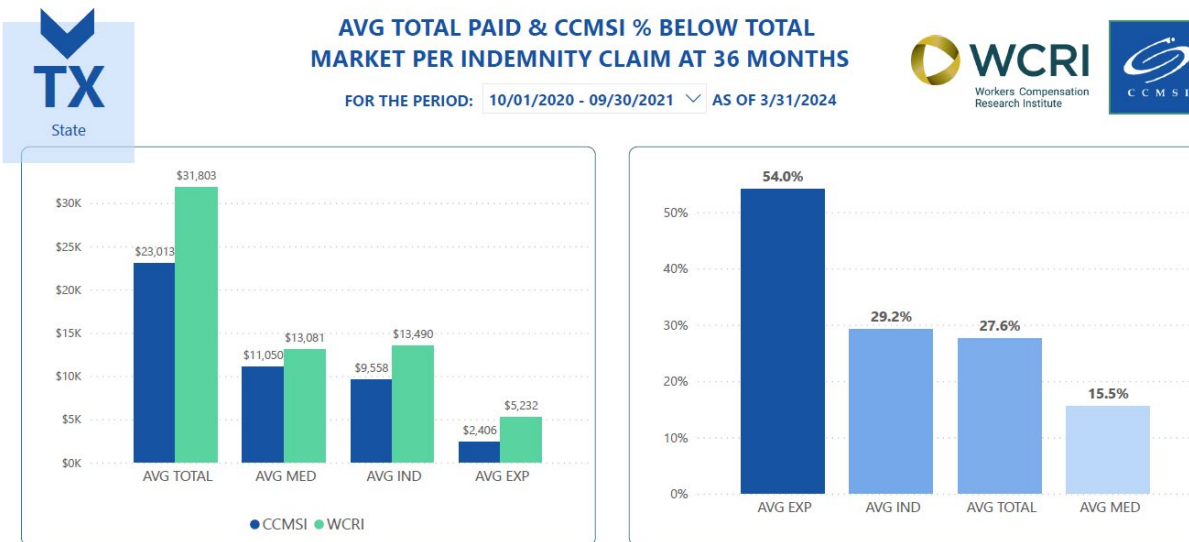
- Establishing a written policy outlining the client's philosophy on alternative duty employment and communicating it to all employees. Involving employees in its development fosters their support

- and engagement.
- Creating approved written job descriptions with titles and physical demands, ensuring clarity and consistency.
 - Identifying job assignments that minimize the risk of aggravating existing conditions. Consider factors like lifting, bending, standing, and repetitive tasks, and be innovative when tailoring assignments to meet specific physician-recommended restrictions. Defined assignments beneficial to a department's operation often generate more management support and will be viewed more favorably by arbitrators.
 - Communicating the program and philosophy to highly utilized medical providers and inviting them to observe your workplace, ensuring they are familiar with regular duty activities and alternative duty roles.
 - A licensed physician must specify physical restrictions. To streamline the process, provide a Work Capacity form to the treating physician with a request for medical release to the employee's regular job or alternative duty. Including a list of potential assignments during the initial visit helps the physician facilitate a timely release. Their comfort level with the employer and potential job assignments is key to securing a swift return-to-work approval.
 - Managers and supervisors should monitor the employee's alternative duty activities, ensuring they remain within the prescribed restrictions.
 - Setting a clear end date for alternative duty employment, with a scheduled medical re-evaluation to avoid indefinite assignments and ensure timely recovery and return to full duties.

Alternative duty assignments don't have to be limited to specific shifts or the most desirable tasks, but they should hold value for the employer and the employee. The key to a successful program is motivating the injured worker and keeping them engaged, which minimizes the duration of physical restrictions and expedites their return to regular duties as soon as medically possible.

5. Please provide additional information that reflects your company's cost reduction outcomes.

The Workers Compensation Research Institute (WCRI) is an independent, not-for-profit research organization providing high-quality, objective information about public policy issues involving workers' compensation systems. The Institute's work helps those interested in improving workers' compensation systems by providing new, objective analyses.



MARKET DATA CAPTURED FROM WCRI COMPScore BENCHMARKS, 25th ED.

17 ➔ ➜

The above data is from 10/01/2020 - 09/30/2021, valued as of 3/31/2024. These claims were evaluated at 36 months maturity. CCMSI received 773 Indemnity claims in TX and closed 749 claims at this evaluation point, which is a 96.9% closure rate. WCRI categorical data has been adjusted for injury, wages, and industry mix.

6. Please confirm that TPA is willing to unbundle Medical Cost Containment and if so, use a FBC preferred MCC Vendor partner (include in your bid your MCC solutions).

CCMSI agrees.

V. Legal, Regulatory and Ethics Actions

1. Provide a summary of any litigation, arbitration and regulatory proceedings, pending, adjudicated or settled that your firm has been subject to within the last three years involving services your firm provided as a third party claims administrator.

Within the last three years, CCMSI has resolved eighteen litigated claims under its applicable professional liability policies or regulatory proceedings nationwide. CCMSI is presently defending three litigated claims under its applicable professional liability policies nationwide.

2. Please describe each regulatory proceeding in detail and any litigation or arbitration proceeding resulting in judgments, settlements or damage claims.

All litigated claims under its applicable professional liability policies were dismissed with prejudice and without any admission of liability. CCMSI is prepared to defend the active claims in earnest and consider settlement for a percentage of prospective defense costs when applicable. All contested regulatory proceedings were resolved without any admission of wrongdoing if not voluntarily withdrawn.

W. Licenses

1. Provide evidence that the third party administrator and persons performing the work for the County maintain all Texas licenses in order to provide the service insurance sought pursuant to this RFP/Q relating to third party administration.

[See Exhibit 7 for our Texas licenses.](#)

X. OTHER

1. What are your standard procedures with regard to the termination of an account? Describe your procedures for moving both physical files and electronic data. Specifically address your position on transfer of adjuster notes in the electronic information. Provide details on fees associated with transfer of both paper and electronic files. Include information on pricing and terms for claims handling after termination. Finally, include your policy on access to electronic system upon termination of account – including pricing.

[Please refer to Exhibit 8 – Standard Service Agreement.](#) Our standard contract details termination options.

2. Discuss your procedures for participation in workers' compensation hearings. Please define roles and responsibilities of in-house resources versus outside representatives – including legal counsel. What is the experience level of hearing representatives?

[Our claims teams partner with defense counsel, ensuring legal strategies are researched and properly executed throughout the dispute resolution process. CCMSI adjusters are trained and prepared to present at hearings if necessary; however, defense counsel is the preferred representative. In collaboration, we maintain a consistent and solid defense from dispute initiation to resolution.](#)

[Adjusters maintain direct involvement in their litigated cases and have a complete understanding of the applicable laws. They communicate their expert case knowledge to defense counsel and work together as a cohesive unit. This seamless collaboration allows for the best possible outcome and ultimately increases our chances of prevailing at the hearing.](#)

[CCMSI adjusters hold defense counsel accountable for having accurate case facts and the appropriate defense strategies in place in accordance with the law. Our claims teams lead with confidence while building a strong hedge around the case with defense counsel, which significantly increases our ability to have a fair trial, protects all parties involved, and reduces our client's exposure to pay only what is reasonably owed.](#)

3. Please describe in detail the various banking options for bill payment that are available to Client. Be sure to include information on any paid loss deposit or claim service fee fund requirements, large loss funding thresholds and wire transfer payment options. Include information on the process of actually producing checks including information on checkstock, options or procedure relating to creating, maintenance, and funding of the necessary bank accounts and other related items. Describe the process

of managing and reconciling these accounts.

[Please refer to Exhibit 5 – Banking Options.](#)

4. Please provide a sample contract.

[Please refer to Exhibit 8 – Standard Service Agreement.](#)

Print Name and Title of person completing this form: [Sharada Rogers, TX State Director](#)

Name of Agency/Company: [CCMSI](#)

Signature: *Sharada Rogers*

Qualification/Experience/References

Since 1978, **Cannon Cochran Management Services, Inc. (CCMSI)** has set the gold standard as the leading boutique third-party administrator for property and casualty programs. Specializing in workers' compensation, liability, and property claims management, we attract top industry talent and prioritize meeting each client's needs, goals, and expectations with innovative solutions, advanced technology, and tailored approaches to claim services, loss control, managed care, internet claims analysis, and reporting services.

As a privately held, **100% employee-owned company**, CCMSI is accountable to our clients, not insurance carriers, brokers, or private equity funds, empowering our team to make client-centric decisions and focus on long-term client value creation versus short-term financial performance. Our commitment to transparency, exceptional client satisfaction, and delivering superior results with integrity has earned us the trust and respect of clients and partners nationwide.

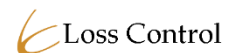
At CCMSI, we don't believe in a one-size-fits-all approach and recognize that each client has unique needs. Through close collaboration with our clients, we deliver customized, strategic solutions that exceed expectations while maximizing cost savings. With a **98% client retention rate**, our client-focused approach has established us as the industry's quality standard, proudly partnering with self-insured groups and employers across diverse sectors, including government, retail, healthcare, manufacturing, gaming, construction, transportation, and higher education.

For the eighth consecutive year, CCMSI has earned certification as a Great Place to Work®—a testament to our commitment to fostering a positive and supportive work environment. This culture is vital to our success and growth, helping us attract and retain top talent and maintain the lowest industry turnover. By investing in our greatest asset—our people—we ensure continuity and deliver exceptional, consistent service to our clients. Without our dedicated staff, we could not successfully *deliver what matters most* to our clients. See the results here: <https://www.greatplacetowork.com/certified-company/7010279>.



CCMSI provides a wide range of risk management services, offering comprehensive coverage and administrative efficiencies. Services include:

- Client-specific third-party claims administration
- Self-insured group administration: Accounting, underwriting, marketing, and excess placement
- Loss control: Industry-specific loss control programs
- iCE: Web-based claims analysis and reporting tool
- Comp MC: Private label managed care program
- FIRE: Special Investigation Unit program
- CLEAR: Legal bill review program



CCMSI generates an annual revenue of \$225 million and employs over 1,600 people across thirty-two offices. We provide services to more than five hundred individual employers, ten-plus captives, forty-plus primary insurance companies, and fifty-plus self-insurance groups.



Public Entity Experience

Serving over five thousand public entities nationwide, CCMSI excels in delivering claims management solutions to self-insured and governmental entities. With over 95% of our clients in this sector, we understand their unique and complex risk management needs. Our TPA model ensures precise, efficient management with a focus on aggressive claims handling, clear communication, and tailored processes, addressing the high stakes of budgeting, litigation, subrogation, public scrutiny, and direct claim payments.

From law enforcement and firefighting to judges, healthcare workers, volunteers, and clerical staff, CCMSI understands the complex risks public entities face. Each role, from heavy physical trades to administrative functions, demands a varied approach to claims handling and return-to-work strategies.

We specialize in navigating the unique needs of unionized employees, coordinating with cities and counties to ensure benefit payments align with contract requirements. Our experienced adjusters foster open communication with all parties, delivering effective and efficient claim resolutions.

A sample of our county clients includes:

Client Primary Name	Client Since Date	Client Profile State
Arapahoe County	7/1/2017	Colorado
Bexar County Mgmt. & Finance	8/1/2019	Texas
City And County Of Denver	1/1/1990	Colorado
Cook County	12/13/2010	Illinois
County Of Kane	12/1/2011	Illinois
County Of Racine	1/1/2010	Wisconsin
Dona Ana County New Mexico	7/1/2024	New Mexico
Douglas County	6/15/2006	Kansas

El Paso County	1/1/2009	Colorado
Grundy County Insurance Trust	1/1/1988	Illinois
Jackson County Oregon	7/1/2010	Oregon
Lafayette City-Parish Consolidated Government	9/1/2015	Louisiana
Lasalle County Insurance Trust	11/16/2004	Illinois
Marion County	7/1/2008	Oregon
MCMRMA	7/1/2008	Illinois
Missouri Association Of Counties Workers Compensation	8/1/2017	Missouri
Nye County / Town Of Pahrump	7/1/2021	Nevada
Orange County	12/12/2017	Florida
Parish Government Risk Management Agency	1/1/1997	Louisiana
Parish Of Jefferson	5/1/2019	Louisiana
Pitkin County	1/1/1998	Colorado
Roane County	10/1/2006	Tennessee
Rutherford County Government & Board Of Education	7/1/2023	Tennessee
St. Bernard Parish Government	2/1/2022	Louisiana
St. Charles Parish	5/1/2024	Louisiana
St. Martin Parish Government	9/15/2006	Louisiana
St. Mary Parish Government	12/29/2006	Louisiana
St. Tammany Parish Government	8/1/2013	Louisiana
Vermilion County	12/1/1994	Illinois
Washoe County	7/1/2007	Nevada

References:

University of Texas System

210 W. 7th Street | Austin, TX 78701

Contact: JoAnn Anderson

Phone: 512-499-4645

joanderson@utsystem.edu

Services provided: Workers' compensation claims management services

Bexar County

101 W. Nueva St., Suite 901 | San Antonio, TX 78205

Contact: Veronica Guevara

Phone: 210-335-2559

veronica.guevara@bexar.org

Services provided: Workers' compensation and liability claims management services

Houston Independent School District (HISD)

4400 West 18th Street | Houston, TX 77092

Contact: Donna Fernandez

Phone: 713-556-6676

donna.fernandez@houstonisd.org

Services provided: Workers' compensation claims management services

Client-Focused Service

CCMSI prioritizes client-focused service, crafting tailored solutions that deliver significant cost savings by gaining insight into each client's objectives and challenges.

Appreciate Unique Needs: We understand that every client has distinct needs. By aligning with their business goals and key performance indicators, we deliver exceptional services that exceed expectations. Our claims services not only support our clients' safety culture but also provide critical insights to help leadership make informed decisions.

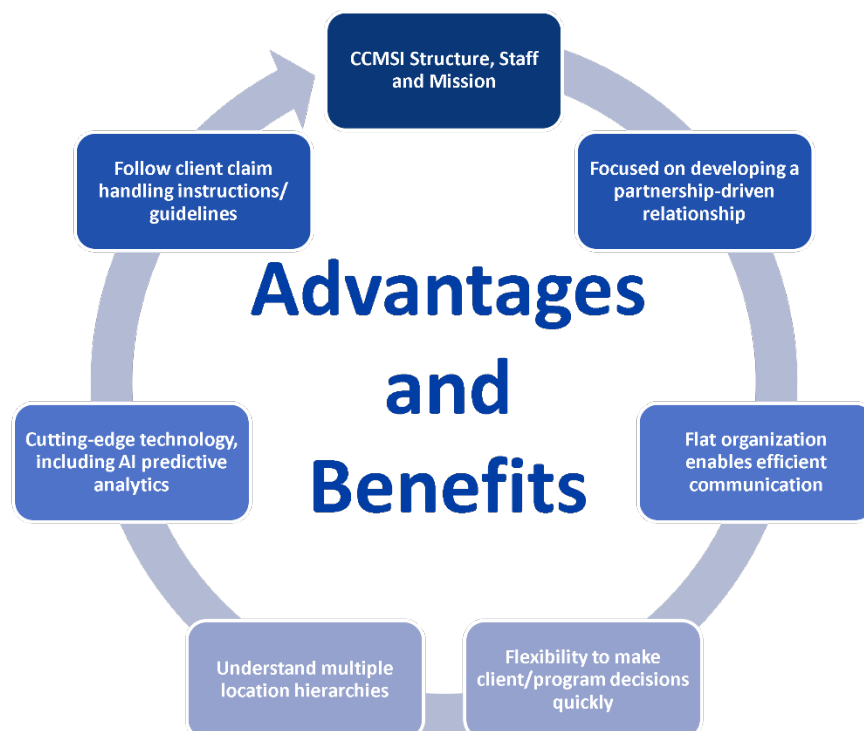
Quality Service Plan: CCMSI designs each client's program to meet their exact specifications by creating custom, detailed handling instructions and working closely with them to ensure continuous and consistent compliance.

Stewardship: We hold annual stewardship meetings with our clients to comprehensively review the past year's performance, focusing on service quality, claim causes, and loss cost trends. Together, we develop and implement strategies to enhance program performance for the year ahead.

What Sets CCMSI Apart

The County deserves a claims management partner who not only understands the complexities of risk management but also delivers proactive, data-driven solutions aligned with its goals. With an unmatched reputation, proprietary advanced technology, and an unwavering commitment to client satisfaction, CCMSI is the authority in custom, innovative claims management.

We outpace the competition through several key advantages and benefits, including claims handling, customer service, and cutting-edge technology solutions.



Tailored Approach: CCMSI offers a customizable claims management experience, tailor-made to the County’s individual needs and objectives. Our personalized service ensures we fully understand your priorities and deliver strategic, effective solutions.

High-Quality Adjusters and Low Caseloads: CCMSI hires only the highest-caliber adjusters and ensures they manage smaller caseloads than our competitors. With more time to dedicate to each claim, we can drive better outcomes, reduce loss costs, and provide more attentive care to your injured parties.

Superior Resources and Workflow Technology: Adjusters at CCMSI are supported by superior workflow technology and resources, including claim assistants. Instead of being bogged down by paperwork, adjusters can concentrate on proactive claims management and delivering value to the County.

Employee-Owned Company: As a 100% employee-owned organization, CCMSI operates with broader autonomy than companies controlled by insurance carriers, brokers, or private equity funds. Our independence enables us to make decisions and form partnerships that serve our clients’ best interests, rather than those of external stakeholders. It also fosters a culture of ownership among employees, attracting the best industry talent and enhancing their commitment to excellence and client satisfaction.

Recruiting and Retaining Elite Professionals: CCMSI’s unique employee-owned culture attracts top talent, ensuring the County works with highly dedicated professionals committed to delivering customizable services and driving measurable cost savings.

Systems and Technology: While competitors may offer similar capabilities, CCMSI stands apart with more extensive customization, proactive insights, and client-focused tools. Below, we highlight the key differentiators of our RMIS iCE system, Vendor Portal, and advanced analytics and AI solutions.

- **iCE**
 - **Fully customizable dashboards and reports:** Tailored to our clients, ensuring data is actionable and relevant.
 - **Proactive alerts:** Automated notifications for claim milestones and deadlines, minimizing missed opportunities or delays.
 - **Seamless integration expertise:** Proven track record of integrating with diverse systems, like Origami Risk, to maintain operational continuity.
- **Vendor Portal**
 - **Enhanced transparency:** Offers clients complete visibility into vendor activities and associated costs, promoting accountability.
 - **Centralized, integrated platform:** Delivers actionable insights, streamlines workflows, and offers recommendations like pharmacy reviews to ensure efficient and proactive claims management.
- **AI Integration**
 - **Risk classification and reserve analysis:** Accurately categorizes claims by risk level (high, medium, low) and benchmarks reserves against similar cases for precise financial planning.
 - **Treatment planning:** Predicts potential treatments, including surgeries, physical therapy, diagnostics, and opioid management, helping to optimize care pathways and reduce costs.

By partnering with CCMSI, the County gains more than a TPA—it gains a designated team that understands its industry, prioritizes its objectives, and delivers bespoke solutions to drive its business forward.

CLEAR Legal Bill Review

CCMSI is proud to partner with Bill ReviewIQ, the industry’s leading legal spend management service since 1989, to offer a versatile litigation expense management solution—Comprehensive Legal Expense Analysis & Review (CLEAR). Since CLEAR’s launch in 2020, CCMSI clients have



benefited from our innovative legal bill review program with best-in-class technology, line-by-line reviews, and litigation billing guideline compliance, merging to deliver a measurable return on investment.

Features

- **Automated legal cost submission and tracking:** Streamlines the process and reduces administrative burdens and the risk of manual errors.
- **Centralized invoice management:** Ensures consistency and quicker processing times.
- **Expert review:** Bill ReviewIQ’s U.S.-based audit attorneys, who are experts dedicated solely to legal bill review, meticulously review each invoice.
- **In-depth reporting:** Clients can access detailed legal spend reports, including firm performance metrics.
- **Benchmarking insights:** Clients can compare their program’s performance with similar programs across CCMSI’s client base, providing valuable insight into how their results measure up.

Benefits

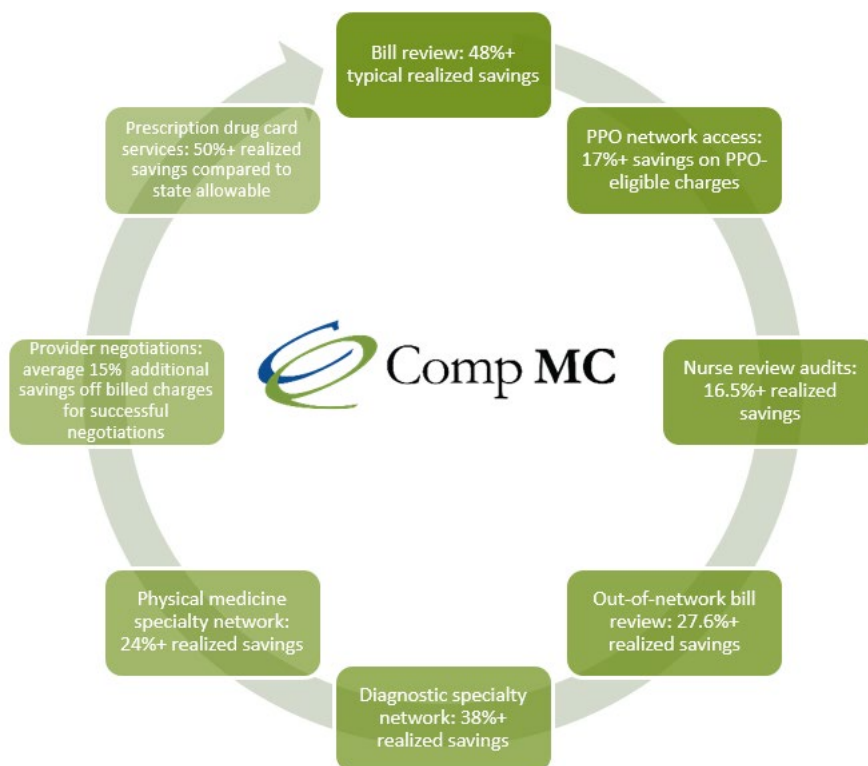
- **Electronic invoice submission and data collection:** Saves time, simplifies processes, and increases accuracy.
- **Data-driven decisions:** Leverages data to optimize legal strategies, strengthen our panel counsel, and select the best firms for our clients.

- **Cost control and savings:** Reduces costs through effective bill review and billing guideline compliance.
- **Comprehensive analytics:** Detailed reporting, including spend by firm and compliance tracking, enables clients to make informed decisions and fortify their legal programs.
- **Claim professionals:** With efficient legal spend management, claim professionals can focus on what matters most—rapid claim settlement.

Comp MC Managed Care

Comp MC defines the standard with a proven, straightforward approach. Our success stems from a sharp focus on and outstanding execution of several critical areas, ensuring superior outcomes that speak for themselves.

- Robust, customized bill review services with our rules engine Pathways™
- PPO mosaic approach
- Out-of-network review services, ensuring maximum savings
- Complete integration with our claims system for review and reporting
- Duplicate bill detection
- Ad hoc and custom reports available 24/7



Comp MC maximizes savings throughout the entire claims lifecycle—from the initial report to the final payment. We start with bill review reductions to align costs with the appropriate fee schedule or usual and customary (U&C) charges. Next, we apply our custom PPO mosaic strategy, followed by out-of-network specialty reviews, negotiations, nurse audits, and retrospective specialty networks. Our flexible,

transparent total managed care solution consistently improves bill outcomes and delivers measurable savings for clients.

RMIS Technology

Internet Claims Edge (iCE), CCMSI's innovative Risk Management Information System, is designed to be flexible, user-friendly, and accessible. Fully customizable to meet client needs, iCE allows real-time, 24/7 access to claims via a web-based, mobile-friendly platform. Through user-defined filters, including claim type and date of loss, clients can view their claims, complete with adjuster notes and bill images, in as much or as little detail as they wish.

- **Initial reporting:** Create initial report forms online in iCE or submit claims via web service or custom interfaces. Benefit from industry-specific custom reporting, such as accident reports for transportation clients.
- **Executive Summary dashboard:** Customize a high-level risk management analysis overview for quick insights.
- **Claims Analysis:** A flexible tool that lets clients explore claims in-depth or at a high level.
- **MyReports:** CCMSI's robust reporting engine delivers countless customizable data combinations. Export to PDF or Excel, schedule automatic email reports, or post to iCE.
- **Comp MC:** Through MyReports, run managed care reports for CCMSI's Comp MC program, such as PPO penetration and location-specific savings.
- **OSHA reporting:** Simplify OSHA compliance by auto-generating 300 (Log), 300-A (Summary), and 301 (Incident Report) forms using claims data from the Initial Report. Print at any time for any location.
- **Claim Risk Assessment:** Predictive modeling that identifies potential high-risk claims, enabling early intervention for better outcomes.
- **iCE mobile app:** Access and report claims data anytime, anywhere on Android and Apple devices.
- **ClaimView:** A mobile-friendly claimant portal for injured workers to view lost-time payments, upload documents, and communicate with their adjuster.
- **Stewardship and benchmarking:** Leveraging historical trends and industry benchmarks (such as WCRI and IDS), we regularly analyze and evaluate our performance to drive successful claims management programs.
- **Automated outbound text and email:** A customizable feature offering workers' compensation claimants a personalized welcome message, key claim details, resources, and their claim representative's contact info. Opt-in claimants receive real-time notifications on indemnity payments, including amounts, issue dates, and service dates.

Reporting Features

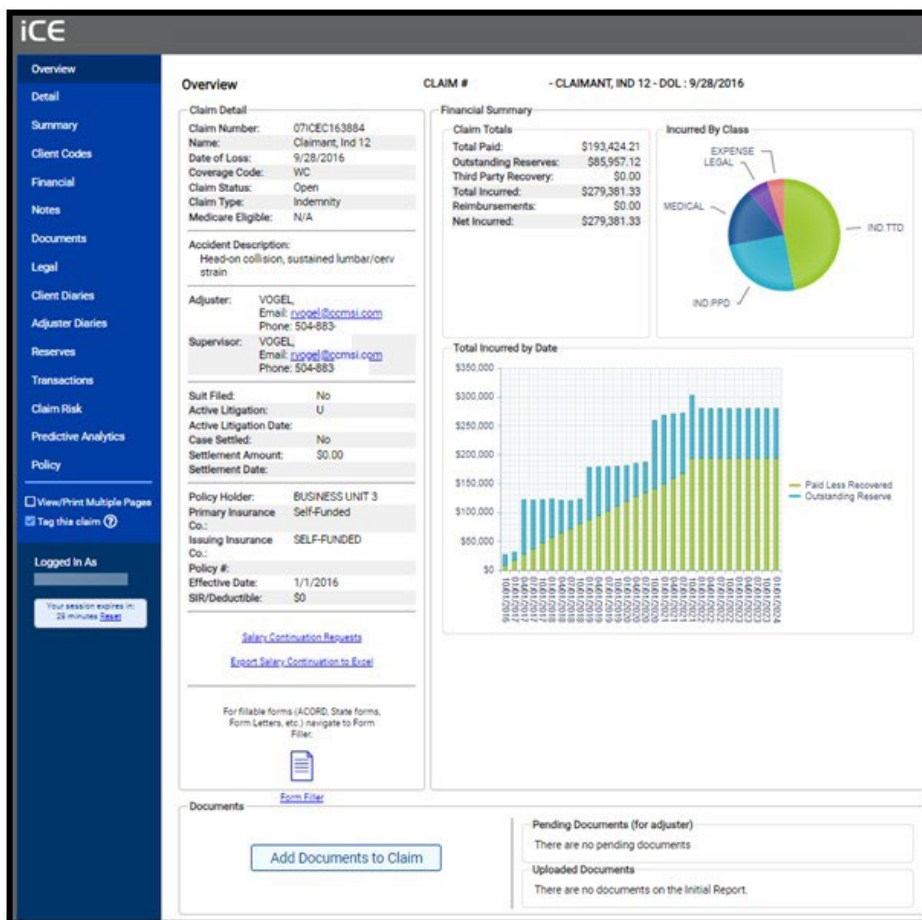
- **Report access:** Instant online access to standard monthly reports for the past twenty-four months.
- **Executive portal:** A personalized portal displaying key data at login for quick insights.
- **Customizable dashboard:** Tailored to fit each client's needs.
- **Ad hoc reporting:** Create custom reports covering financial, claims detail, and loss control data.
- **Multi-level reporting:** View summary and detailed claim reporting with drill-down capabilities for deeper analyses.
- **Analytical tools:** Compare historical and current data with various graphical presentations.
- **Cost-containment reporting:** Track savings and fees with comprehensive cost-containment reports.

Additional features

- **Data integration:** Seamlessly receive data from multiple sources for comprehensive insights.
- **Security:** Password protection with customizable security access levels for enhanced protection.
- **Hierarchical tracking:** Track data across twenty-five levels, including by state, department, and more.
- **Custom user fields:** Modify the system to meet specific needs by creating personalized user fields.
- **Adjuster notes:** Easily view adjuster notes by category (summary, medical, litigation, reserves, etc.).
- **State-specific reports:** Generate state-specific First Reports of Injury and other forms in PDF.
- **Document upload:** Clients can upload documents directly to the claim file or adjuster.
- **Medical bills and reports:** Access medical bills and reports online.
- **Predictive analytics:** Utilize AI-driven insights to predict risk drivers, future treatments, and financial forecasts.

Access and Reporting Overview

We can assign varying levels of access to our clients' designated employees, allowing them to review every aspect of the claim file based on a selected group (e.g., department or division), time frame, or the entire organization. Client-specific reports, including loss, financial, and summary reports; monthly check registers; and monthly vendor payments, are posted to the iCE Report tab and maintained in PDF format for a rolling twelve-month period.

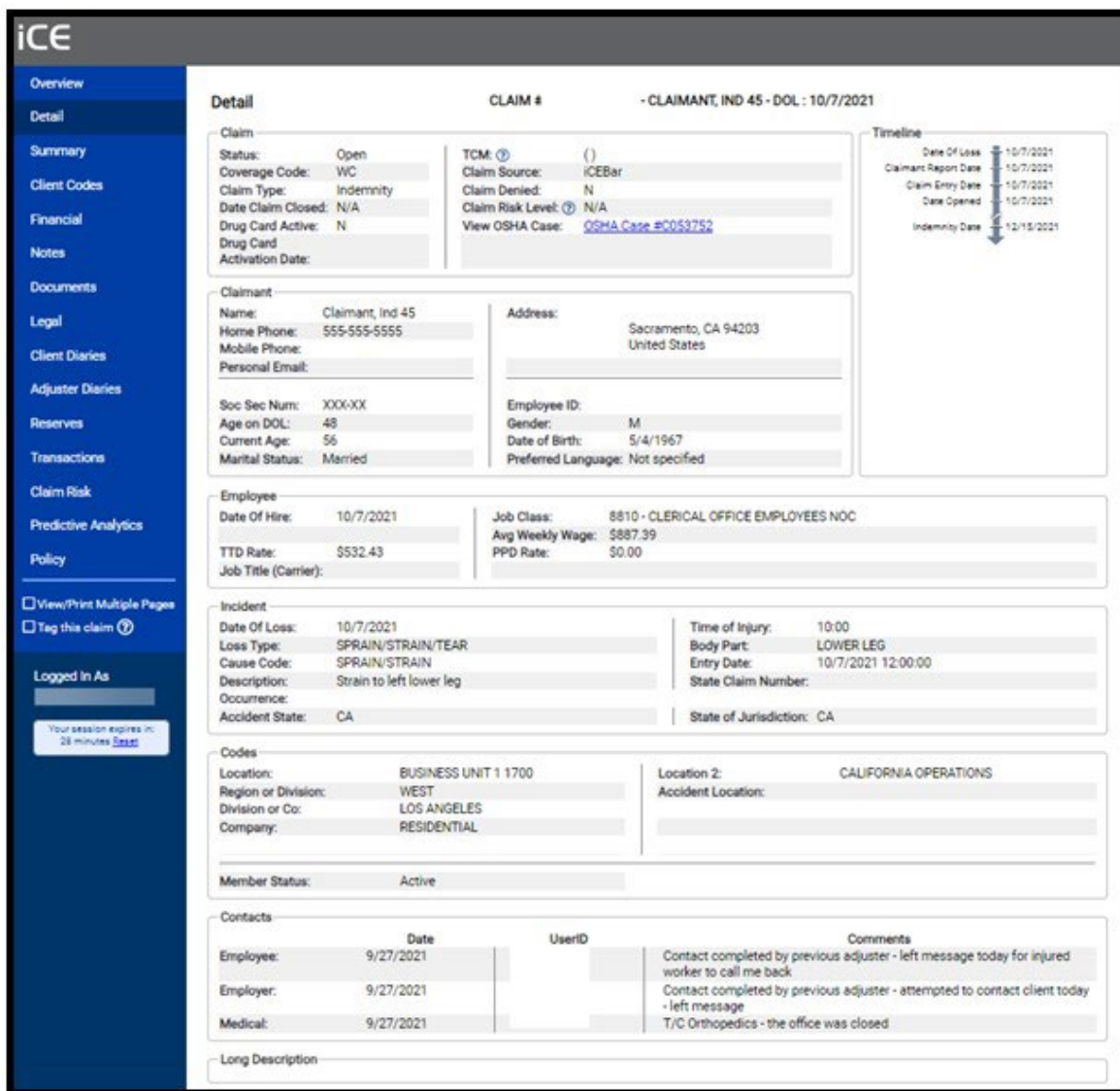


The screenshot displays the iCE software interface for a specific claim. The interface is divided into several sections:

- Overview:** Shows claim details such as Claim Number (07ICEC163884), Name (Claimant, Ind 12), Date of Loss (9/28/2016), Coverage Code (WC), Claim Status (Open), Claim Type (Indemnity), and Medicare Eligible (N/A). It also includes the Adjuster (VOGEL) and Supervisor information.
- Financial Summary:** A table showing Claim Totals: Total Paid (\$193,424.21), Outstanding Reserves (\$85,957.12), Third Party Recovery (\$0.00), Total Incurred (\$279,381.33), Reimbursements (\$0.00), and Net Incurred (\$279,381.33).
- Incurred By Class:** A pie chart showing the distribution of incurred costs across classes: EXPENSE, LEGAL, MEDICAL, and IND.TTD.
- Total Incurred by Date:** A bar chart showing the cumulative total incurred over time, with a legend for Paid Less Recovered (green) and Outstanding Reserve (blue).
- Documents:** A section for uploading documents, including a button for "Add Documents to Claim" and a note about pending documents.

Financial transaction screens provide a comprehensive list of all payments made on a claim, including detailed information and links to scanned images of medical bills and reports with added commentary. Additionally, our system offers as-of-date financial data with a simple calendar selector, enabling users to view information from a previous date for complete transparency and control.

The following screenshot displays claim file categories and a navigational sidebar containing other vital data for client review.



CCMSI clients can easily filter claim information by various data fields, such as date of loss, claimant name or Social Security Number, claims denied, and total incurred over a specific dollar amount. Once they locate the desired claim, clients can view and download details, including claim status (i.e., open, closed, pending), a detailed claim summary, employment information (e.g., average weekly wage and PPD rate), and all adjuster notes, such as action plans, settlement evaluations, and medical treatment summaries.

Clients also have quick access to financial transactions and analyses, including payment details, medical invoices, and charts, offering a clear, visual breakdown of claim reserves and reserve development.

CCMSI Claim Risk Assessment (CRA) and Gradient AI Daily Claim Scorecard

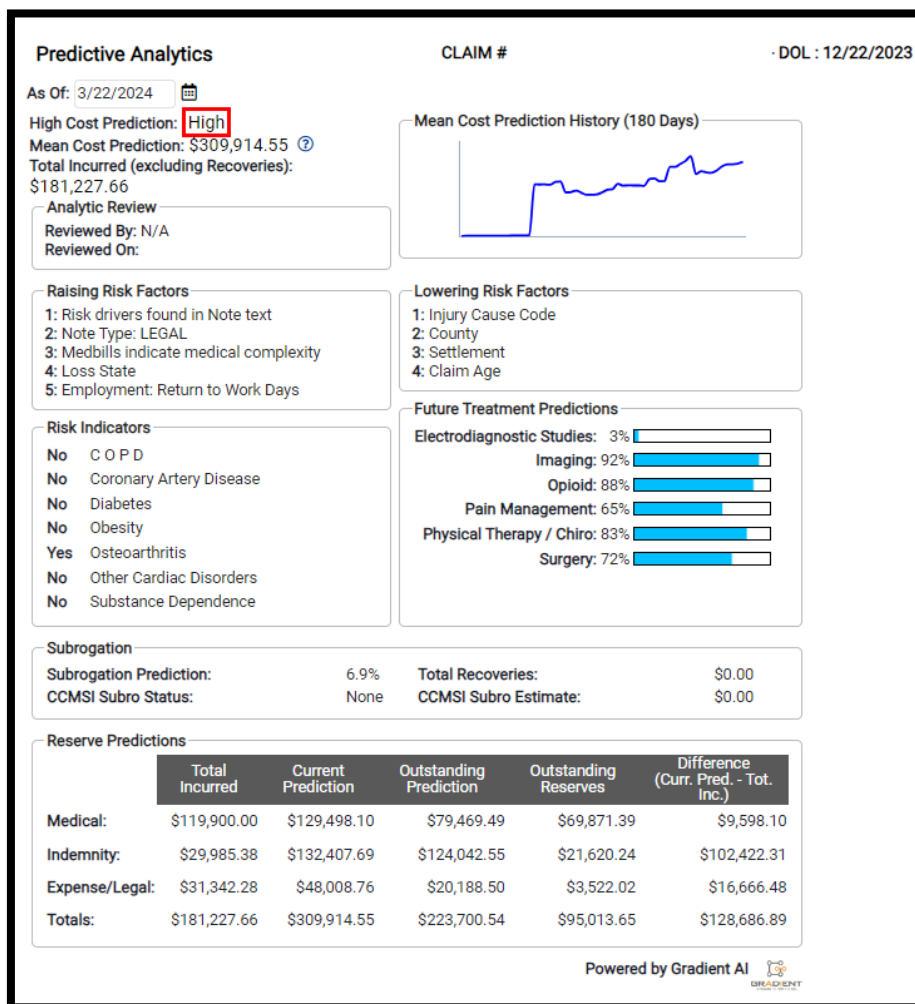
Understanding that early identification and intervention in potential high-risk claims can lead to significant cost savings, CCMSI has utilized our customized Claim Risk Assessment (CRA) adjuster tool to classify indemnity claims as potential high, moderate, or low risk since 2015. This scoring system analyzes seventy-five data fields, such as comorbidities, proximity to medical care, and the claimant’s likelihood of returning to work, helping to identify potential issues before they escalate. (A complete list of data fields is available upon request.)

Since partnering with Gradient AI in the First Quarter of 2019, CCMSI has leveraged AI to score all indemnity and medical-only claims nightly. Using over forty million workers’ compensation claims and additional third-party data, Gradient AI performs daily analyses to identify key claim drivers and costs early on, significantly improving our ability to manage claims effectively and proactively.

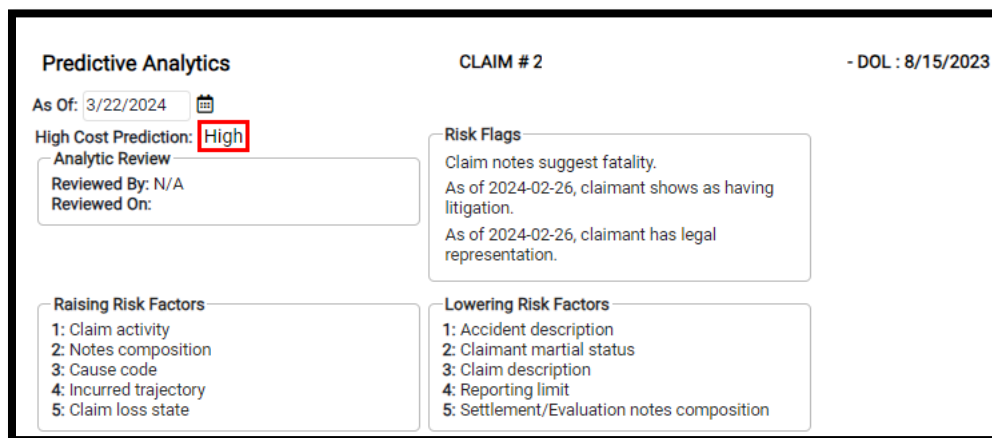
Each evening, CCMSI transmits all claims data fields in our system to Gradient AI, including transactions, adjuster notes, medical bills, prescriptions, and Claim Risk Assessment fields. Gradient then scores the claims and provides CCMSI with the following information:

- Risk classification of High, Medium, or Low of a claim being high cost
- Total incurred predication through generative artificial intelligence (GAI) models versus the current CCMSI adjuster incurred value
- Treatment predictions (e.g., surgery, PT, imaging, opioids, electrodiagnostics, pain management)
- List of all comorbidities
- List of factors impacting the claim cost (e.g., legal, return to work, future medical)

The screenshot to the right shows how the adjuster iCEBAR system and client iCE portal display these analytics.



The iCE client portal presents liability analytics in a format similar to our workers' compensation model. The screenshot below previews the available data guidance presented to adjusters.

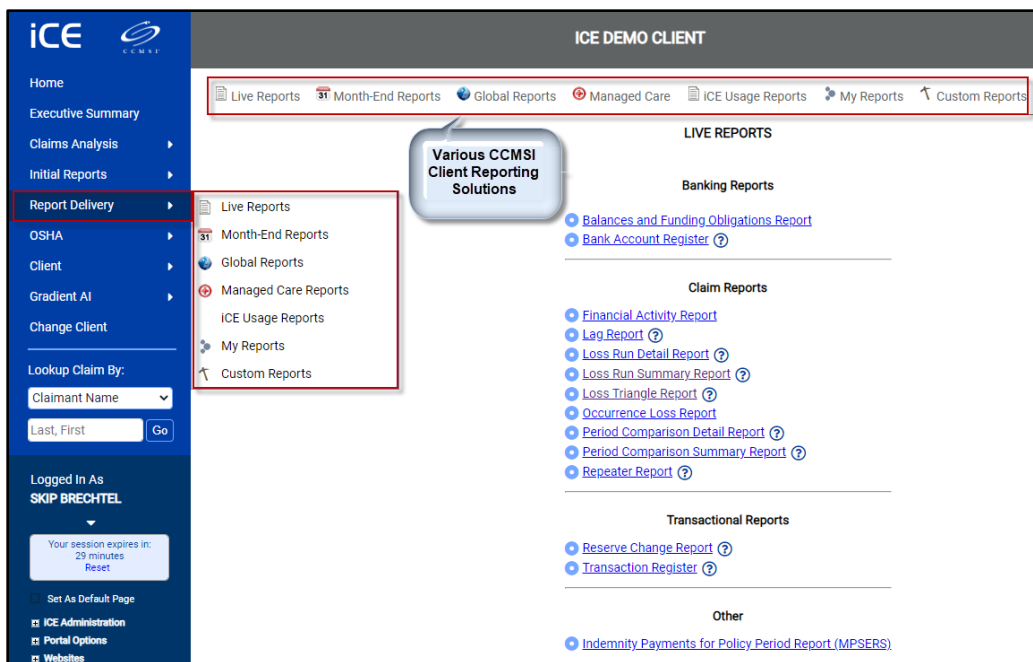


CCMSI adjusters, supervisors, and account managers use this tool to support claim evaluations and facilitate discussions with our clients.

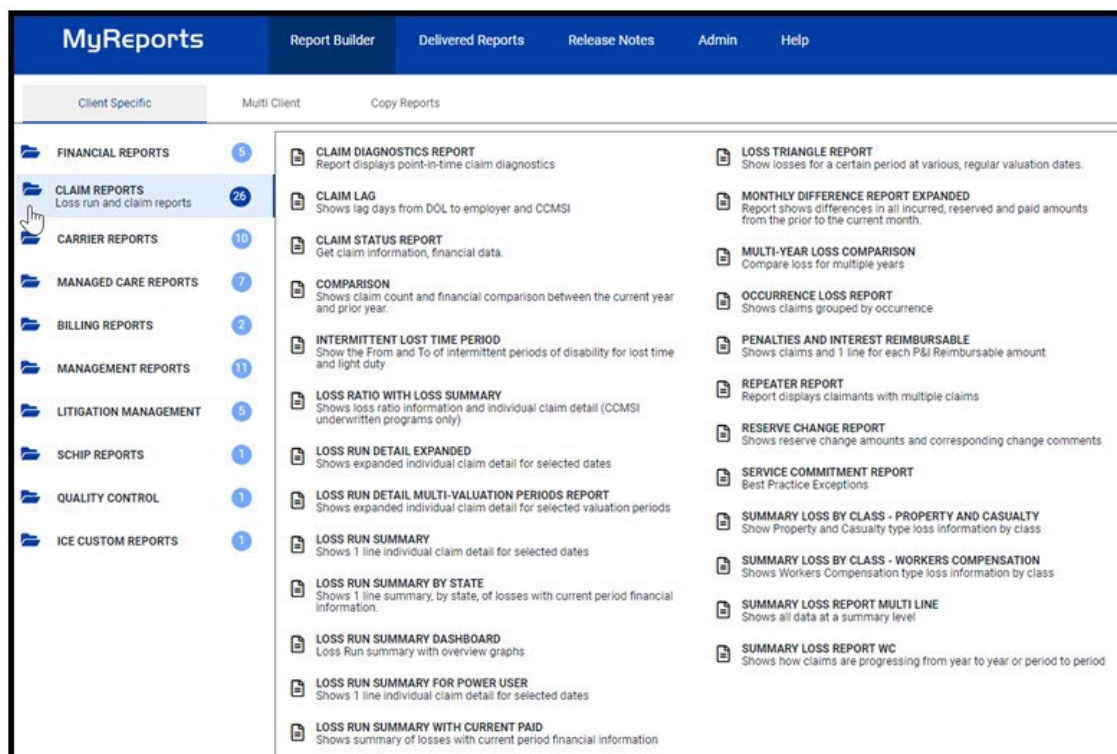
Reports

iCE delivers timely, accurate, and comprehensive data. Users can easily access standard and custom online reports, offering the flexibility to view claims and loss control data at a high level or in greater detail.

- **Standard reports:** CCMSI has developed a catalog of over four hundred reports based on specific client requirements, including detailed claim information, summary (at various reporting levels), check and payment registers, and loss ratio (by desired operating levels). These static reports are posted online within five business days and are available 24/7 within iCE.
- **Ad hoc reporting:** Clients can generate diverse ad hoc reports with the ability to sort and categorize by various fields and data. Analytics, including charts and graphs, are available for deeper insights and easy data visualization.
- **Special customized reports:** If our standard and ad hoc reporting options don't fully meet our client's needs, we offer custom report design and development to fit exact specifications. While we typically bill custom reports at a standard hourly rate, we will likely provide most minimal requests at no additional charge.
- **Live reports:** This feature provides our thirteen most commonly used reports, including detail and summary loss runs, comparative periods, loss triangles, and reserve change reports. Users can generate these reports with user-selected periods and as-of dates.



- **MyReports:** Clients can build a customized loss run using over three hundred data fields, which can be scheduled to run automatically and delivered via email in PDF or Excel or posted directly to iCE. Our customer service team is available to assist with creating and tailoring these reports.



Talent Acquisition and Culture

CCMSI’s Core Values and Principles are the cornerstones that drive our business, ensuring exceptional results for our clients through innovative solutions, cutting-edge technology, and comprehensive expertise. At CCMSI, our focus is on *delivering what matters most* to our clients.



A positive work environment is foundational to our success, while our distinctive culture attracts and retains top-tier talent, resulting in one of the lowest turnover rates in the industry. This continuity empowers us to deliver the consistent, high-quality service our clients have come to rely on.

We utilize a variety of strategies to source talent, build bench strength, and retain our workforce. At CCMSI, staffing a new account begins well before securing a contract. We proactively recruit, develop, onboard, continually train, and ultimately retain valued team members to serve our clients’ needs.



We accomplish this through:

- **CCMSI LevelUP Career Pathways Program:** Established to develop and train associates for adjuster roles.
- **Ongoing Corporate Training:** Ensures staff are current with the latest skills and knowledge.
- **Sourcing and Recruiting:** Utilizing platforms like Indeed and LinkedIn, maintaining a presence at job fairs and trade shows, and employing proactive recruitment measures.

The Cornerstones of CCMSI's Culture

Team member ownership: As a 100% employee-owned company, every CCMSI team member is personally invested in delivering exceptional service, appreciating that client satisfaction drives our success.

Manageable caseloads and claims support: One way we attract elite adjusters is by offering robust administrative support and manageable caseloads (on average: 125 indemnity/225 medical-only files for workers' compensation and 125 liability files for liability), enabling adjusters to focus on claimant recovery and claim resolution—ultimately reducing our clients' cost of risk.

Flexibility: CCMSI offers its employees flexible work schedules and work-from-home opportunities, supporting overall balance and growth as professionals and individuals.

Our unique culture creates an environment where top talent thrives and where delivering exceptional client service is our standard.

ATTACHMENT 2: PRICING

Please fill in a rate or dollar amount and check mark where applicable in the appropriate column. Please fill in your estimate of claims. Only fill in areas that apply to your proposal. Should you need to explain a fee/charge that was not addressed, use the bottom of the page, and you may go into greater detail in your individual proposal. Please attach this page to the section of your proposal including pricing.

Full Legal Name of Firm/Entity: Cannon Cochran Management Services, Inc. (CCMSI)

Name of Person(s) Completing this form: Sharada Rogers, TX State Director

	Incurred 2024	Incurred 2025 as of 7/1/2025	Open claims as of 7/1/2025
Workers Compensation	350	175	150
Medical only	100	120	80
Indemnity	40	50	70
AL/GL	359	185	150
Property Damage Non litigated	139	77	20
Bodily Injury Non litigated	11	3	10
Bodily Injury Litigated	0	0	7
Law Enforcement Liability Litigated (Civil Rights)	6	1	11
Employment Practices Liability Litigated	5	1	10
Subrogation for Property Damage	7	2	6
Subrogation for Workers' Compensation	15	10	
Subrogation for GL/AL	61	29	50

All lines of Coverage Flat Fee	See guaranteed annual flat fee below.		
Attending TDI Hearings Other	N/A		
Data Conversion	\$15,000		
On-Line Computer Services (Incident Reporting)	\$25 per claim No fee if entered in iCE by FBC.		
RMIS System and Services – Annual Administration Fee (Interfaces and other fees)	\$50,000 Includes RMIS access for up to 5 users; \$200 per additional user		
Run-Off Costs	N/A		
Run IN costs <i>¹Pricing is for 12 months – claims open longer are \$55 per month until closure or capped at new per-claim rate</i>	¹ \$700 Indemnity ¹ \$550 BI/EL/LEL ¹ \$325 PD		
Field Services/Investigation	Market Rates		
Designated Doctor review	\$300 per review + physician fee		
RME Coordination	\$300 per review + physician fee		

**INSURANCE COMPANY ADMINISTRATION, THIRD PARTY ADMINISTRATION
AND COST CONTAINMENT ADMINISTRATION**

	Flat Fee	Fee per Review	Fee per Hour	Fee per Bill	T/E mileage				
Hospital Bill Audit				\$10					
Physician Peer-Review	\$750								
Chiropractic Peer-Review	\$750								
Pre-Authorization		\$105 (Nurse) \$250 (Physician)							
Utilization Review		\$105 (Nurse) \$250 (Physician)							
Medical/Rx Bill Audits				\$10					
Use of PPO Networks				33%					
Rehabilitation Services	N/A								
Vocational Case Management			\$100						
Impairment Rating review	\$425								
	Other Charges/Fees Explanation: Account Setup - \$7,500 (one-time fee)								
	Other Charges/Fees Explanation: ISO – Market Rate (Currently \$20 per index)								
	Other Charges/ Fees Explanation: MMSEA/SCHIP – Market Rate (Currently \$25 per claim)								
	Other Charges/Fees Explanation: EDI – Market Rate (Currently \$15 per FROI & \$10 per SROI)								
	Do you require any deposits? ✓ / N If yes, please explain purpose and dollar amounts: Deposits are necessary to pay for claim costs. The Initial Escrow Deposit (Imprest) is calculated by Treasury Funding based on 1.5 times the average paid claims, funding frequency (daily, weekly, or monthly), and funding method (ACH, wire, or check).								
	Does your proposal offer multi-year pricing? ✓ / N If yes, explain how long pricing is in effect: Two to five-year pricing is available with an annual 4% increase to the flat fee for all lines of coverage.								
	State your guaranteed annual flat fee: First Year - \$400,000 (includes all lines of coverage for run-off and new claim volume provided above, Annual Administration Fee, Account Setup, Data Transition, and RMIS)								
	State your estimated annual fee including all charges: <ul style="list-style-type: none"> • First Year - \$400,000 (Includes all lines of coverage for run-off and new claim volume) 								

	<p>provided above, Annual Administration, Account Setup, Data Transition, and RMIS)</p> <ul style="list-style-type: none">• Second Year - \$339,931• Third Year - \$350,329• Fourth Year - \$361,142• Fifth Year - \$372,387 <p><i>The estimated annual fees include annual administration and RMIS and are based on the claim volume provided above. If the actual claim volume increases by 10% or more, the following per-claim fees will apply:</i></p> <ul style="list-style-type: none">• <i>Indemnity - \$1,283</i>• <i>Medical Only - \$210</i>• <i>GLB/ALB - \$1,255</i>• <i>EO, EPL, LSM, PLE - \$1,535</i>• <i>Property Damage - \$558</i>
	<p>Name/Signature: <i>Sharada Rogers</i></p>
	<p>Company/Agency: CCMSI</p>



CCMSI

Required Forms



CERTIFICATE OF INTERESTED PARTIES

FORM 1295

1 of 1

Complete Nos. 1 - 4 and 6 if there are interested parties.
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

**OFFICE USE ONLY
CERTIFICATION OF FILING**

Certificate Number:
2025-1361357

Date Filed:
09/10/2025

Date Acknowledged:

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.
Cannon Cochran Management Services, Inc. (CCMSI)
Danville, IL United States

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.
Fort Bend County

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.
RFP 26-001
Property & Casualty Insurance Program Third Party Administration Services

4	Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
			Controlling	Intermediary

5 Check only if there is NO Interested Party.

6 UNSWORN DECLARATION

My name is _____, and my date of birth is _____.

My address is _____, _____, _____, _____, _____.
(city) (state) (zip code) (country)

I declare under penalty of perjury that the foregoing is true and correct.

Executed in _____ County, State of _____, on the _____ day of _____, 20____.
(month) (year)

Signature of authorized agent of contracting business entity
(Declarant)



COUNTY PURCHASING AGENT
Fort Bend County, Texas

Vendor Information

Brooke Lindemann
Purchasing Agent

Office (281) 341-8640

Legal Company Name (top line of W9)	Cannon Cochran Management Services, Inc.			
Business Name (if different from legal name)	CCMSI			
Type of Business	<input checked="" type="checkbox"/> Corporation/LLC	<input type="checkbox"/> Partnership	Age in Business?	
	<input type="checkbox"/> Sole Proprietor/Individual	<input type="checkbox"/> Tax Exempt	47 Years	
Federal ID # or S.S. #	37-1057804	SAM.gov Unique Entity ID #	ZM81NS4BU4A1 / 7J2C9	
SAM.gov CAGE / NCAGE	ZM81NS4BU4A1 / 7J2C9			
Publicly Traded Business	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Ticker Symbol _____			
Remittance Address	2 East Main Street			
City/State/Zip	Danville, IL 61832			
Physical Address	5001 Spring Valley Rd, Suite 750 W			
City/State/Zip	Dallas, TX 75244			
Phone Number	713.268.7812			
E-mail	srodgers@ccmsi.com			
Contact Person	Sharada Rogers			
Check all that apply to the company listed above and provide certification number.	DBE-Disadvantaged Business Enterprise <input type="checkbox"/>	Certification # _____	<u>Cert Date</u>	<u>Exp Date</u>
	SBE-Small Business Enterprise <input type="checkbox"/>	Certification # _____	_____	_____
	HUB-Texas Historically Underutilized Business <input type="checkbox"/>	Certification # _____	_____	_____
	WBE-Women's Business Enterprise <input type="checkbox"/>	Certification # _____	_____	_____
Company's gross annual receipts	<\$500,000 _____	\$500,000-\$4,999,999 _____		
	\$5,000,000-\$16,999,999 <input checked="" type="checkbox"/>	\$17,000,000-\$22,399,999 _____ >\$22,400,000 <input checked="" type="checkbox"/>		
NAICs codes (Please enter all that apply)	524292			
Signature of Authorized Representative				
Printed Name	John E. Kluth, II			
Title	Chief Financial Officer			
Date				

THIS FORM MUST BE SUBMITTED WITH THE SOLICITATION RESPONSE

Request for Taxpayer Identification Number and Certification

**Give Form to the
requester. Do not
send to the IRS.**

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank. Cannon Cochran Management Services, Inc.		
	2 Business name/disregarded entity name, if different from above		
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	<input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ▶ _____		
	5 Address (number, street, and apt. or suite no.) See instructions. 2 E Main Street, Suite 208		Requester's name and address (optional)
	6 City, state, and ZIP code Danville, IL 61832		
	7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number									
or									
Employer identification number									
3	7		-	1	0	5	7	8	4

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ▶ <i>Jiffay Jantre</i>	Date ▶ 3/19/25
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Job No.: RFQ

TAX FORM/DEBT/ RESIDENCE CERTIFICATION
(for Advertised Projects)

Taxpayer Identification Number (T.I.N.): 37-1057804

Company Name submitting Bid/Proposal: Cannon Cochran Management Services, Inc.

Mailing Address: 2 East Main Street, Danville, IL 61832

Are you registered to do business in the State of Texas? Yes No

If you are an individual, list the names and addresses of any partnership of which you are a general partner or any assumed name(s) under which you operate your business
N/A

I. **Property:** List all taxable property in Fort Bend County owned by you or above partnerships as well as any d/b/a names. Include real and personal property as well as mineral interest accounts. (Use a second sheet of paper if necessary.)

<u>Fort Bend County Tax Acct. No.*</u>	<u>Property address or location**</u>
N/A	

* This is the property account identification number assigned by the Fort Bend County Appraisal District.
 ** For real property, specify the property address or legal description. For business personal property, specify the address where the property is located. For example, office equipment will normally be at your office, but inventory may be stored at a warehouse or other location.

II. **Fort Bend County Debt** - Do you owe any debts to Fort Bend County (taxes on properties listed in I above, tickets, fines, tolls, court judgments, etc.)?
 Yes No If yes, attach a separate page explaining the debt.

III. **Residence Certification** - Pursuant to Texas Government Code §2252.001 *et seq.*, as amended, Fort Bend County requests Residence Certification. §2252.001 *et seq.* of the Government Code provides some restrictions on the awarding of governmental contracts; pertinent provisions of §2252.001 are stated below:

- (3) "Nonresident bidder" refers to a person who is not a resident.
- (4) "Resident bidder" refers to a person whose principal place of business is in this state, including a contractor whose ultimate parent company or majority owner has its principal place of business in this state.

I certify that _____ is a Resident Bidder of Texas as defined in Government Code §2252.001.
 [Company Name]

I certify that Cannon Cochran Management Services, Inc. is a Nonresident Bidder as defined in Government Code §2252.001 and our principal place of business is Danville, IL.
 [City and State]



CCMSI

Exhibits





Richard Cangiolosi

**Regional Vice President | Western Region
Albuquerque, NM**

Biographical Information

Professional Experience

With a career spanning over three decades, Mr. Cangiolosi is a respected claims and risk management expert who joined Cannon Cochran Management Services, Inc. (CCMSI) in 2004 as the New Mexico state director. His leadership skills and industry expertise quickly earned him a promotion to regional vice president for CCMSI's Western region, a role in which he also serves the needs of several major educational institutions, including the New Mexico Public School Insurance Authority (NMPSIA) and Albuquerque Public Schools, delivering tailored solutions to mitigate risks while ensuring operational efficiency.

Before joining CCMSI, Mr. Cangiolosi's career included diverse insurance and risk management roles, beginning in 1991 as an all-lines claims adjuster for the United States Fidelity and Guarantee Corporation (USF&G) in Albuquerque. He later transitioned to Hospital Service Corporation for seven years, specializing in workers' compensation as a claims analyst. In this position, he supervised adjusters and provided quality assurance oversight, ensuring the highest standards for customer accounts.

By this point, Mr. Cangiolosi had built a respected reputation in the industry, which led him to become the director of risk management for Albuquerque Public Schools. In this capacity, he oversaw their litigation management, the Office of Equal Opportunity Services, safety programs, and property, liability, and workers' compensation insurance, significantly enhancing the District's risk management capabilities.

With a well-rounded background in claims adjusting, risk management, and insurance, Mr. Cangiolosi brings invaluable expertise to his current role, making him a trusted advisor and ideal resource for clients seeking comprehensive insurance and risk management solutions.

Education and Professional Activities

Mr. Cangiolosi graduated from New Mexico State University with a Bachelor of Business Administration (BBA) in Finance and is pursuing an Associate in Risk Management (ARM). He has been active in the New Mexico Workers' Compensation Association Foundation for over twenty years, serving as a board member and treasurer and facilitating the Association's annual golf tournament and scholarship fundraising program.



Sharada Rogers, ARM

State Director – Houston, TX

Biographical Information

Professional Experience

With over two decades of experience in the risk and insurance industry, Ms. Rogers has cultivated a distinguished career collaborating with clients across diverse sectors, including national corporations, public entities, and municipalities. Her expertise spans insurance program management, claims and contract administration, auditing and analytics, budget oversight, cost containment, litigation management, loss control analysis, training, performance metrics, and benchmarking—delivering tailored solutions to meet her clients' unique needs.

Ms. Rogers began her career in 2005 as an administrative assistant in the City of Waco Risk Management Department, where she quickly earned recognition for her leadership, commitment, and ability to make a meaningful impact on client programs and the industry. After seven successful years with the City of Waco, she advanced to senior manager of workers' compensation at Houston Independent School District, the largest school district in Texas, supervising workers' compensation and unemployment programs for over 29,000 employees.

In 2017, Ms. Rogers joined McKesson Corporation, a publicly traded Fortune 500 company, as a risk management analyst, supporting all insurance-related programs for the company's U.S. Oncology and Specialty Health business units. In 2020, she transitioned from the employer side to Cannon Cochran Management Services, Inc. (CCMSI), where she now serves as the Texas state director, overseeing state operations for company offices, two client-based offices, and numerous claims staff, including two dedicated claim units.

Education and Professional Training

Ms. Rogers holds a bachelor's degree in Business Administration from the University of Texas at Arlington, an Associate in Risk Management (ARM), a Texas All-Lines Adjuster license, and an Oklahoma Workers' Compensation Adjuster license.



Princess Lott

Account Manager – Houston, TX

Biographical Information

Professional Experience

With nearly twenty-five years of workers' compensation industry experience for carriers and third-party administrators, Ms. Lott joined Cannon Cochran Management Services, Inc. (CCMSI) as an account manager in May 2022. She brings a wealth of experience to her clients, including Darling Ingredients and G&A Partners, servicing accounts in industries ranging from national corporations to small businesses, sports leagues, public entities, and municipalities.

As a workers' compensation and risk management expert, Ms. Lott skillfully executes complex initiatives on time and under budget. Her reputation as an engaging communicator is backed by her positive relationships with peers, direct reports, and customers, which ensures operational excellence.

She began her workers' compensation career in 2001 with leading carriers in the industry. Throughout the years, Ms. Lott has exemplified the heart of a teacher and strength of a leader in various roles, including adjuster level 2 with The Travelers; claim plus team lead adjuster for multimillion-dollar accounts at The Hartford; and senior adjuster, trainer, and project manager at Texas Mutual. She began her transition into the TPA world in 2015 as a claims supervisor, where she incorporated her knowledge and comprehensive experience with the core values associated with the industry.

Ms. Lott has extensive experience managing workers' compensation compliance for multiple jurisdictions, including Texas, Louisiana, Arkansas, and Oklahoma, specializing in operations management, risk management, process improvements, and training and development. However, her passion is helping her clients by removing confusion regarding their risk program while defining and driving successful strategic initiatives.

Education and Professional Training

Ms. Lott holds a Texas All-Lines license and Workers' Compensation licenses in Oklahoma, Louisiana, and Arkansas. She completed business and physical therapy courses at San Jacinto College and obtained her Real Estate license at the Champions School of Real Estate.



Melissa Aires

**Workers' Compensation Claim Supervisor
Albuquerque, NM**

Biographical Information

Professional Experience

Ms. Aires is a respected workers' compensation claim expert with over twenty-five years of industry experience, beginning at Frank Gates in 1998 in an administrative capacity before quickly advancing to an adjuster role. Throughout her career, she has managed lost-time claims for third-party administrators and insurance companies, including Hospital Services Corporation and ESIS.

Leveraging her extensive experience, skills, and expertise, Ms. Aires joined Cannon Cochran Management Services, Inc. (CCMSI) in 2001 and presently serves as a workers' compensation claim supervisor in the Albuquerque office.

Professional Training

Ms. Aires holds Oklahoma and New Mexico Adjuster licenses, in addition to her Texas All-Lines Adjuster license.



Latasha Harris

Workers' Compensation Claim Specialist – Texas Biographical Information

Professional Experience

Ms. Harris is a skilled and dedicated claims management professional with over a decade of experience in the insurance industry. Before joining Cannon Cochran Management Services, Inc. (CCMSI) in January 2025, she worked with several prominent companies, including TRISTAR Risk Management, Sedgwick, CorVel Corporation, and Esurance. Throughout her career, she has managed high-volume caseloads, investigated complex claims, negotiated settlements, and collaborated with cross-functional teams to achieve favorable outcomes.

As a well-rounded professional, Ms. Harris has built a foundation through her roles at United Healthcare, beginning in 2012, and Southern Management Corporation, which equipped her with a comprehensive understanding of customer needs, regulatory standards, and operational efficiency. In 2019, as a licensed claims associate at Esurance, she leveraged her knowledge of insurance policies to guide customers through the auto claims process while fostering positive relationships.

Ms. Harris later gained invaluable experience at Sedgwick and CorVel Corporation, managing workers' compensation claims, coordinating with medical professionals and attorneys, and ensuring compliance with state regulations. As a senior claims specialist at CorVel, she helped develop return-to-work plans and conducted claim reviews to maintain compliance and improve operational efficiency.

In 2023, Ms. Harris accepted a claims examiner III position with TRISTAR, responsible for managing a high volume of indemnity claims, analyzing complex insurance policies, conducting investigations, and negotiating settlements with claimants, attorneys, and other stakeholders. Her ability to interpret coverage terms and ensure timely claim decisions led to markedly improved outcomes.

Whether managing a caseload or leading a team, Ms. Harris is dedicated to delivering exceptional service and achieving optimal results. Her ability to navigate complex claims, negotiate effectively, and manage teams has made her a trusted professional in the insurance industry.

Education

Ms. Harris earned an Associate of Arts (AA) with a foundation in Business from the University of Phoenix.



Sylvia Ibanez

Medical Only Claim Representative – San Antonio, TX

Biographical Information

Professional Experience

Ms. Ibanez is an English-Spanish bilingual claim representative in the San Antonio Cannon Cochran Management Services, Inc. (CCMSI) office, joining in 2022 with an expansive insurance and customer service background.

She entered the insurance field in 2001 with Northeast Agencies in a clerical capacity and earned a promotion to assistant underwriter within a year. After nearly a decade with Northeast, she pursued a career in claims/processing with Litchfield Special Risks, taking loss reports on behalf of the carrier for various lines of business; verifying policy information and obtaining any that was missing; entering loss payments, expense payments, and claim close dates into the system; and referring the file to an underwriter for additional review if claim payments exceeded a pre-determined threshold or if it moved to litigation.

In 2017, she began working for third-party administrator 1-2-1 Claims Inc. as a claims assistant, setting up new claims, translating for Spanish-speaking callers, obtaining medical and work status reports from physicians, processing and entering workers' compensation forms, and preparing medical records for DD packets.

Professional Training

Ms. Ibanez holds a Texas All-Lines Adjuster license.



Devin M. Carter

**Multi-Line Claim Supervisor
Property Casualty Claims & Recovery Division**

Biographical Information

Professional Experience

Since stepping into the industry in 2010, Mr. Carter has developed a remarkable career specializing in in-depth coverage issues, complex coverage and liability analysis, and negotiations. Early on, he worked as a personal lines home and auto agent with Nationwide Insurance, leveraging his in-depth knowledge of policy language and company products to address complex billing, coverage limits, and deductible concerns. Mr. Carter quickly advanced to total loss auto adjuster and bodily injury adjuster II (attorney represented), determining proper policy coverage, negotiating settlements, investigating coverage and liability, and setting appropriate reserves. His expertise in settlement methods and claim evaluation proved to be a vital asset in this role.

Before transitioning into management, Mr. Carter was a complex liability claims adjuster at Root Insurance, where he conducted recorded interviews and collaborated with vendors to evaluate reported losses for coverage and liability. As a complex liability claims manager, he coached and developed a team of eight adjusters, utilizing his in-depth understanding of coverage issues, policy forms, contracts, regulatory requirements, and the fluid legal landscape for casualty claims.

Prior to joining Cannon Cochran Management Services, Inc. (CCMSI) in 2024, he worked as the Auto Physical Damage Unit leader at Branch Insurance, providing technical direction on coverage analysis, investigation, damage assessment, and other relevant claims functions. Additionally, he executed strategic claims initiatives to meet quality, customer service, and operational goals and conducted monthly file quality audits to enhance case outcomes and ensure optimal performance.

Education and Professional Training

Mr. Carter studied Business Forensics at Franklin University and holds Property and Casualty Adjuster licenses in Alabama, Connecticut, Delaware, Florida, Kentucky, Idaho, Louisiana, Maine, North and South Carolina, New Hampshire, New Mexico, Oklahoma, Texas, Vermont, West Virginia, and Wyoming.



Stacy Culberson, CP

Multi-Line Claim Representative II Property Casualty Claims & Recovery Division

Biographical Information

Professional Experience

With over twenty years of experience in the insurance industry, Ms. Culberson has built a distinguished career specializing in large loss, commercial claims, and litigation. Known for her ability to manage complex claims and craft effective litigation strategies, she has become a trusted expert in the field, delivering results while mentoring and developing talent within her teams.

Ms. Culberson began her career as a senior claims adjuster – auto/property at USAA in 2002, adjusting complex non-injury auto and property claims across the Southwest region. Her role involved gathering critical data, negotiating settlements, and building relationships with members, which set the stage for her future success.

In 2007, Ms. Culberson joined Farmers Insurance as a senior commercial claims specialist, where she handled a high-volume litigation caseload involving injury claims, uninsured motorist claims, and complex nationwide coverage issues for Business Auto and Garagekeepers policies. She quickly developed a reputation for thorough coverage analysis and expertise in heavy equipment APD claims while mentoring new adjusters and attending trials and mediations to facilitate settlements.

Ms. Culberson transitioned to a senior general adjuster role with Bristol West in 2016, managing large loss and complex claims nationwide. She specialized in litigated claims, investigating, evaluating, and negotiating settlements with a focus on cases exceeding \$100,000. In 2022, she accepted a claim specialist position with Philadelphia Insurance, where she handled large loss commercial auto claims with policies up to \$20 million, again focused on litigated cases. Ms. Culberson worked closely with legal, underwriting, and management teams to develop proactive strategies and resolve claims efficiently. A firm believer in mentorship, she fostered the growth of junior staff, ensuring her team's continued success.

Since joining Cannon Cochran Management Services, Inc. (CCMSI) as a multi-line claim representative in December 2024, she has already proven to be an invaluable asset with expertise in commercial claims and strategic litigation management.

Education and Professional Training

Ms. Culberson studied Criminal Justice through the Phoenix College Honors Program and Business Management/Business Marketing through the University of Phoenix. She holds an Associate of Arts and Science (AAS) in Paralegal Studies through the American Institute, a Paralegal Certificate (CP), and Arizona Property & Casualty and Life & Health licenses. In addition, she is pursuing an Associate in Claims (AIC) designation.



Tanaya Francis

Multi-Line Claim Representative II Property Casualty Claims & Recovery Division

Biographical Information

Professional Experience

Ms. Francis joined the Cannon Cochran Management Services, Inc. (CCMSI) Property-Casualty Claims & Recovery Division as a multi-line claim representative II in October 2024 with over a decade of experience in the claims industry. Specializing in complex multi-line claims, she leverages her extensive expertise to ensure effective resolution and client satisfaction.

She began her career at Nationwide Insurance in Harrisburg, Pennsylvania, where she progressed through several roles, starting as a medical processor in 2011 and ultimately serving as a bodily injury specialist I. During this time, Ms. Francis managed litigated and non-litigated claims, earning recognition for her proactive approach to claims resolution and collaboration with the Special Investigations Units to identify subrogation opportunities and fraud.

Prior to CCMSI, Ms. Francis spent eight years with Gallagher Bassett, advancing to senior resolution manager, investigating, evaluating, and resolving general liability claims, including premises, products, foodborne illness, and workers' compensation. Managing a portfolio of predominantly litigated transportation cases, she excelled in determining exposure and establishing reserves while adhering to best practices. Her analytical skills were crucial in reviewing medical documentation, property damage estimates, and inspection reports while navigating the complexities of multi-state claims and maintaining communication with attorneys, clients, and other stakeholders.

In addition to her claims-handling skills, Ms. Francis is celebrated for her dedication to mentorship and leadership, having trained new associates and streamlined processes that reduced pending volumes and enhanced team performance.

Education and Professional Training

Ms. Francis holds a bachelor's degree in Criminal Justice from Central Penn College and Texas, New York, Rhode Island, Connecticut, and Vermont Adjuster licenses.



CCMSI

Exhibit 2: Audited Financial Statements



CCMSI HOLDINGS, INC.
CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED JUNE 30, 2024 AND 2023



CPAs | CONSULTANTS | WEALTH ADVISORS

[CLAconnect.com](https://www.CLAconnect.com)

**CCMSI HOLDINGS, INC.
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YEARS ENDED JUNE 30, 2024 AND 2023**

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INDEPENDENT AUDITORS' REPORT

Board of Directors
CCMSI Holdings, Inc.
Danville, Illinois

Report on the Audit of the Consolidated Financial Statements

Opinion

We have audited the accompanying consolidated financial statements of CCMSI Holdings, Inc. and its subsidiary, which comprise the consolidated balance sheets as of June 30, 2024 and 2023, and the related consolidated statements of comprehensive income, stockholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CCMSI Holdings, Inc. and its subsidiary, as of June 30, 2024 and 2023, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of CCMSI Holdings, Inc. and its subsidiary and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about CCMSI Holdings, Inc. and its subsidiary's ability to continue as a going concern for one year after the date the consolidated financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of CCMSI Holdings, Inc. and its subsidiary's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about CCMSI Holdings, Inc. and its subsidiary's ability to continue as a going concern for a reasonable period of time.

Board of Directors
CCMSI Holdings, Inc.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

A handwritten signature in black ink that reads "CliftonLarsonAllen LLP". The signature is written in a cursive, flowing style.

CliftonLarsonAllen LLP

Champaign, Illinois
September 19, 2024

**CCMSI HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS
JUNE 30, 2024 AND 2023**

	2024	2023
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents:		
Operating	\$ 12,037,244	\$ 7,196,823
Premium Trust	96,022	616,418
Debt Securities Available for Sale	13,899,557	10,168,192
Receivables:		
Management Fees, Net of Allowance for Credit Losses of \$200,000	27,470,288	21,657,072
Premiums	943,653	1,136,802
Other	769,508	1,453,169
Prepaid Expenses and Other Assets	3,232,670	3,117,372
Total Current Assets	58,448,942	45,345,848
INVESTMENT IN LIMITED LIABILITY COMPANY	108,736	138,462
RIGHT-OF-USE ASSET - OPERATING LEASES	20,438,004	18,226,629
PROPERTY AND EQUIPMENT, NET	15,711,580	17,710,560
Total Assets	\$ 94,707,262	\$ 81,421,499
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	\$ 6,130,851	\$ 6,799,988
Accrued Expenses	9,418,533	7,165,319
Premium Accounts Payable	15,253	18,555
Deferred Revenue	8,128,372	8,771,083
Current Lease Liability - Operating	5,798,353	5,414,667
Total Current Liabilities	29,491,362	28,169,612
LONG-TERM LIABILITIES		
Long-Term Lease Liability - Operating (Less Current Maturities)	15,998,256	13,933,947
Total Liabilities	45,489,618	42,103,559
STOCKHOLDERS' EQUITY		
Common Stock - \$0.01 Par Value, 1,000,000 Shares		
Authorized; 290,353 Issued and Outstanding	2,903	2,903
Additional Paid-In Capital	4,797,112	4,797,112
Retained Earnings	44,445,454	34,708,347
Accumulated Other Comprehensive Loss	(27,825)	(190,422)
Total Stockholders' Equity	49,217,644	39,317,940
Total Liabilities and Stockholders' Equity	\$ 94,707,262	\$ 81,421,499

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
YEARS ENDED JUNE 30, 2024 AND 2023

	2024	2023
OPERATING REVENUE	\$ 211,074,601	\$ 201,267,904
OPERATING EXPENSES		
Personnel Salaries and Benefits	161,353,782	153,488,672
Managed Care Services	16,344,276	16,949,097
Occupancy	10,204,839	10,777,856
Depreciation and Amortization	5,470,718	5,872,099
Supplies and Postage	2,523,047	2,441,442
Travel	4,123,455	3,214,964
Professional Fees	527,076	563,906
Consulting	639,469	786,823
Computer	3,712,325	3,148,843
Marketing and Sales	391,659	245,726
Miscellaneous	1,146,831	1,626,701
Total Operating Expenses	206,437,477	199,116,129
INCOME FROM OPERATIONS	4,637,124	2,151,775
OTHER INCOME (EXPENSE)		
Undistributed Equity in Income (Loss) of Limited Liability Company	(29,730)	23,070
Gain on Sale of 10% of Limited Liability Company	-	65,576
Interest Income	5,129,713	2,418,159
Total Other Income	5,099,983	2,506,805
NET INCOME	9,737,107	4,658,580
OTHER COMPREHENSIVE INCOME		
Unrealized Holding Gain on Debt Securities Available for Sale	162,597	63,427
COMPREHENSIVE INCOME	\$ 9,899,704	\$ 4,722,007

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
YEARS ENDED JUNE 30, 2024 AND 2023

	<u>Total</u>	<u>Common Stock</u>	<u>Additional Paid-In Capital</u>	<u>Retained Earnings</u>	<u>Accumulated Other Comprehensive Loss</u>
BALANCE - JUNE 30, 2022	\$ 34,595,933	\$ 2,903	\$ 4,797,112	\$ 30,049,767	\$ (253,849)
Other Comprehensive Income	63,427	-	-	-	63,427
Net Income	<u>4,658,580</u>	<u>-</u>	<u>-</u>	<u>4,658,580</u>	<u>-</u>
BALANCE - JUNE 30, 2023	39,317,940	2,903	4,797,112	34,708,347	(190,422)
Other Comprehensive Income	162,597	-	-	-	162,597
Net Income	<u>9,737,107</u>	<u>-</u>	<u>-</u>	<u>9,737,107</u>	<u>-</u>
BALANCE - JUNE 30, 2024	<u>\$ 49,217,644</u>	<u>\$ 2,903</u>	<u>\$ 4,797,112</u>	<u>\$ 44,445,454</u>	<u>\$ (27,825)</u>

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2024 AND 2023

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Net Income	\$ 9,737,107	\$ 4,658,580
Adjustments to Reconcile Net Income to Net Cash Provided (Used) by Operating Activities:		
Depreciation	5,470,718	5,872,099
Amortization on Debt Securities Available for Sale	(50,599)	(40,537)
Provision for Credit Losses	60,000	-
Loss on Sale of Property and Equipment	-	262,291
Noncash Compensation Expense	-	2,310,599
Lease Expense Adjustment	236,620	14,276
Gain on Sale of 10% of Limited Liability Company	-	(65,576)
Undistributed Equity in (Income) Loss of Limited Liability Company	29,730	(23,070)
Effects of Changes in Operating Assets and Liabilities:		
Receivables	(4,996,406)	(1,423,834)
Prepaid Expenses and Other Assets	(115,302)	258,382
Accounts Payable	(669,137)	482,088
Accrued Expenses	2,249,912	(11,418,005)
Deferred Revenue	(642,711)	(2,817,525)
Payroll Tax Deferral - FICA Tax	-	(2,015,147)
Net Cash Provided (Used) by Operating Activities	11,309,932	(3,945,379)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of Equipment and Leasehold Improvements	(3,471,738)	(5,604,996)
Purchases of Debt Securities Available for Sale	(12,859,709)	(9,480,809)
Proceeds from Sales and Maturities of Debt Securities	9,341,540	9,188,418
Proceeds from Sale of 10% of Limited Liability Company	-	80,000
Net Cash Used by Investing Activities	(6,989,907)	(5,817,387)
NET INCREASE (DECREASE) IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	4,320,025	(9,762,766)
Cash, Cash Equivalents, and Restricted Cash – Beginning of Year	7,813,241	17,576,007
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH – END OF YEAR	\$ 12,133,266	\$ 7,813,241
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION		
Operating Cash	\$ 12,037,244	\$ 7,196,823
Premium Trust (Restricted Cash)	96,022	616,418
Total Cash, Cash Equivalents, and Restricted Cash	\$ 12,133,266	\$ 7,813,241
SUPPLEMENTAL DISCLOSURES OF NONCASH ACTIVITIES		
Right-of-Use Assets Obtained in Exchange for Lease Liability, at Adoption	\$ -	\$ 24,689,798
Right-of-Use Assets Obtained in Exchange for New Operating Lease Liabilities	8,226,294	1,062,622
	\$ 8,226,294	\$ 25,752,420

See accompanying Notes to Consolidated Financial Statements.

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CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

CCMSI Holdings, Inc. (the Company) is a holding company whose subsidiary provides third-party administration services for workers' compensation, property/casualty, and professional liability self-insurance programs of various businesses, governments, and pooled associations. The Company is subject to regulations of certain regulatory agencies and undergoes periodic examinations by those regulatory agencies.

The significant accounting and reporting policies for CCMSI Holdings, Inc. follow:

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and its wholly owned subsidiaries, Cannon Cochran Management Services, Inc. (dba: CCMSI) and Comp MC, Inc. The accounts of Comp MC, Inc. are included with the accounts of CCMSI for financial statement presentation. All significant intercompany accounts and transactions have been eliminated in the consolidation.

The consolidated financial statements of the Company have been prepared in conformity with accounting principles generally accepted in the United States of America and conform to predominant practice within the industry.

Use of Estimates in Preparing Financial Statements

In preparing the accompanying consolidated financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements and the reported amounts of revenues and expenses for the reporting period. Actual results could differ from those estimates. Material estimates which are particularly susceptible to significant change in the near term include the fair value of the Company's shares of common stock outstanding determined by an independent appraisal of the Company. The fair value estimates of the Company's common stock are used to determine share-based compensation liabilities, ESOP compensation expenses, and stock repurchase commitments.

Fiduciary Assets and Liabilities

The Company collects funds used to pay claims for self-insurance programs administered by CCMSI. The funds are not assets of the Company and, accordingly, are not included in the accompanying consolidated financial statements. See Note 13 for more information.

Cash and Cash Equivalents

For purposes of the statements of cash flows, any highly liquid debt instruments with an original maturity of three months or less are considered to be cash equivalents, including investments in commercial paper. Amounts included in premium trust accounts represent restricted cash from insurance premiums collected from the insured and held by the Company. The restricted cash is required to be set aside by contractual agreement for the remittance of premiums collected on behalf of carriers.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Cash and Cash Equivalents (Continued)

The Company maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Company has not experienced any losses in such accounts. The Company believes it is not exposed to any significant credit risk on cash.

Debt Securities

Management determines the appropriate classification of the securities at the time they are acquired and evaluates the appropriateness of such classifications at each balance sheet date. The Company's debt securities are classified as available for sale. Debt securities that are classified as available for sale are stated at fair value, and unrealized holding gains and losses are reported as accumulated other comprehensive loss within stockholders' equity.

Realized gains and losses are determined on the basis of the cost of the securities sold. The cost of securities sold is based on the specific-identification method. The amortization of premiums and accretion of discounts are recognized in interest income using methods approximating the interest method over the period to maturity. For callable debt securities purchased at a premium, the amortization period is shortened to the earliest call date.

Effective July 1, 2023, with the adoption of ASC 326, for available for sale debt securities in an unrealized loss position, the Company first assesses whether it intends to sell, or is more likely than not that it will be required to sell the security before recovery of its amortized cost basis. If either of these criteria are met, the security's amortized costs basis is written down to fair value through income. If these criteria are not met, the Company evaluates whether the decline in fair value has resulted from credit losses or other factors. In making this assessment, management considers the extent to which fair value is less than amortized costs, any changes in the underlying credit rating of the security, and adverse conditions specifically related to the security, among other factors. If it is determined that a credit loss exists, the present value of cash flows expected to be collected from the security are compared to the amortized cost basis of the security. If the present value of the cash flows expected to be collected is less than the amortized cost basis, a credit loss exists and an allowance for credit losses is recorded, which is limited by the amount that the fair value is less than the amortized costs basis. Any impairment that has not been recorded through an allowance for credit losses is recognized as a component of other comprehensive income. Changes in the allowance for credit losses are recorded as a provision for credit loss. Prior to the adoption of ASC 326, the Company used an other than temporary impairment model.

Receivables

Receivables are uncollateralized customer obligations which generally require payment within 30 days from the invoice date. Payments of accounts receivable are applied to the specific invoices identified on the customer's remittance advice or, if unspecified, to the earliest unpaid invoices.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Receivables (Continued)

The carrying amounts of accounts receivable is reduced by a valuation allowance that reflects management's best estimate of amounts that will not be collected. The allowance for credit losses is based on management's assessment of the collectability of specific customer accounts, aging of the accounts receivable, and forward-looking information. If there is a deterioration of a major customer's credit worthiness or actual defaults are higher than the historical experience, management's estimates of the recoverability of amounts due the Company could be adversely affected. All accounts or portions thereof deemed to be uncollectible or to require an excessive collection cost are written off to the allowance for credit losses.

Revenue Recognition and Deferred Revenue

The Company recognizes revenues when control of the product or service has been delivered to the customer, in an amount that reflects the consideration that the Company expects to be entitled in the exchange. To determine revenue recognition arrangements that an entity determines to be in the scope of ASC 606, the Company performs the following five step evaluation: 1) identify the contract with a customer, 2) identify performance obligations in the contract, 3) determine the transaction price, 4) allocate the transaction price to the performance obligations, 5) recognize revenue when or as the entity satisfies a performance obligation.

The Company's principal revenue generating activities includes compensation for management services rendered in connection with the operation and management of self-insurance programs for stand-alone organizations and self-insured risk groups. The Company also receives compensation for certain medical bill review services (Comp MC). Fees for management services are recorded as earned over the period which the service is to be provided. Fees for medical bill review services are recognized in the period when the service is provided. The Company may bill and collect fees in advance for services to be performed over a period of time and those fees are deferred and recognized ratably over that same period or as the services are provided. The Company may also bill and collect fees subsequent to the performance of the services and those fees are recognized as earned in the period which the service is provided.

The Company uses independent brokers in connection with the marketing of certain self-insurance programs. Operating revenue is stated net of commissions paid to these brokers.

The timing of revenue recognition, billings, and cash collections results in receivables, contract assets, and contract liabilities. Accounts receivable are recorded when the right to consideration becomes unconditional and are presented separately in the consolidated balance sheets. When the Company's billing occurs subsequent to revenue recognition a contract asset is recognized and is recorded as unbilled receivables, which is included in management fees receivable in the consolidated balance sheets. When the Company is entitled to bill a customer in advance of the recognition of revenue, a contract liability is recognized and is recorded as deferred revenue in the consolidated balance sheets.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revenue Recognition and Deferred Revenue (Continued)

The Company may incur incremental costs to obtain a sales contract, which under ASC 606 should be capitalized and amortized over the life of the contract. The Company elected the practical expedient to allow the Company to expense these costs since the majority of the contracts are short-term in nature with a life of one year or less.

The Company disaggregates its revenue from contracts with customers as follows for the years ended June 30:

	<u>2024</u>	<u>2023</u>
Stand-Alone Organizations	\$ 101,915,723	\$ 97,065,829
Self-Insured Risk Groups	61,690,660	60,886,049
Comp MC Fees	39,379,772	37,191,171
Other Income	8,088,446	6,124,855
Total Operating Revenue	<u>\$ 211,074,601</u>	<u>\$ 201,267,904</u>

Investment in Limited Liability Company

The Company holds a 80% interest in HT Air, LLC as of June 30, 2024 and 2023. The Company is accounting for its investment in this company under the equity method of accounting since the assets and liabilities are not significant. The assets and liabilities of HT Air, LLC totaled \$441,119 and \$195,882, respectively as of June 30, 2024. The LLC had assets and liabilities of \$282,406 and \$64, respectively, as of June 30, 2023.

Property and Equipment

Property and equipment is stated at cost less accumulated depreciation. Depreciation is computed principally by accelerated methods over the estimated useful lives of the related assets. Artwork is carried at the lower of cost or market. Market values for artwork are determined using independent appraisers. The Company capitalizes certain costs to develop, purchase, or modify software for the internal use of the Company. The depreciation expense on assets acquired under capital leases, depreciated over the shorter of the term of the lease or their estimated useful lives, is included with depreciation expense on owned assets. Leasehold improvements are amortized over their estimated useful lives or the respective lease terms, whichever is shorter. The estimated economic useful lives are as follows:

Computer Equipment and Accessories, Including Software	3 to 5 Years
Furniture, Fixtures, and Equipment, Including Acquired	5 to 10 Years
Leasehold Improvements	3 to 10 Years

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Long-Lived Assets

Long-lived assets to be held and used are tested for recoverability whenever events or changes in circumstances indicate that the related carrying amount may not be recoverable. When required, impairment losses on assets to be held and used are recognized based on the excess of the asset's carrying amount over the fair value of the asset. Certain long-lived assets to be disposed of by sale are reported at the lower of carrying amount or fair value less cost to sell. As of June 30, 2024 and 2023, long-lived assets are not considered to be impaired by management.

Advertising

The Company expenses advertising costs as incurred.

Income Taxes

The Company, with the consent of its stockholders, has elected to be taxed under sections of federal and state income tax law, which provide that, in lieu of corporation income taxes, the stockholders separately account for their pro rata shares of the Company's items of income, deductions, losses, and credits. The election was effective as of July 1, 1998. As a result of this election, no income taxes have been recognized in the accompanying consolidated financial statements.

Share-Based Compensation

The Company has issued Stock Appreciation Rights (SARs) and Stock Warrants to certain employees that require the Company to pay the fair value of the SAR and warrant to the employee at the date of exercise. These awards are considered to be liability awards as defined in Codification Topic 718 *Compensation – Stock Compensation*. These awards are more fully described in Note 7.

Leases

The Company leases office space, office equipment, and vehicles. The Company determines if an arrangement is a lease at inception. Operating leases are included in operating lease right-of-use (ROU) assets, other current liabilities, and operating lease liabilities on the consolidated balance sheets.

ROU assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. ROU assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. As most of leases do not provide an implicit rate, the Company uses a risk-free rate based on the information available at commencement date in determining the present value of lease payments. The operating lease ROU asset also includes any lease payments made and excludes lease incentives. The lease terms may include options to extend or terminate the lease when it is reasonably certain that the Company will exercise that option. Lease expense for lease payments is recognized on a straight-line basis over the lease term.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Leases (Continued)

The Company has elected not to separate nonlease components from lease components and instead accounts for each separate lease component and the nonlease component as a single lease component.

The Company's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

In evaluating contracts to determine if they qualify as a lease, the Company considers factors such as if the Company has obtained substantially all of the rights to the underlying asset through exclusivity, if the Company can direct the use of the asset by making decisions about how and for what purpose the asset will be used and if the lessor has substantive substitution rights. This evaluation may require significant judgment.

Adoption of New Accounting Standard

On July 1, 2023, the Company adopted ASU 2016-03, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, as amended (ASC 326), which replaces the incurred loss methodology with an expected loss methodology that is referred to as the current expected credit loss methodology (CECL). The measurement of expected credit losses under CECL is applicable to financial assets measured at amortized cost, including receivables. In addition, changes were made to the accounting for available for sale securities, which requires credit losses to be presented as an allowance rather than as a direct write-down of the available for sale securities when management does not intend to sell or believes that it is more likely than not that they will be required to sell.

The Company adopted the standard using the modified retrospective method for all financial assets measured at amortized cost. Results for annual periods beginning after July 1, 2023 are presented under the new CECL model while prior reporting periods continue to be reported in accordance with previously applicable GAAP. There was no impact to the financial statements related to the adoption of ASU 2016-03.

Subsequent Events

Management evaluated subsequent events through September 19, 2024, the date the financial statements were available to be issued.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 2 PROPERTY AND EQUIPMENT

Property and equipment consists of:

	2024	2023
Computer Equipment, Accessories, and Software	\$ 41,528,671	\$ 38,289,601
Furniture, Fixtures, and Equipment	6,706,966	6,496,663
Leasehold Improvements	2,424,704	2,402,345
Total Property and Equipment	50,660,341	47,188,609
Less: Accumulated Depreciation	34,948,761	29,478,049
Property and Equipment, Net	<u>\$ 15,711,580</u>	<u>\$ 17,710,560</u>

Included in computer equipment, accessories, and software above are costs for internally developed software products. Total cost was \$29,553,192 and \$27,524,807, respectively, and accumulated depreciation was \$18,570,448 and \$15,618,503, respectively, for the years ended June 30, 2024 and 2023, respectively.

NOTE 3 INVESTMENT IN DEBT SECURITIES AND FAIR VALUE MEASUREMENTS

The following is a summary of the Company's investments in debt securities available for sale as of June 30, 2024 and 2023, respectively:

	2024			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Corporate Bonds	\$ 12,911,092	\$ -	\$ (27,425)	\$ 12,883,667
Agency Securities	1,016,290	-	(400)	1,015,890
Total	<u>\$ 13,927,382</u>	<u>\$ -</u>	<u>\$ (27,825)</u>	<u>\$ 13,899,557</u>
	2023			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Corporate Bonds	<u>\$ 10,358,614</u>	<u>\$ -</u>	<u>\$ (190,422)</u>	<u>\$ 10,168,192</u>

The bonds included in debt securities available for sale at June 30, 2024 all mature within two years. Expected maturities may differ from contractual maturities because the issuers of debt securities may have the right to call or prepay their obligations without any prepayment penalties.

The *Fair Value Measurements and Disclosures* Topic of the FASB Standards Codification defines fair value and establishes a framework for measuring fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

**NOTE 3 INVESTMENTS IN DEBT SECURITIES AND FAIR VALUE MEASUREMENTS
(CONTINUED)**

In determining fair value, the Company uses various methods including market, income, and cost approaches. Based on these approaches, the Company often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Company utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs.

Based on the observability of the inputs used in the valuation techniques, the Company is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values.

Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third-party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer, or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

The following are descriptions of the valuation methodologies used for instruments measured at fair value:

Debt Securities: Debt securities consisting of bonds in corporations, U.S. government corporations and agencies, municipal bonds, and mortgage-backed securities are generally valued at the most recent price of the equivalent quoted yield for such securities, or those of comparable maturity, quality, and type. Such securities are generally classified within Level 2 of the valuation hierarchy.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

**NOTE 3 INVESTMENTS IN DEBT SECURITIES AND FAIR VALUE MEASUREMENTS
(CONTINUED)**

The following table summarizes assets and liabilities measured at fair value on a recurring basis segregated by the level of the fair value hierarchy as of June 30, 2024 and 2023, respectively:

	2024			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Corporate Bonds	\$ -	\$ 12,883,667	\$ -	\$ 12,883,667
Agency Securities	-	1,015,890	-	1,015,890
Total	\$ -	\$ 13,899,557	\$ -	\$ 13,899,557

	2023			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Corporate Bonds	\$ -	\$ 10,168,192	\$ -	\$ 10,168,192

Securities with a decline in fair value below cost or amortized cost as of June 30, 2024, including the length of time of such decline, are shown in the following schedule.

	2024					
	12 Months or More		Less than 12 Months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Corporate Bonds	\$ 2,993,053	\$ (19,472)	\$ 9,887,932	\$ (7,953)	\$ 12,880,984	\$ (27,425)
Agency Securities	1,015,890	(400)	-	-	1,015,890	(400)
Total	\$ 4,008,943	\$ (19,872)	\$ 9,887,932	\$ (7,953)	\$ 13,896,874	\$ (27,825)

	2023					
	12 Months or More		Less than 12 Months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Corporate Bonds	\$ 2,874,058	\$ (101,675)	\$ 7,218,746	\$ (88,747)	\$ 10,092,804	\$ (190,422)
Municipal Bonds	-	-	-	-	-	-
Total	\$ 2,874,058	\$ (101,675)	\$ 7,218,746	\$ (88,747)	\$ 10,092,804	\$ (190,422)

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

**NOTE 3 INVESTMENTS IN DEBT SECURITIES AND FAIR VALUE MEASUREMENTS
(CONTINUED)**

The Company does not believe that the available for sale securities that were in an unrealized loss position as of June 30, 2024, which were comprised of 13 individual securities, represent a credit loss impairment. Total gross unrealized losses were primarily attributable to changes in interest rates, relative to when the investment securities were purchased, and not due to the credit quality of the investment securities. The Company does not intend to sell the investment securities that were in an unrealized loss position and it is not more likely than not that the Company will be required to sell the investment securities before recovery of their amortized cost basis, which may be at maturity.

In general, investments are exposed to various risks, such as interest rate, credit, and overall market volatility risk. Due to the level of risk associated with certain investments, it is reasonably possible that changes in the values of the investments will occur in the near term and that such changes could be material.

NOTE 4 ACCRUED EXPENSES

The Company's accrued expenses are summarized as follows at June 30:

	2024	2023
Payroll, Commissions, Bonuses and Other Benefits	\$ 2,135,171	\$ 2,132,208
Stock Appreciation Rights (Vested)	4,881,990	2,335,886
Stock Warrants	1,757,980	1,500,240
Other	643,392	1,196,985
Total Accrued Expenses	\$ 9,418,533	\$ 7,165,319

NOTE 5 DEBT

Line of Credit

The Company has a line of credit of \$15,000,000 of which \$-0- was used as of June 30, 2024 and 2023. Amounts drawn against the line of credit are payable on demand and bear interest at the lender's prime rate minus 0.50% for an effective rate of 8.50% and 2.75% at June 30, 2024 and 2023, respectively. The line of credit is collateralized by substantially all of the Company's assets. The line of credit matures on March 7, 2025.

NOTE 6 EMPLOYEE RETIREMENT PLANS

The Company sponsors a 401(k) savings plan under which eligible employees may choose to save a percentage of their salary on a pre-tax basis, subject to certain Internal Revenue Service (IRS) limits. The Company may make discretionary matching and profit sharing contributions to the plan. The Company did not make any matching or profit sharing contributions during the years ended June 30, 2024 and 2023.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 6 EMPLOYEE RETIREMENT PLANS (CONTINUED)

The Company sponsors an Employee Stock Ownership Plan (the ESOP) for the benefit of employees who meet certain eligibility requirements. The ESOP's shares were purchased by the ESOP with the proceeds of a note from the Company. The Company made annual contributions to the ESOP equal to the ESOP's debt service, less dividends received by the ESOP. As principal and interest were paid, shares were released from collateral and allocated to participants based on the proportion of debt service paid in the year. The ESOP allocates released shares to all participants who meet certain eligibility requirements. The ESOP's loan to the Company is paid off and all shares have been released into the ESOP.

Compensation expense is recorded for additional contributions paid to the ESOP for benefit payments to participants. Compensation expense for the ESOP was \$5,900,000 and \$5,000,000 for the years ended June 30, 2024 and 2023, respectively.

Company shares held in the ESOP and allocated to participants totaled 282,853 as of June 30, 2024 and 2023. In the event of termination from employment or if eligible participants elect to diversify their account balances, the Company may be required to purchase the shares from the participant at the shares' fair market value unless the ESOP fulfills this obligation. The repurchase obligation totaled approximately \$98 million and \$97 million as of June 30, 2024 and 2023, respectively.

NOTE 7 SHARE-BASED COMPENSATION

Stock Appreciation Rights (SARs)

Effective January 1, 2020, the Company issued 112,000 SARs to certain employees with a base value of \$184.61 for each award and a vesting period of 33.33% each June 30. During 2023, 69,150 SARs were exercised, resulting in final payout as of June 30, 2023 under the 2020 Plan.

Effective January 1, 2023, the Company issued 69,150 SARs to certain employees with a base value of \$287.86 for each award and are vested immediately upon issuance. Through June 30, 2023, no SARs have been forfeited or exercised, resulting in 69,150 SARs outstanding as of June 30, 2023 under the 2023 Plan. The vested portion of the outstanding SARs totaled \$4,881,990 and \$2,335,886 as of June 30, 2024 and 2023, respectively and is included in accrued expenses in the accompanying consolidated financial statements.

Stock Warrants

In December 2013 and January 2014, the Company issued 46,504 stock warrants in connection with the redemption of stock held by individuals (the Holder). The Holders have the option to exercise the warrants at any time. Included in the redemption agreement is a put option in which the individual exercising the warrants has the right to require the Company to purchase the warrants by paying the Holder an amount equal to the difference between the fair market value at the surrender date of the warrants and the warrant strike price of \$107.32 per warrant. From 2013 through 2024, 39,504 warrants were exercised, resulting in 7,000 warrants outstanding as of June 30, 2024 and 2023. At June 30, 2024 and 2023, the fair value of the outstanding warrants totaled \$1,757,980 and \$1,500,240, respectively, and is included in Accrued Expenses in the accompanying consolidated balance sheets.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 7 SHARE-BASED COMPENSATION (CONTINUED)

The fair market value of the vested portion of all outstanding SARs and stock warrants included in accrued expenses is determined by an independent appraiser as of the reporting date. The Company's stock price was valued at \$358.46 and \$321.64 as of June 30, 2024 and 2023, respectively. The expense for the SARs and stock warrants totaled \$2,803,843 and \$2,690,892 for the years ended June 30, 2024 and 2023, respectively, and is included in Personnel Salaries and Benefits in the accompanying consolidated statements of comprehensive income.

NOTE 8 INCOME TAXES

The Company files consolidated income tax returns in the U.S. federal jurisdiction and multiple states. The Company is a pass-through entity for income tax purposes whereby any income tax liabilities or benefits are attributable to the Company's members. Any amounts paid by the Company for income taxes are accounted for as transactions with the Company's members. Federal and state income tax returns are subject to examination by the IRS and state taxing authorities, generally for three years after they are filed.

NOTE 9 COMMITMENTS

Stock Repurchase Commitment

The Company maintains stock repurchase agreements with all stockholders of the Company whereby at the stockholder's notification to the Company and the remaining stockholders of his intent to sell, the Company will repurchase the stockholder's stock at a price determined by an independent appraiser. The potential liability for the repurchase of shares held by the stockholders, other than the ESOP, is approximately \$2,688,450 and \$2,412,300 as of June 30, 2024 and 2023, respectively.

NOTE 10 CONTINGENT LIABILITIES

The Company is involved in litigation relating to various disputes with certain individuals and companies. The Company is vigorously defending its position in these cases and believes damages, if awarded to the defendants, will not be material. The Company includes in accrued expenses any expected settlements of these cases that are estimated to result in losses.

The Company acts as a third-party administrator of self-insurance programs for various businesses, governments, and pooled risk management associations. In carrying out these services, the Company has check signing authority over various cash accounts of these entities.

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 11 SELF-INSURANCE

The Company is self-insured for health benefits provided to employees. Medical claims exceeding \$300,000 in both 2024 and 2023, on any one individual, and aggregate losses in excess of approximately \$23,040,000 and \$21,010,000 incurred and paid during the years ended June 30, 2024 and 2023, respectively, were covered by stop-loss insurance purchased from a commercial insurance carrier. The Company has estimated a liability for claims incurred but not reported (IBNR) of \$1,700,000 and \$1,750,000, which is included in accrued expenses in the accompanying balance sheet for the years ended June 30, 2024 and 2023, respectively. Claims expense under the self-insured health plan totaled \$17,873,932 and \$16,337,573 for the years ended June 30, 2024 and 2023, respectively.

NOTE 12 LEASES

The Company leases office buildings, office equipment, and vehicles for various terms under long-term, noncancelable lease agreements. The leases expire at various dates through 2032.

The following table provides quantitative information concerning the Company's leases.

	<u>2024</u>	<u>2023</u>
Lease Costs:		
Operating Lease Cost	\$ 6,558,632	\$ 6,845,268
Short Term Lease Cost	1,457,919	1,031,406
Total lease costs	<u>\$ 8,016,551</u>	<u>\$ 7,876,674</u>
Other Information:		
Cash Paid for Amounts Included in the Measurement of Lease Liabilities:		
Operating Cash Flows from Operating Leases	\$ 6,303,555	\$ 24,689,798
Right-of-Use Assets Obtained in Exchange for New Operating Lease Liabilities	\$ 8,226,294	\$ 1,062,622
Estimated Weighted-Average Remaining Lease Term - Operating Leases	5.01 Years	5.37 Years
Estimated Weighted-Average Discount Rate - Operating Leases	2.81%	1.86%

CCMSI HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2024 AND 2023

NOTE 12 LEASES (CONTINUED)

The Company classifies the total undiscounted lease payments that are due in the next 12 months as current. A maturity analysis of annual undiscounted cash flows for lease liabilities as of June 30, 2024, is as follows:

<u>Year Ending June 30,</u>	<u>Amount</u>
2025	\$ 6,330,706
2026	4,919,416
2027	4,101,082
2028	3,067,861
2029	2,141,884
Thereafter	<u>2,781,104</u>
Total Undiscounted Lease Payments	23,342,053
Less: Interest	<u>(1,545,444)</u>
Present Value of Lease Liabilities	<u><u>\$ 21,796,609</u></u>

NOTE 13 CLIENT FUNDS

The Company maintains funds in custodial accounts at financial institutions to administer claims for certain clients. These funds are not available for the Company's general operating activities and, as such, have not been recorded in the accompanying consolidated balance sheets. The amount of these funds totaled \$151,459,375 and \$138,315,457 at June 30, 2024 and 2023, respectively. Interest earned on these accounts totaled \$4,479,051 and \$2,084,443 for the years ended June 30, 2024 and 2023, respectively

CCMSI INTERNAL AUDIT OVERVIEW



CCMSI Audit Team Mission Statement

The CCMSI audit team will serve our clients, claim professionals, and organization as a whole. We will accomplish this by conducting regular claim file audits in each office to assess compliance with CCMSI Best Practices. The audits we perform will be objective and provide constructive feedback to both the individual office as well as CCMSI's executive management. We will assist each office by identifying opportunities for employee development and assessing internal management controls.

Ultimately, our aim is to assist CCMSI in ensuring that we consistently deliver what matters most—a high level of claim service to our clients. Our audit process is reflective of this goal by maintaining a corporate-level quality control program. We believe that our commitment to quality claim service will position CCMSI to take advantage of new business opportunities in the future.

Strategy and Objectives

We plan to annually audit a sample of claims handled by each adjuster, which will be done through a standard method understood by all claims staff. After each review, feedback will be provided to the individual office. If needed, the management of that office will implement Corrective Plans of Action to address any areas identified as needing improvement.

This continuous evaluation of the claims staff, as well as the processes and systems, will be communicated to executive management. This ongoing communication will foster growth and development in the claims staff and management, and will encourage continuous improvement in CCMSI's quality handling of claims.

Goals of the Audit Team

- Ensure compliance with Best Practices, Client Handling Instructions and Carrier Requirements
- Provide an objective audit with constructive feedback;
- Help management and claims staff proactively identify areas for improvement;
- Work with our claims staff to provide solutions to any areas that were identified as needing improvement;
- Foster understanding of our mission with all claims staff;
- Streamline processes to ensure timely delivery of services to our clients; and
- Ensure quality service and value to our clients.

Confidentiality

Audit results are confidential and should not be shared externally without approval of your Regional Vice-President (RVP).

CCMSI INTERNAL AUDIT OVERVIEW



Internal Audit Process

- Each office will be audited annually with the exception of those eligible for the “QC Incentive Program for Rewarding Excellence by Office” (described later in this document).
- The lead auditor will contact the point person in advance to confirm the planned audit date.
- The lead auditor will obtain a current employee list from Human Resources and determine all appropriate staff to audit based on whether they carry a claims load and their date of hire.
- The lead auditor will ask the point person to instruct all adjusters to complete a Pre-Audit Survey.
- The lead auditor will request the point person to complete the State-Specific Fact Sheet.
- The claims selected will include those assigned to the adjuster since the last internal audit. For a one-year audit, the date range is typically within the past eight to nine months in order to finalize the prior audit, and then not within the last one to two months. For offices on the “QC Incentive Program for Rewarding Excellence by Office”, claims within the past 1-2 years may be audited to evaluate more mature claims.
- For indemnity adjusters, it is preferred they are assigned the claim from the start or receive the transfer from a medical only adjuster; avoiding transfers from another indemnity adjuster, if at all possible.
- The audit will include a review of all adjusters handling files, including supervisors with significant caseloads, P&C adjusters, indemnity adjusters, and medical only adjusters.
- Staff who handle special caseloads such as Subrogation-only, Litigation-only, Lifetime/Open-Medical or Med-Pay claims will not be included in the internal audit group.
- LevelUp adjusters will not be included in the annual audit, as this is a training program with an audit performed at the local level.
- It is not mandatory for adjusters employed fewer than six months to be included in the audit, but may be spot-checked, if appropriate. Typically, they will have recently had a new-employee spot-check.
- The audit will include eight to ten files for each adjuster. If clear trends are evident after reviewing eight claims, the auditor may elect not to review further files.
- For staff who earned 93% - 95% on their last two audits, the auditor will audit four claims and review the score at that point. If the score is 93% or higher, the score on these four claims will be used as the final score. If the score is below 93%, an additional four to six claims will be reviewed for a full audit.
- For staff who earned 96% - 100% on their last two audits, the auditor will audit two claims and review the score at that point. If the score is 96% or higher, the score on these two claims will be used as the final score. If the score is 93% or higher, an additional two claims will be audited. If the score is 93% or higher, the score of these four claims will be used as the final score. If the score is below 93%, an additional four to six claims will be reviewed for a full audit.
- Audit Worksheets will be completed for each reviewed claim, as well as an Audit Tally Sheet for each audited adjuster.
- Comments are provided on the Audit Worksheets to help support the marks and should provide constructive feedback.
- Audits will be conducted primarily online, but may include some on-site audits, which will include meeting with the appropriate staff (manager, point person, and/or supervisors) and a brief review of the audit findings.
- The lead auditor will provide a draft copy of the Audit Report to the point person in a timely manner and provide a due date for any reconsiderations to be returned.
- If no response is received, the draft copy will be posted as the final report in ten business days.

CCMSI INTERNAL AUDIT OVERVIEW



- Local management will disseminate and communicate audit results to claims staff in a timely manner as well as provide any training necessary.
- All Pre-Audit Surveys, Audit Worksheets, and Final Audit Reports generated for each audit will be posted to the O: drive as a resource for future audits.

QC Corrective Plan of Action

When an office receives 86% or lower:

- Local management is required to complete a Corrective Plan of Action within ten days of the lead auditor's request.
- A Teams-meeting or on-site training may be provided by the QC team, if appropriate.
- The lead auditor will follow up within ninety (90) days to confirm progress and/or completion of the appropriate action steps in the Corrective Plan of Action.
- The QC team will pull claims for local management to perform required spot-checks six months after the audit results are finalized for all adjusters/supervisors who scored 86% or lower in the formal audit.
- Six months later, the QC team will perform the regularly scheduled annual audit.
- Overall audit scores remain the same until the next formal audit (spot-check scores do not change the official score).

QC Spot-Checks

A spot-check consists of:

- Completed Audit Worksheets in Excel of three to four claims;
- Completed Audit Tally Sheet; and
- Brief summary of the findings for each adjuster, including any ongoing deficiencies that need work.
- Local management will disseminate and communicate audit results to claims staff in a timely manner.
- All Spot-Checks will be posted to the O: drive as a resource for future audits.

Spot-Checks completed by local management:

- The lead auditor will confirm who will be audited with the point person.
- The lead auditor will pick claims and run audit reports, if needed.
- The lead auditor will provide forms (worksheets/tally sheet) to the point person to complete the audit.
- Point person will return all audit material in thirty days.

New-Hire Spot-Checks

- One hundred and twenty (120) days after the adjuster date of hire, the auditor will reach out to the point person to confirm they have been handling claims.
- The auditor will pick claims since the date of hire and audit three to four claims.
- If the adjuster scored 80% or below, another spot-check may be completed by the QC team in ninety (90) days. This will consist of two claims received after the initial spot-check to gauge progress.

CCMSI INTERNAL AUDIT OVERVIEW



QC Incentive Program for Rewarding Excellence by Office

When an office achieves 90% or higher on the overall office audit score:

Office will receive \$15 per claim professional, including clerical staff or any others who work on claims, to go toward an office luncheon or in-house celebration for the claims staff. Betsy McConkey will provide a budget to the point person who will submit the costs on their expense report, showing in the business purpose "Audit Incentive Celebration". Suzi Wear in Accounting will then move it to the right budget/Corporate.

When an office achieves 90% or higher for two consecutive audits:

- Office is not formally audited by the QC team for the following **two audit cycles**.
- Office is allowed to carry over their score from the previous audit or the average of the past two audits, whichever is higher.
- In lieu of a formal audit:
 - *Year one*: a spot-check will be completed by local management for any adjusters who scored less than 87% in the formal audit.
 - *Year two*: a spot-check will be completed by the audit team for any adjusters who scored less than 87% in the year-one skip.
- In year three (when re-audited after a two-year skip):
 - If the office earns 90% or higher, they will again be skipped for two years and retain the year-three score.
 - If the office earns 87-89%, they will be skipped for one year, as outlined below.

When an office achieves 87% or above for two consecutive audit cycles:

- Office is not formally audited by the QC team for **one audit cycle**.
- Office is allowed to carry over their score from the previous audit.
- In lieu of a formal audit:
 - *Year one*: a spot-check is required to be completed by local management for any adjusters who scored less than 87% in the formal audit.
- In year two (when re-audited after a one-year skip):
 - If the office earns 90% or higher, they will be skipped for two years and retain the year-two score.
 - If the office earns 87-89%, they will be skipped again for one audit cycle.
- The audit team has the discretion to audit an office earlier if there are significant changes in the office (turnover, significant new hires, large accounts, etc.).

QC Incentive Program for Rewarding Excellence by Claim Professional

- All claim professionals who earn a score of 90% or higher on their individual score will be provided a Certificate of Claims Excellence signed by Rod Golden, COO; Carrie Milholland, Vice President-Corporate Claims; and Betsy McConkey, Senior QC Manager.
- Any claim professional who scores 93-95% on their individual scores will be provided a certificate entitling them to a half day off to be used within three months, of which their direct supervisor or manager must approve and keep record. The individual receiving this reward shall NOT make notation of the half day in e-time sheets.
- Any claim professional who scores 96-100% on their individual scores will be provided a certificate entitling them to a full day off to be used within three months, of which their direct supervisor or manager must approve and keep record. The individual receiving this reward shall NOT make notation of the day off in e-time sheets.

Handling Office	
Adjuster Name	
Supervisor Name	

Claimant Name	
Claim Number	
Date/Day of Loss	
Date/Day of Entry	
Date/Day Adj Assigned	
File Status (O/C)	
Date Closed	

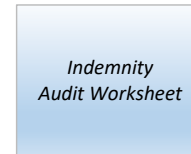
Client	
Carrier Name	
Risk Exposure Type	
Reporting Level/Amount	
Coverage	
Jurisdiction	

Date Audited	
Auditor Name	

Days from Date Assigned:
 n/a - 10 business days
 n/a - 30 calendar days

Score	CORE COMPETENCY
n/a	COVERAGE
n/a	INITIAL CONTACT
n/a	INVESTIGATION & CRA
n/a	RESERVES & WAGE INFORMATION
n/a	MEDICAL & DISABILITY MANAGEMENT
n/a	LITIGATION MANAGEMENT & SETTLEMENT EVALUATION
n/a	CARRIER REPORTING
n/a	DOCUMENTATION & ONGOING MANAGEMENT
n/a	MINIMUM SYSTEM REQUIREMENTS
n/a	OVERALL - Claim #

n/a	SUPERVISION - Claim #
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Core Competency	Question	Question #	YES	NO	N/A	Comments
COVERAGE	Deductible Claims: Was coverage promptly documented in the notes as a part of the initial coverage review? (within 10 business days) Other policy types: score as Y if documented promptly, N if documented after 30 days, N/A if no mention.	1				
COVERAGE	Deductible Claims: Was the coverage correctly documented in the notes with the coverage type, insurance carrier/company, policy number, policy period, deductible or retention amount, and reporting level? Other policy types: score as Y if documented correctly, N if documented incorrectly, N/A if no mention.	2				
COVERAGE	Were potential coverage issues identified and documented in the notes within 10 business days?	3				
INITIAL CONTACT - Client	Was <u>verbal or written</u> client contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day; generic acknowledgement not sufficient)	4				
INITIAL CONTACT - Client	If the client was not reached on the first attempt, was client contact attempted at least every 3 business days thereafter until the client was reached?	5				
INITIAL CONTACT - Client	Was the client contact thorough and effective?	6				
INITIAL CONTACT - Client	If attempts to contact the client were discontinued, was the rationale stated in the notes?	7				
INITIAL CONTACT - Claimant	Was <u>verbal</u> claimant contact made or attempted within 2 business days of receipt, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)	8				
INITIAL CONTACT - Claimant	If the claimant was not reached on the first attempt, was claimant contact attempted at least every 3 business days thereafter until the claimant was reached?	9				
INITIAL CONTACT - Claimant	If verbal contact was unsuccessful, was a written follow-up sent promptly to the claimant requesting contact?	10				

Core Competency	Question	Question #	YES	NO	N/A	Comments
INITIAL CONTACT - Claimant	Was claimant contact thorough and effective?	11				
INITIAL CONTACT - Claimant	If attempts to contact the claimant were discontinued, was the rationale stated in the notes?	12				
INITIAL CONTACT - Medical	Were the initial medical records documented in the notes? If not, was verbal or written health provider contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)	13				
INITIAL CONTACT - Medical	If the medical records were needed to determine compensability, were attempts to obtain these evident in the notes?	14				
INITIAL CONTACT - Witness	Were witnesses contacted/interviewed, if appropriate?	15				
INVESTIGATION	Was a description of the accident input early in the claim notes?	16				
INVESTIGATION	Were red-flag fraud indicators recognized and addressed in the investigation? (ex: multiple past claims per ISO or ICEbar, no witnesses, Monday morning accidents, etc.)	17				
INVESTIGATION - ISO/Index	Was the initial ISO/Index Report generated as part of the initial investigation of the claim? (need early so can review with client/claimant during investigation if there were any pertinent hits. Also need to add the score-range to the CRA)	18				
INVESTIGATION - ISO/Index	Was a diary established to re-index the claim after 18 months, then every 6 months?	19				
INVESTIGATION - ISO/Index	Was the claim re-indexed after 18 months, then every 6 months?	20				
INVESTIGATION - ISO/Index	Was the ISO/Index results promptly reviewed in the notes, with comments of whether or not any follow up was needed?	21				
INVESTIGATION - ISO/Index	If there were any relevant hits found on the ISO report, any prior injuries or prior claims, were these fully investigated?	22				
INVESTIGATION - CRA	Was the CRA form sufficiently completed for a valid profile scoring? (all n/a's generate a false CRA rating)	23				
INVESTIGATION - CRA	Was the CRA form completed within 10 business days from receipt of the first notice of injury? If not, were continued efforts to gather the information evident?	24				
INVESTIGATION - CRA	If the CRA was not completed, was "the CRA will not be completed on this file" checked with an explanation?	25				
INVESTIGATION - Subrogation/ Recovery	Was sufficient subrogation, recovery or SIF investigation completed within 10 business days to rule out or identify recovery potential? If not, were continued efforts to gather the information evident?	26				
INVESTIGATION - Subrogation/ Recovery	Was a claim-specific subro, recovery or SIF exposure rationale documented once this was ruled out or identified?	27				
INVESTIGATION - Subrogation/ Recovery	Were all potentially responsible parties put on notice immediately, if applicable?	28				
INVESTIGATION - Subrogation/ Recovery	Was a request for written acknowledgement from the insurance carrier(s) requested & pursued until obtained from all potentially responsible parties, if applicable?	29				
INVESTIGATION - Subrogation/ Recovery	If notice of representation was received on a claim with subrogation potential, was our lien notice sent to the claimant's attorney requesting acknowledgement of our lien?	30				
INVESTIGATION - Subrogation/ Recovery	If the claimant's attorney did not acknowledge our subro lien, was follow up made every 30-90 days until acknowledged?	31				
INVESTIGATION - Subrogation/ Recovery	Was follow-up on subrogation, recovery or SIF completed at a maximum every 90 days?	32				

Core Competency	Question	Question #	YES	NO	N/A	Comments
INVESTIGATION - Subrogation/ Recovery	Was the carrier and/or client consulted prior to waiving or compromising any recoveries?	33				
INVESTIGATION - Compensability	Was a sufficient investigation completed timely to determine compensability? (within 10 business days)	34				
INVESTIGATION - Compensability	If the investigation was incomplete, were continued efforts to gather the information evident? (unresolved contacts, witness statements, subro follow up, prior medical records, etc.)	35				
INVESTIGATION - Compensability	Was the compensability statement appropriate and clear? (stated after investigation complete, specific to the claim, and reflect the adjuster's review of all important issues unique to the claim)	36				
INVESTIGATION - Compensability	Were denials clearly documented in the notes, discussed with the client (if required), and reported to the state (if applicable)?	37				
RESERVES	Were the initial reserves established timely? (w/in 10 business days, or within the carrier or client service commitments, whichever is stricter)	38				
RESERVES	Were the initial reserves adequate with detailed reserve rationales specific to the claim? (credit for bulk-reserving only if client-directive in CSI's)	39				
RESERVES	Were subsequent reserves adjusted timely as developments occurred? (w/in 10 business days)	40				
RESERVES	Were detailed reserve rationales documented for subsequent reserves? (including anticipated medical based on the current treatment plan, calculations for TTD, permanency or impairment)	41				
RESERVES	Were reserves established in compliance with corporate philosophy? (no stair stepping)	42				
RESERVES	Were the reserves sufficient to bring the claim to a conclusion, based on the facts of the claim at the time of review?	43				
RESERVES - Wage Information	Was the wage statement/wage information promptly requested?	44				
RESERVES - Wage Information	Was the wage statement/wage information regularly pursued until received?	45				
RESERVES - Wage Information	Was an appropriate explanation of the wage rates with all calculations documented in the notes?	46				
RESERVES - Wage Information	Was the Wage Statement attached to the notes, if received?	47				
MED & DISAB MGMT	Was a medical authorization form requested? (Yes if documented, N/A if no mention)	48				
MED & DISAB MGMT	Were pertinent medical records requested, with appropriate follow up if not received?	49				
MED & DISAB MGMT	Were the medical records regularly summarized and attached in the notes? (including date, provider name, summary)	50				
MED & DISAB MGMT	Was the medical treatment plan proactively managed? (RTW & MMI targets tracked, IME/2nd opinion requests, prompt authorization of treatment, DME, Rx requests/approvals, etc.)	51				
MED & DISAB MGMT	Was light duty work aggressively pursued and coordinated, if available? (with treating physician and client)	52				
MED & DISAB MGMT	If applicable, was UR/Pre-Cert appropriately used?	53				
MED & DISAB MGMT	If relevant in a particular state, was a PPD rating timely requested?	54				
MED & DISAB MGMT - Nurse CM/Voc Rehab	Was NCM or Voc Rehab considered and assigned timely, with clear instructions? (task assignment vs. ongoing management)	55				
MED & DISAB MGMT - Nurse CM/Voc Rehab	Was regular collaboration with the NCM/Voc Rehab Specialist evident, showing the adjuster was overseeing the medical/Voc Rehab?	56				

Core Competency	Question	Question #	YES	NO	N/A	Comments
MED & DISAB MGMT - Nurse CM/Voc Rehab	Was NCM correspondence/e-mails/documents summarized regularly and attached to the notes? (including date, CM/Voc Rehab name)	57				
LIT MGMT/ SETLMNT EVAL - Claimant Attorney	Was the claimant's attorney letter of representation acknowledged in writing within 10 business days?	58				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was the file referred to a defense attorney timely? (In states where counsel files an answer, 10 business days)	59				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Did the assignment to the defense attorney include clear instructions and expectations? (including an overview of the claim facts, investigation to date, as well as the issuing carrier name, as applicable)	60				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was there prompt follow up for the defense attorney's initial review/evaluation if not received within 30 calendar days from referral?	61				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was legal correspondence/e-mails/documents summarized regularly and attached to the notes? (including date, attorney name)	62				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was regular collaboration with the defense attorney evident (or claimant's attorney if no defense on file), showing adjuster was managing the litigation plan?	63				
LIT MGMT/SETLMNT EVAL - Budget/ Approved Atty	Deductible Claims: Was a legal budget requested? (Other policy types: do not mark down)	64				
LIT MGMT/SETLMNT EVAL - Budget/ Approved Atty	Deductible Claims: Was there continued follow up for a budget from the DA until received? (Other policy types: do not mark down)	65				
LIT MGMT/SETLMNT EVAL - Budget/ Approved Atty	Deductible Claims: Was a carrier-approved defense attorney used, if applicable? (Other policy types: do not mark down)	66				
LIT MGMT/SETLMNT EVAL - Exposure/ Settlement	Was the claim exposure, settlement values and plans for disposition evident in the notes?	67				
LIT MGMT/SETLMNT EVAL - Exposure/ Settlement	If settling out future medical, was consideration shown for MMSEA/SCHIP submission & eligibility based on age or SSDI status, if applicable?	68				
LIT MGMT/SETLMNT EVAL - Exposure/ Settlement	Was appropriate settlement authority/concurrence obtained from the client contact and/or supervisor, if applicable?	69				
CARRIER REPORTING	If the claim meets carrier reporting requirements, was the claim reported within 30 days or per the carrier's required timeline?	70				
CARRIER REPORTING	Was the claim reported on the carrier's form (if required) and a request for acknowledgement requested?	71				
CARRIER REPORTING	Was the notice sent via email with return receipt, fax with confirmation or certified mail and documented in the notes?	72				
CARRIER REPORTING	Was a diary established for follow up every 15 calendar days until acknowledgement was received from the carrier contact?	73				
CARRIER REPORTING	Were timely follow-up reports provided to the carrier once the initial report was made? If the carrier decontrolled the file, this should be clearly shown in the notes.	74				
CARRIER REPORTING	Was reserve/settlement authority obtained timely from the carrier per their reporting requirements and documented in the notes?	75				
DOCUMENTATION - Action Plans/File Mgmt	Was an initial action plan documented within 30 calendar days, or within the carrier or client service commitments, whichever is stricter?	76				

Core Competency	Question	Question #	YES	NO	N/A	Comments
DOCUMENTATION - Action Plans/File Mgmt	Was the initial action plan thorough and effective?	77				
DOCUMENTATION - Action Plans/File Mgmt	Was a thorough and effective action plan updated every 30-90 calendar days thereafter with appropriate follow up? (Should be able to follow the current treatment status, estimated RTW date, expected MMI date, plans for disposition, current legal status, etc.)	78				
DOCUMENTATION - Action Plans/File Mgmt	Did the adjuster regularly complete their diaries no later than 10 calendar days?	79				
DOCUMENTATION - Action Plans/File Mgmt	Were directions and recommendations from supervisors consistently acknowledged or acted upon?	80				
DOCUMENTATION - Benefits/State Forms	Were the benefit rates properly calculated, based on the jurisdiction?	81				
DOCUMENTATION - Benefits/State Forms	Were initial indemnity benefits paid timely and accurately, based on the jurisdictional requirements?	82				
DOCUMENTATION - Benefits/State Forms	Were ongoing indemnity benefits paid timely and accurately? (print date regular and near the period paid)	83				
DOCUMENTATION - Benefits/State Forms	If applicable, were adjustments to benefits clearly documented, showing the amount and reason? Were underpayments issued promptly, recovery of overpayments attempted or plans for recovery noted? If recovery is not allowed in the jurisdiction, was this clearly stated?	84				
DOCUMENTATION - Benefits/State Forms	Was a summary/explanation provided for state filings, TPD pays, etc.	85				
DOCUMENTATION - Surveillance	If surveillance was used, did the assignment to the surveillance company include clear instructions/expectations?	86				
DOCUMENTATION - Surveillance	Was surveillance managed and used appropriately, if applicable?	87				
DOCUMENTATION - Surveillance	Was a summary provided for surveillance reports/e-mails/documents/videos? (including date, company name)	88				
DOCUMENTATION - Ongoing Contact/ Mgmt	Was follow up contact made with the claimant, when appropriate, or as issues arose?	89				
DOCUMENTATION - Ongoing Contact/ Mgmt	Was follow up contact made with the client, when appropriate, or if issues arose? (concurrence with denials, reserves, settlement or assignment to: CM, surveillance, attorney, etc.)	90				
DOCUMENTATION - Ongoing Contact/ Mgmt	Were the carrier instructions followed, if different/stricter than CCBP?	91				
DOCUMENTATION - Ongoing Contact/ Mgmt	Deductible Claims: Was the correct Underwriting Company (Issuing Carrier) included on all correspondence, including paper, email, settlement documents and State forms?	92				
DOCUMENTATION - Ongoing Contact/ Mgmt	Was the claim progressing appropriately and/or concluded effectively and timely?	93				
MINIMUM SYSTEM REQUIREMENTS	Were the 3-point contact fields on the Miscellaneous screen completed?	94				
MINIMUM SYSTEM REQUIREMENTS	Was the recovery tab on the Miscellaneous screen completed appropriately?	95				
MINIMUM SYSTEM REQUIREMENTS	Was the "Lien on Claim" box on the Miscellaneous screen completed, if applicable?	96				
MINIMUM SYSTEM REQUIREMENTS	Was the "Overpayment on Claim" box on the Miscellaneous screen completed, if applicable?	97				
MINIMUM SYSTEM REQUIREMENTS	Was the "Claim Denied" box checked on the Claim Edit screen, if applicable?	98				

Core Competency	Question	Question #	YES	NO	N/A	Comments
MINIMUM SYSTEM REQUIREMENTS	Were the Claimant and Defendant tabs on the Legal screen completed, if applicable?	99				
MINIMUM SYSTEM REQUIREMENTS	Deductible Claims: Was the litigation budget amount properly entered on the Legal Screen/Defendant tab? (Other policy types: do not mark down unless required by Client)	100				
MINIMUM SYSTEM REQUIREMENTS	Deductible Claims: Were the loss type/body part/cause codes accurate for the current status of the claim? (Other policy types: do not mark down at this time)	101				
MINIMUM SYSTEM REQUIREMENTS	Were the compensable or denied body parts properly coded in the SCHIP field? (SCHIP coding required for ALL injury claims)	102				
MINIMUM SYSTEM REQUIREMENTS	Were the Carrier fields completed, if applicable?	103				
MINIMUM SYSTEM REQUIREMENTS	Did the claim summary provide a good overview of the claim? (current, concise and complete)	104				
SUPERVISION - Initial 30-day review	Did the supervisor document an initial review within the required 30 calendar days?	105				
SUPERVISION - Initial 30-day review	Was the supervisor's initial review effective, addressing all pertinent details of the claim? (mark as n/a if there was not a review)	106				
SUPERVISION - Initial 30-day review	Did the supervisor review the reserves (adequacy and rationale) and provide guidance if necessary, ensuring sufficient reserves in each class based on known exposures?	107				
SUPERVISION	If the documentation was incomplete, did the supervisor direct the adjuster to finalize any missing investigation details? (coverage note, compensability statement, subrogation rationale, reserve rationale, action plans, CRA, ISO review, investigation of relevant ISO hits, etc.)	108				
SUPERVISION	Did the supervisor direct the adjuster to update or complete any system fields that were incomplete or outdated? (3-pt contact, recovery, ISO, lien, overpayment, denied, legal, coding, carrier, claim summary, etc.)	109				
SUPERVISION	Did the supervisor provide appropriate guidance or direction for any claims handling deficiencies throughout the life of the claim? (incomplete investigation, claim accepted without support, subrogation not pursued, medical follow up needed, calculation errors, overpayment/underpayments, referral to vendor needed, reporting to carrier, Medicare issues, settlement evaluation, etc.)	110				
SUPERVISION	If deficiencies were noted, did the supervisor follow up timely to ensure the claims professional executed on the provided direction?	111				
SUPERVISION	Were regular reviews completed? (maximum of every 90 days)	112				
SUPERVISION	Was the reserve adequacy and rationales reviewed with direction, if needed, throughout the life of the claim?	113				
SUPERVISION	If the supervisor diary was removed, was an adequate explanation provided? (Note: Diaries cannot be removed on Deductible claims)	114				

Handling Office	
Adjuster Name	
Supervisor Name	

Claimant Name	
Claim Number	
Date/Day of Loss	
Date/Day of Entry	
Date/Day Adj Assigned	
File Status (O/C)	
Date Closed	

Client	
Carrier Name	
Risk Exposure Type	
Reporting Level/Amount	
Coverage	
Jurisdiction	

Date Audited	
Auditor Name	

Score	CORE COMPETENCY
n/a	INVESTIGATION & FIRST NOTICE OF LOSS
n/a	RESERVES
n/a	MEDICAL & DISABILITY MANAGEMENT
n/a	DOCUMENTATION & ONGOING MANAGEMENT
n/a	OVERALL - Claim #

n/a	SUPERVISION - Claim #
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Days from Date Assigned:
 n/a - 10 business days
 n/a - 30 calendar days



Core Competency	Question	Question #	YES	NO	N/A	Comments
INVESTIGATION/FNOL	Was the claim input and the claims management initiated within 2 business days of the first notice of injury?	1				
INVESTIGATION/FNOL	Was a description of the accident input early in the claim notes?	2				
INVESTIGATION/FNOL	If a coverage note was documented, was it correctly stated, including coverage type, insurance carrier/company, policy number, policy period, deductible or retention amount, and reporting level? (Score as Y if documented correctly, N if documented incorrectly, N/A if no mention)	3				
INVESTIGATION/FNOL	Was the compensability statement appropriate and clear? (stated after investigation complete; specific to the claim)	4				
Do not score down if not required by Carrier or Client Service Instructions						
INVESTIGATION/FNOL - INITIAL CONTACTS	Was initial 2-pt or 3-pt contact completed timely?	5				
INVESTIGATION/FNOL - INITIAL CONTACTS	Was initial 2-pt or 3-pt contact completed appropriately? (thorough and effective)	6				
Do not score down if not required by Carrier or Client Service Instructions						
INVESTIGATION/FNOL - ISO/Index	Was the initial ISO/Index Report generated as part of the initial investigation of the claim? (need early so can review with client/claimant during investigation if there were any pertinent hits. Also need to add the score-range to the CRA)	7				
INVESTIGATION/FNOL - ISO/Index	Was a diary established to re-index the claim after 18 months, then every 6 months?	8				
INVESTIGATION/FNOL - ISO/Index	Was the ISO/Index results promptly reviewed in the notes, with comments of whether or not any follow up was needed?	9				
INVESTIGATION/FNOL - ISO/Index	If there were any relevant hits found on the ISO report, any prior injuries or prior claims, were these fully investigated?	10				
INVESTIGATION/FNOL - Subro/Recovery	Was sufficient subrogation, recovery or SIF investigation completed within 10 business days to rule out or identify recovery potential? If not, were continued efforts to gather the information evident?	11				

Core Competency	Question	Question #	YES	NO	N/A	Comments
INVESTIGATION/FNOL - Subro/Recovery	Was a claim-specific subro, recovery or SIF exposure rationale documented once this was ruled out or identified?	12				
INVESTIGATION/FNOL - Subro/Recovery	Were all potentially responsible parties put on notice immediately, if applicable?	13				
INVESTIGATION/FNOL - Subro/Recovery	Was a request for written acknowledgement from the insurance carrier(s) requested & pursued until obtained from all potentially responsible parties, if applicable?	14				
INVESTIGATION/FNOL - Subro/Recovery	If notice of representation was received on a claim with subrogation potential, was our lien notice sent to the claimant's attorney requesting acknowledgement of our lien?	15				
INVESTIGATION/FNOL - Subro/Recovery	If the claimant's attorney did not acknowledge our subro lien, was follow up made every 30-90 days until acknowledged?	16				
INVESTIGATION/FNOL - Subro/Recovery	Was follow-up on subrogation, recovery or SIF completed at a maximum every 90 days?	17				
INVESTIGATION/FNOL - Subro/Recovery	Was the carrier and/or client consulted prior to waiving or compromising any recoveries?	18				
RESERVES	Were the initial reserves established timely? (w/in 10 business days, or within the carrier or client service commitments, whichever is stricter)	19				
RESERVES	Were the initial reserves adequate with detailed reserve rationales specific to the claim? (credit for bulk-reserving only if client-directive in CSI's)	20				
RESERVES	Were subsequent reserves adjusted timely as developments occurred? (w/in 10 business days)	21				
RESERVES	Were detailed reserve rationales documented for subsequent reserves? (including anticipated medical based on the current treatment plan)	22				
RESERVES	Were reserves established in compliance with corporate philosophy? (no stair stepping)	23				
RESERVES	Were the reserves sufficient to bring the claim to a conclusion, based on the facts of the claim at the time of review?	24				
MED & DISAB MGMT	Was a medical authorization form requested? (Yes if documented, N/A if no mention)	25				
MED & DISAB MGMT	Were pertinent medical records requested, with appropriate follow up if not received?	26				
MED & DISAB MGMT	Were the medical records regularly summarized and attached in the notes? (including date, provider name, summary)	27				
MED & DISAB MGMT	Was the medical treatment plan proactively managed? (RTW & MMI targets tracked, prompt authorization of treatment, DME, Rx requests/approvals, etc.)	28				
DOCUMENTATION - Action Plans/File Mgmt	Was an initial action plan documented within 30 calendar days, or within the carrier or client service commitments, whichever is stricter?	29				
DOCUMENTATION - Action Plans/File Mgmt	Was the initial action plan thorough and effective?	30				
DOCUMENTATION - Action Plans/File Mgmt	Was a thorough and effective action plan updated every 30-90 calendar days thereafter with appropriate follow up? (Should be able to follow the current treatment status, estimated RTW date, expected MMI date, etc.)	31				
DOCUMENTATION & ONGOING MGMT	Did the adjuster regularly complete their diaries no later than 10 calendar days?	32				
DOCUMENTATION & ONGOING MGMT	Were directions and recommendations from supervisors consistently acknowledged or acted upon?	33				
DOCUMENTATION & ONGOING MGMT	Was input sought from the supervisor/indemnity adjuster on complex or questionable issues?	34				
DOCUMENTATION & ONGOING MGMT	Did the adjuster request transfer to an Indemnity claim timely?	35				

Core Competency	Question	Question #	YES	NO	N/A	Comments
DOCUMENTATION - Ongoing Contact/ Mgmt	Was follow up contact made with the client, when appropriate, or if issues arose?	36				
DOCUMENTATION - Ongoing Contact/ Mgmt	Were the carrier instructions followed, if different/stricter than CCBP?	37				
DOCUMENTATION - Ongoing Contact/ Mgmt	Deductible Claims: Was the correct Underwriting Company (Issuing Carrier) included on all correspondence, including paper, email and State forms?	38				
DOCUMENTATION - Ongoing Contact/ Mgmt	Was the claim progressing appropriately and/or concluded effectively and timely?	39				
Mark this section as n/a for claims under \$5,000 unless supervision is required by the client.						
SUPERVISION	Once the reserves reached \$5,000, did the supervisor document an initial review within the required 30 calendar days?	40				
SUPERVISION	Was the supervisor's initial review effective, addressing all pertinent details of the claim? (mark as n/a if there was not a review)	41				
SUPERVISION	Did the supervisor review the reserves (adequacy and rationale) and provide guidance if necessary, ensuring sufficient reserves in each class based on known exposures?	42				
SUPERVISION	If the documentation was incomplete, did the supervisor direct the adjuster to finalize any missing investigation details? (coverage note, compensability statement, subrogation rationale, reserve rationale, action plans or other areas required by client on Med Only files - CRA, ISO review, investigation of relevant ISO hits, etc.)	43				
SUPERVISION	Did the supervisor direct the adjuster to update or complete any system fields that were incomplete or outdated? (2-pt- or 3-pt contact, recovery, ISO, lien, overpayment, denied, legal, coding, carrier, claim summary, etc.) ** Only if required by client on Med Only claims, otherwise N/A	44				
SUPERVISION	Did the supervisor provide appropriate guidance or direction for any claims handling deficiencies throughout the life of the claim? (incomplete initial contacts, incomplete ISO review, claim accepted without support, subrogation not pursued, medical follow up needed, overpayment/underpayments, etc.)	45				
SUPERVISION	If deficiencies were noted, did the supervisor follow up timely to ensure the claims professional executed on the provided direction?	46				
SUPERVISION	Were regular reviews completed? (maximum of every 90 days)	47				
SUPERVISION	Was the reserve adequacy and rationales reviewed with direction, if needed, throughout the life of the claim?	48				
SUPERVISION	If the supervisor diary was removed, was an adequate explanation provided?	49				

Handling Office	
Adjuster Name	
Supervisor Name	

Claimant Name	
Claim Number	
Date/Day of Loss	
Date/Day of Entry	
Date/Day Adj Assigned	
File Status (O/C)	
Date Closed	

Client	
Carrier Name	
Risk Exposure Type	
Reporting Level/Amount	
Coverage	
Jurisdiction	

Date Audited	
Auditor Name	

Days from Date Assigned:
 n/a - 10 business days
 n/a - 30 calendar days

Score	CORE COMPETENCY
n/a	COVERAGE
n/a	INITIAL CONTACT
n/a	INVESTIGATION
n/a	RESERVES
n/a	DAMAGES EVALUATION
n/a	LITIGATION MANAGEMENT & SETTLEMENT EVALUATION
n/a	CARRIER REPORTING
n/a	DOCUMENTATION & ONGOING MANAGEMENT
n/a	MINIMUM SYSTEM REQUIREMENTS
n/a	OVERALL - Claim #

n/a	SUPERVISION - Claim #
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Core Competency	Question	Question #	YES	NO	N/A	Comments
COVERAGE	Was coverage promptly documented in the log notes as a part of the initial coverage review? (within 10 business days)	1				
COVERAGE	Did the coverage analysis include the carrier name, policy number, reporting level, policy effective dates, limits of coverage, deductibles, replacement cost vs. actual cost value, sub limits, SIR limit, and any applicable endorsements? (limits of coverage above the SIR limit must be included)	2				
COVERAGE	Were potential coverage issues identified and documented in the notes within 10 business days?	3				
INITIAL CONTACT - Client	Was <u>verbal or written</u> client contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day; generic acknow not appropriate)	4				
INITIAL CONTACT - Client	If client not reached on first attempt, was client contact attempted at least every 3 business days thereafter until the client was reached?	5				
INITIAL CONTACT - Client	Was the client contact thorough and effective?	6				
INITIAL CONTACT - Client	If attempts to contact client were discontinued, was a sufficient note provided in the log notes?	7				
INITIAL CONTACT - Claimant	Was <u>verbal</u> claimant contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)	8				
INITIAL CONTACT - Claimant	If claimant not reached on first attempt, was claimant contact attempted at least every 3 business days thereafter until the claimant was reached?	9				
INITIAL CONTACT - Claimant	If verbal contact was unsuccessful, was a written follow-up sent promptly to the claimant requesting contact?	10				
INITIAL CONTACT - Claimant	Was claimant contact thorough and effective?	11				
INITIAL CONTACT - Claimant	If attempts to contact claimant were discontinued, was a sufficient note provided in the log notes?	12				

Core Competency	Question	Question #	YES	NO	N/A	Comments
INITIAL CONTACT - Witness	Were witnesses contacted/interviewed, if appropriate?	13				
INVESTIGATION	Was a description of the accident input early in the claim notes?	14				
INVESTIGATION	Were red-flag fraud indicators recognized and addressed in the investigation? (ex: multiple past claims per ISO or iCEbar, no witnesses, etc.)	15				
INVESTIGATION - ISO/Index	Was the initial ISO/Index Report generated as part of the initial investigation of the claim? (need early so can review with client/claimant during investigation if there were any pertinent hits.)	16				
INVESTIGATION - ISO/Index	Was a diary established to re-index the claim after 18 months, then every 6 months?	17				
INVESTIGATION - ISO/Index	Was the claim re-indexed after 18 months, then every 6 months?	18				
INVESTIGATION - ISO/Index	Was the ISO/Index results promptly reviewed in the log notes, with comments of whether or not any follow up was needed?	19				
INVESTIGATION - ISO/Index	If there were any relevant hits found on the ISO report, any prior injuries or prior claims, were these fully investigated?	20				
INVESTIGATION - Subrogation/ Recovery	Was sufficient subrogation, recovery, including potential third party contribution and/or risk transfers, or salvage investigation completed within 10 business days to rule out or identify recovery potential? If not, were continued efforts to gather the information evident?	21				
INVESTIGATION - Subrogation/ Recovery	Was a claim-specific subro, recovery, potential third party contribution and/or risk transfers, or salvage exposure rationale documented once this was ruled out or identified?	22				
INVESTIGATION - Subrogation/ Recovery	Were all potentially responsible parties put on notice immediately, if applicable?	23				
INVESTIGATION - Subrogation/ Recovery	Was a request for written acknowledgement from the insurance carrier(s) requested & pursued until obtained from all potentially responsible parties, if applicable?	24				
INVESTIGATION - Subrogation/ Recovery	Was follow-up on subrogation, recovery or salvage completed at a maximum every 90 days?	25				
INVESTIGATION - Subrogation/ Recovery	Were potential third party tortfeasors identified, investigated and pursued for third party contribution?	26				
INVESTIGATION - Subrogation/ Recovery	Were contractual risk transfers identified, investigated and evaluated?	27				
INVESTIGATION - Subrogation/ Recovery	If a potential contractual risk transfer existed, was a tender appropriately pursued?	28				
INVESTIGATION - Subrogation/ Recovery	Was the carrier and/or client consulted prior to waiving or compromising any recoveries?	29				
INVESTIGATION - Liability Determination	Was a sufficient investigation completed timely to determine liability? (within 30 days)	30				
INVESTIGATION - Liability Determination	If the investigation was incomplete, were continued efforts to gather the information evident? (unresolved contacts, witness statements, subro follow up, prior medical records, etc.)	31				
INVESTIGATION - Liability Determination	Was the liability statement appropriate and clear? (stated after investigation complete, specific to the claim, include the alleged cause of action and appropriate liability analysis against the client or the standard of care, when applicable)	32				
INVESTIGATION - Liability Determination	Did the adjuster document comparative or contributory negligence in the liability statement, if applicable?	33				

Core Competency	Question	Question #	YES	NO	N/A	Comments
INVESTIGATION - Liability Determination	Did the adjuster obtain, document and evaluate investigative documents to support the liability statement? ex: police report, photos, scene investigation, use of experts, etc.	34				
INVESTIGATION - Liability Determination	Were denials clearly documented in the notes, including State Specific denial language in the denial letter?	35				
RESERVES	Were the initial reserves established timely? (w/in 10 business days, or within the carrier or client service commitments, whichever is stricter)	36				
RESERVES	Were the initial reserves adequate with detailed reserve rationales specific to the claim? (credit for bulk-reserving only if client-directive in CSI's)	37				
RESERVES	Were subsequent reserves adjusted timely as developments occurred? (w/in 10 business days)	38				
RESERVES	Were detailed reserve rationales documented for subsequent reserves?	39				
RESERVES	Were reserves established in compliance with corporate philosophy? (no stair stepping)	40				
RESERVES	Were the reserves sufficient to bring the claim to a conclusion, based on the facts of the claim at the time of review?	41				
DAMAGES EVALUATION	Was the claimant or claimant's attorney questioned about prior injuries and/or claims?	42				
DAMAGES EVALUATION	If there were prior injuries, pre-existing medical conditions and/or claims noted by the claimant and/or attorney, were these fully investigated?	43				
DAMAGES EVALUATION	Was a medical authorization form requested? (Yes if documented, N/A if no mention)	44				
DAMAGES EVALUATION	Were pertinent medical records requested, with appropriate follow up if not received?	45				
DAMAGES EVALUATION	Were the medical records regularly summarized and attached in the notes? (including date, provider name, summary)	46				
DAMAGES EVALUATION	Was the adjuster proactive in obtaining/documenting the claimant's injury and treatment information?	47				
DAMAGES EVALUATION	If lost wages were claimed, were pertinent proofs requested, received, documented and evaluated in the log notes?	48				
DAMAGES EVALUATION	Were proofs of all other applicable damages requested, received, documented and evaluated in the log notes? (general damages, special damages, property damages, auto damages, loss of use, etc.)	49				
DAMAGES EVALUATION	Did the adjuster identify and evaluate unrelated and/or mitigation of damages? (unrelated medical treatment, unrelated property damages, depreciation, etc.)	50				
DAMAGES EVALUATION	Were collateral sources appropriately identified, investigated, documented and evaluated in the log notes? (other health insurance, etc.)	51				
LIT MGMT/ SETLMNT EVAL - Claimant Attorney	Was the claimant's attorney letter of representation acknowledged timely? (within 10 business days)	52				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was the file referred to a defense attorney timely? (within 3 business days)	53				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Did the assignment to a defense attorney include clear instructions and expectations? (including an overview of the claim facts, investigation to date, as well as the issuing carrier name, as applicable)	54				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was there prompt follow up for the defense attorney's initial review/evaluation if not received within 30 calendar days from referral?	55				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was legal correspondence/e-mails/documents summarized regularly and attached to the notes? (including date, attorney name)	56				

Core Competency	Question	Question #	YES	NO	N/A	Comments
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Was regular collaboration with the defense attorney evident, showing adjuster was managing the litigation plan?	57				
LIT MGMT/ SETLMNT EVAL - Defense Attorney	Did the adjuster perform all duties that could be accomplished by the adjuster rather than allowing the defense attorney to handle?	58				
LIT MGMT/SETLMNT EVAL - Budget/ Approved Atty	Deductible Claims: Was a legal budget requested? (Other policy types: do not mark down)	59				
LIT MGMT/SETLMNT EVAL - Budget/ Approved Atty	Deductible Claims: Was there continued follow up for a budget from the DA until received? (Other policy types: do not mark down)	60				
LIT MGMT/SETLMNT EVAL - Budget/ Approved Atty	Deductible Claims: Was a carrier-approved defense attorney used, if applicable? (Other policy types: do not mark down)	61				
LIT MGMT/SETLMNT EVAL - Exposure/ Settlement	Was the settlement and/or damage exposure and plans for disposition evident in the notes?	62				
LIT MGMT/SETLMNT EVAL - Exposure/ Settlement	If settling out future medical, was consideration shown for MMSEA/SCHIP submission & eligibility based on age or SSDI status, if applicable?	63				
LIT MGMT/SETLMNT EVAL - Exposure/ Settlement	Was appropriate settlement authority/concurrence obtained from the client contact and/or supervisor, if applicable?	64				
CARRIER REPORTING	If the claim meets carrier reporting requirements, was the claim reported within 30 days or per the carrier's required timeline?	65				
CARRIER REPORTING	Was the claim reported on the carrier's form (if required) and a request for acknowledgement requested?	66				
CARRIER REPORTING	Was the notice sent via email with return receipt, fax with confirmation or certified mail and documented in the notes?	67				
CARRIER REPORTING	Was a diary established for follow up every 15 calendar days until acknowledgement was received from the carrier contact?	68				
CARRIER REPORTING	Were timely follow-up reports provided to the carrier once the initial report was made? If the carrier decontrolled the file, this should be clearly shown in the notes.	69				
CARRIER REPORTING	Was reserve/settlement authority obtained timely from the carrier per their reporting requirements and documented in the notes?	70				
DOCUMENTATION - Action Plans/File Mgmt	Was an initial action plan documented within 30 calendar days, or within the carrier or client service commitments, whichever is stricter?	71				
DOCUMENTATION - Action Plans/File Mgmt	Was the initial action plan thorough and effective?	72				
DOCUMENTATION - Action Plans/File Mgmt	Was a thorough and effective action plan updated every 30-90 calendar days thereafter with appropriate follow up? (Should be able to follow the plans for disposition, current legal status, etc.)	73				
DOCUMENTATION - Action Plans/File Mgmt	Did the adjuster regularly complete their diaries no later than 10 calendar days?	74				
DOCUMENTATION - Action Plans/File Mgmt	Were directions and recommendations from supervisors consistently acknowledged or acted upon?	75				
DOCUMENTATION - Surveillance	If surveillance was used, did the assignment to the surveillance company include clear instructions/expectations?	76				
DOCUMENTATION - Surveillance	Was surveillance managed and used appropriately, if applicable?	77				

Core Competency	Question	Question #	YES	NO	N/A	Comments
DOCUMENTATION - Surveillance	Was a summary provided for surveillance reports/e-mails/documents/videos? (including date, company name)	78				
DOCUMENTATION - Ongoing Contact/ Mgmt	Was follow up contact made with the claimant, when appropriate, or as issues arose?	79				
DOCUMENTATION - Ongoing Contact/ Mgmt	Was follow up contact made with the client, when appropriate, or if issues arose? (concurrence with denials, reserves, settlement or assignment to: surveillance, attorney, etc.)	80				
DOCUMENTATION - Ongoing Contact/ Mgmt	Were the carrier instructions followed, if different/stricter than CCBP?	81				
DOCUMENTATION - Ongoing Contact/ Mgmt	Deductible Claims: Was the correct Underwriting Company (Issuing Carrier) included on all correspondence, including paper, email and settlement documents?	82				
DOCUMENTATION - Ongoing Contact/ Mgmt	Was the claim progressing appropriately and/or concluded effectively and timely?	83				
MINIMUM SYSTEM REQUIREMENTS	Were the 3-point contact fields on the Miscellaneous screen completed?	84				
MINIMUM SYSTEM REQUIREMENTS	Was the recovery tab on the Miscellaneous screen completed appropriately?	85				
MINIMUM SYSTEM REQUIREMENTS	Was the "Lien on Claim" box on the Miscellaneous screen completed, if applicable?	86				
MINIMUM SYSTEM REQUIREMENTS	Was the "Claim Denied" box checked on the Claim Edit screen, if applicable?	87				
MINIMUM SYSTEM REQUIREMENTS	Were the Claimant and Defendant tabs on the Legal screen completed, if applicable?	88				
MINIMUM SYSTEM REQUIREMENTS	Deductible Claims: Was the litigation budget amount properly entered on the Legal Screen/Defendant tab? (Other policy types: do not mark down unless required by Client)	89				
MINIMUM SYSTEM REQUIREMENTS	Deductible Claims: Were the loss type/body part/cause codes accurate for the current status of the claim? (Other policy types: do not mark down at this time)	90				
MINIMUM SYSTEM REQUIREMENTS	Were the compensable or denied body parts properly coded in the SCHIP field? (SCHIP coding required for ALL injury claims)	91				
MINIMUM SYSTEM REQUIREMENTS	Were the Carrier fields completed, if applicable?	92				
MINIMUM SYSTEM REQUIREMENTS	Did the claim summary provide a good overview of the claim? (current, concise and complete)	93				
SUPERVISION - Initial 30-day review	Did the supervisor document an initial review within the required 30 calendar days?	94				
SUPERVISION - Initial 30-day review	Was the supervisor's initial review effective, addressing all pertinent details of the claim? (mark as n/a if there was not a review)	95				
SUPERVISION - Initial 30-day review	Did the supervisor review the reserves (adequacy and rationale) and provide guidance if necessary, ensuring sufficient reserves in each class based on known exposures?	96				
SUPERVISION	If the documentation was incomplete, did the supervisor direct the adjuster to finalize any missing investigation details? (coverage note, liability statement, subrogation rationale, reserve rationale, action plans, ISO review, investigation of relevant ISO hits, etc.)	97				
SUPERVISION	Did the supervisor direct the adjuster to update or complete any system fields that were incomplete or outdated? (2-pt contact, recovery, ISO, lien, overpayment, denied, legal, coding, carrier, claim summary, etc.)	98				

Core Competency	Question	Question #	YES	NO	N/A	Comments
SUPERVISION	Did the supervisor provide appropriate guidance or direction for any claims handling deficiencies throughout the life of the claim? (incomplete investigation, claim accepted without support, subrogation not pursued, medical follow up needed, calculation errors, overpayment/underpayments, referral to vendor needed, reporting to carrier, Medicare issues, settlement evaluation, etc.)	99				
SUPERVISION	If deficiencies were noted, did the supervisor follow up timely to ensure the claims professional executed on the provided direction?	100				
SUPERVISION	Were regular reviews completed? (maximum of every 90 days)	101				
SUPERVISION	Was the reserve adequacy and rationales reviewed with direction, if needed, throughout the life of the claim?	102				
SUPERVISION	If the supervisor diary was removed, was an adequate explanation provided? (Note: Diaries cannot be removed on Deductible claims)	103				



CCMSI

Exhibit 4: Corporate Claims Handling Best Practices



Corporate Claims Best Practices

Executive Summary

This Executive Summary is intended to provide a brief, yet meaningful overview of CCMSI's general philosophies and claim handling best practices applicable to the most important components of claims management.

Our claim professionals have received extensive training and resources to confirm their understanding of these Best Practices, and are audited annually to assure compliance with them, our service commitments, and client-specific instructions.

1. First Notice of Loss (FNOL)

- All FNOLs will be date-stamped and reviewed by a qualified claim professional immediately upon receipt.
- Information contained in the FNOL will be used as the basis for the initial instructions, investigation, and reserves assigned to each file.
- EDI requirements of mandated states will be satisfied.

2. Coverage

- Coverage for every type of claim will be confirmed and documented prior to payment of any claim.
- If coverage cannot be confirmed within ten (10) business days from receipt of FNOL, claim log notes will be documented to reflect the issue and intended course of action to resolve the coverage question.
- Other carriers or parties who may have defense or indemnity obligations to our clients will be identified and pursued.

3. Initial Contact

- Workers' Compensation. On indemnity claims, contact with the employer, claimant, and medical provider will be attempted within two (2) business days from receipt of FNOL.
- Workers' Compensation. On medical only claims, the need for and type of contact with the employer, claimant, and medical provider will be at the discretion of the CCMSI claim professional. This decision will depend upon the nature and complexity of each individual claim.
- Property Damage. On first-party property claims, the insured will be contacted within two (2) business days from receipt of FNOL. On third-party claims, the insured and claimant will be contacted within two (2) business days from receipt of FNOL.
- Other Injury Claims. On all other injury claims, the insured and claimant will be contacted within two (2) business days from receipt of FNOL.
- Failed contact attempts will be followed within three (3) business days until complete or deemed that additional efforts would not be successful.
- Catastrophic Claims. On all catastrophic claims, immediate contact will be made with the employer, claimant, medical provider, and excess/reinsurance carrier, as appropriate. When appropriate, immediate assignment will also be made to a catastrophic medical case management professional.

4. Claim File Documentation

- Documentation will be meaningful, clear, and concise.
- Statutory forms will be completed accurately and timely. Log notes will be documented to show compliance with statutory or regulatory requirements.
- Adherence with all special handling requirements and client instructions will be timely. Documentation of compliance will be evident in the log notes.
- Log notes will be promptly documented with a meaningful summary of all correspondence and important information.
- A Claim Summary will be documented and periodically updated for all claims that are not medical only claims.
- Files will contain an Action Plan, which will outline the current facts of the case and the intended strategy to bring the claim to conclusion. Action Plans will be revised periodically by the claim professional as the claim progresses and new or additional information becomes available.
- All files will be managed in compliance with applicable privacy standards.

5. Investigation

- A complete investigation of each claim will be made within ten (10) business days from receipt of FNOL.
- Each investigation will be thorough enough to justify acceptance or denial of liability or compensability on behalf of our clients.
- Workers' Compensation. Compensability determination will be made within ten (10) business days from receipt of FNOL. If this guideline cannot be met, appropriate documentation and action plan is required.
- Property/Casualty. Liability determination will be made within thirty (30) business days from receipt of FNOL. If this guideline cannot be met, appropriate documentation and action plan is required.
- All claims involving subrogation, salvage, or SIF potential will be investigated, acted upon, monitored, and documented by the claim professional.
- All claims will be monitored for possible fraud. If applicable, claims will be handled in compliance with state fraud requirements and/or referred to CCMSI's Special Investigation Unit, *FRAUD IDENTIFICATION RECOVERY EDGE (FIRE)*.
- All indemnity and third-party injury, fraud, and high-loss property claims will be indexed upon initial receipt of the FNOL. Workers' Compensation claims and BI-type liability claims will receive auto index updates for the first year and open claims will be re-indexed every six (6) months until the claim is settled or closed. Other Property / Casualty claims listed above will be indexed upon receipt and re-indexed every six (6) months until the claim is settled or closed. Indexing will be in compliance with all applicable federal requirements.
- All WC indemnity claims will have a claim risk assessment completed and a risk assessment score as low, moderate, or high. The claim will indicate a reason if the claim risk assessment will not be completed.

6. Reserve Philosophy

- All claims will carry reserves that reflect the expected financial result of each claim. The expected financial result will be factually based and reflect the total probable payment obligation of our client.
- An initial reserve will be established within ten (10) business days from receipt of FNOL.
- Reserves will be adjusted within ten (10) business days of the claim professional receiving new information that materially changes the exposure of the claim. Some examples of new information

that may require a reserve change include a change in the claimant's medical condition, TTD benefits being extended longer than expected, permanency factor changes, claim resolution strategy changes, etc.

- The adequacy of reserves will be reviewed every thirty (30) to ninety (90) days at each adjuster and supervisor diary.
- Upon reserve changes, the log notes will be documented with the information and rationale for the change.

7. Medical & Disability Management

- Our claim professionals will facilitate the earliest possible return to work or maximum medical recovery.
- Transitional work opportunities will be vigorously pursued with the employer and medical provider.
- All appropriate value-added medical case management services will be utilized in order to promote quality care, achieve optimum utilization of services, and avoid any unnecessary, inappropriate, or duplicate services or costs. The claim file will reflect a proactive and continuous effort to confirm that medical treatment being rendered or recommended is appropriate for the injury.
- Medical records will be secured throughout the life of the file to support bill payments and justify temporary total disability payments.
- Log notes will be updated on a regular basis to document the claimant's diagnosis, prognosis, medical treatment plan, and return-to-work strategy.
- Our claim professionals will schedule and coordinate Independent Medical Exams with a physician in the appropriate specialty. Timely written notification will be issued to the claimant and assigned physician.
- Our claim professionals will utilize aggressive managed care and cost containment strategies and techniques to mitigate our client's medical costs in conjunction with CCMSI's managed care program, *Comp MC™*.

8. Claim Supervision

- Claim files will reflect meaningful supervisor involvement pursuant to the claim professional's skill and authority level.
- Initial and follow-up supervisory instructions will reflect guidance and specific directions to the claim professional commensurate with claim complexity and skill level of the claim professional.
- Supervisors will carry diaries commensurate with the complexity of the claim and skill level of the claim professional.

9. Claim Payments

- All bills will be reviewed and approved by the designated claim professional within ten (10) business days from receipt.
- All appropriate bills will be paid within thirty (30) business days from receipt unless there is a dispute, pending investigation, or additional information is needed.
- TTD and PPD payments will be made timely in accordance with jurisdictional requirements.
- A summary of each indemnity payment will be automatically generated to the claim notes.
- Payments will be made in strict compliance with authority levels agreed upon with the client.
- Internal security will exist that prohibits a single claim professional from approving, executing, and releasing payment of the same bill.
- All overpayments will be noted in the misc. screen until fully recovered.

10. Litigation Management

- Our claim professionals have ultimate accountability for all litigation activities.
- Our claim professionals will direct and monitor defense counsel activities.
- Legal bills will be closely reviewed to confirm charges are appropriate and substantiated before payment.
- Our claim professionals will maintain regular contact with the claimant's attorney to achieve a prompt resolution of the claim.
- Our claim professionals will discuss and develop a defense strategy plan with defense counsel and update this plan when the situation dictates a change.
- When appropriate, a defense budget for costs and expenses will be developed and updated.
- On appropriate cases, arbitration or mediation will be utilized in an effort to save costs and achieve prompt settlements.

11. Carrier Reporting

- Claims that meet carrier reporting criteria will be reported timely in compliance with established requirements.
- After initial reporting, our claim professionals will provide periodic updates to the carrier as the claim develops.
- Our claim professionals will work closely with designated claim professionals from carriers to achieve a prompt and appropriate resolution to applicable claims.
- Specific and aggregate recoveries will be obtained from appropriate carriers in compliance with policy terms.

12. Fraud/SIU

- All potential fraud issues must be documented in log notes.
- When fraud indicators are present, the designated claim professional shall consider a referral to CCMSI's fraud program, *FIRE* (Fraud Identification Recovery Edge).

13. Medicare Compliance

- Our claim professionals are responsible for compliance with Mandatory Insurer Reporting (MIR) and Medicare Secondary Payer (MSP) compliance.
- Medicare Query Function (MQF) is performed immediately on all workers' compensation claims to determine Medicare eligibility. The MQF is performed on all liability claims upon verification and receipt of the mandatory *Big Five* data elements.
- All claims meeting the Mandatory Insurer Reporting criteria will be reported quarterly under the appropriate RRE.
- Adjusters will conduct Conditional Payment Research (CPR) and satisfy any related Medicare liens prior to any settlement, judgment, or award.
- Prior to any settlement on all cases involving a Medicare beneficiary, adjusters will determine judgment or award if Medicare has a legitimate secondary payer interest. Where Medicare has an interest as the secondary payer, the adjuster is responsible for demonstrating Medicare's interest was considered.



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Exhibit 5: Banking Options



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CCMSI BANKING OVERVIEW

An overview of banking and funding of client claim escrow accounts

BANKING OPTIONS

CCMSI Clients may choose one of the following banking options for claim payments.

- CCMSI Preferred Escrow
- CCMSI Managed Escrow
- Client Owned Escrow

CCMSI PREFERRED ESCROW

Multi-Employer Account, but all transactions will be uniquely identified to the Client and all analysis and reporting will be at the Client level.

Account is structured to ensure claim payments are in compliance with timelines imposed by various state regulations. CCMSI is responsible for fines and penalties resulting from late payments.

Account is at Bank of America, includes Payee Positive Pay protection and Overdraft protection

Account will have CCMSI's FEIN

Streamlined new client setup – no signature cards, test checks, etc.

Account will be managed via on-line banking within CCMSI's Treasury Department internal control structure

CCMSI prints and issues checks daily for approved claim payments

CCMSI is responsible for preparation of the monthly bank reconciliation and assisting with state escheatment requirements

Client will incur no bank charges (except wire fees) nor receive interest earnings

Client is responsible for appropriate funding of account

CCMSI MANAGED ESCROW

Individual Employer Account

Account is structured to ensure claim payments are in compliance with timelines imposed by various state regulations. CCMSI is responsible for fines and penalties resulting from late payments provided adequate funding is available from Client.

Account is at Bank of America, includes Payee Positive Pay protection

Account will have CCMSI's FEIN

Account will be managed via on-line banking within CCMSI's Treasury Department internal control structure

CCMSI is responsible for preparation of the monthly bank reconciliation and assisting with state escheatment requirements

Client is responsible for appropriate funding of account

CCMSI prints and issues checks daily for approved claim payments provided adequate funding is available from Client. If claim payments exceed imprest balance for a particular funding period, checks WILL NOT be printed until funding is received.

Client is responsible for all bank charges

CLIENT OWNED ESCROW

Client provides Account for claims payments.

Account will have Client's FEIN

Positive Pay data files can be supplied to client bank upon request.

Client is responsible for fines and penalties resulting from late payments. CCMSI issues either checks or vouchers for approved claim payments per timelines prescribed by Client.

Client is responsible for preparation of the monthly bank reconciliation and compliance with state escheatment requirements (CCMSI will provide the appropriate banking reports to assist the client)

Client is responsible for appropriate funding of account

Client is responsible for all bank charges, if applicable

INSURANCE CARRIER ESCROW

This claim escrow alternative is limited to Large-Deductible type accounts with carriers that impose specific banking requirements.

Individual Employer Account

Account is structured to ensure claim payments are in compliance with timelines imposed by various state regulations. CCMSI is responsible for fines and penalties resulting from late payments provided adequate funding is available.

Account is at Bank of America, includes Payee Positive Pay protection and Overdraft protection

Account will have CCMSI's FEIN

Account will be managed via on-line banking within CCMSI's Treasury Department internal control structure

CCMSI prints and issues checks daily for approved claim payments provided adequate funding is available

CCMSI is responsible for preparation of the monthly bank reconciliation and assisting with state escheatment requirements

Client will incur no bank charges (except wire fees) nor receive interest earnings
CCMSI is responsible for coordination of funding of account with appropriate carrier

Carrier is responsible for appropriate funding of account

FUNDING

The Initial Escrow Deposit (Imprest) is calculated by Treasury Funding based on 1.5 times the average paid claims, funding frequency (daily, weekly monthly), and funding method (ACH, wire, check).

Treasury Funding will request Advance Funding for large settlements (\$50,000, or other amount specified by Client).

Funding invoices will be invoiced in arrears based on check registers. **Funding invoices are due prior to end of succeeding funding period. Client must maintain good payment status. Failure to pay funding invoices timely may require an Escrow Deposit increase or account type change.**

Required Escrow Deposit will be reviewed annually or if the client balance goes negative more than three months. Adjustments to the Escrow Deposit will be included on the next funding invoice.

ACH is the preferred method for funding. Each wire transfer will result in a \$9.45 fee to Client included on the monthly funding invoice, regardless of bank account type.

TREASURY/BANKING CONTROLS

Segregation of Funds: Clients electing the Preferred Escrow account structure are part of a multi-employer account at Bank of America. Each Client has a subaccount within the overall account that is unique to the Client and all analysis and reporting is at the Client level.

Positive Pay: All Preferred Escrow, Managed Escrow and Insurance Carrier Escrow accounts are protected by Payee Positive Pay to prevent fraud. Positive Pay files are generated from CCMSI's claims system and sent to the bank daily. Daily a CCMSI Accountant (separate from the assigned Funding Accountant) reviews any positive pay rejections.

Segregation of Duties: Clients are assigned to a Funding Accountant. The Funding Accountant is responsible for the day to day oversight of the Client's account(s) and the monthly reconciliation. The Treasury Manager oversees the day to day functions of the Funding Accountants.

Deposits: Funding deposits received by CCMSI are monitored by the Funding Accounts Receivable Accountant who is responsible for monitoring and posting all deposits received. Deposits are recorded in our Accounting Accounts Receivable system and into our claim system.

Disbursements: Disbursements from the claim account are handled by CCMSI's Treasury Check Printing Team. This team is responsible for printing all checks and reports per the Client's specifications.

Monthly Reconciliations: Monthly the assigned Funding Accountant will reconcile all bank statements to the claims system transaction reports. Client is provided a copy of the reconciliation. The Treasury Manager reviews and approves all bank reconciliations and meets monthly with the Corporate Controller and Chief Financial Officer to review the status of bank reconciliations and escheatment requirements.

Escheatment: CCMSI will review outstanding checks monthly. Any checks uncashed after 8 months will be investigated with the claim staff. Due diligence letters will then be sent to the payees. Based on response to due diligence letters, checks will be void/reissued or voided and provide to the Client to include in their own due diligence filings.

REPORTS

You will receive the following reports via email:

Funding Reports - Included With Funding Invoice: See Exhibit 1 for example.
Transaction Register Report in Standard form. (customized reports available upon request)

Bank Reconciliation Reports - Monthly: See Exhibit 2 for example.

- Bank Reconciliation
- Bank Statement
- Outstanding Check/VPayment Lists
- Bank Account Register Report

REPORTS: EXHIBIT 1



CCMSI
2 E. Main Street
Danville, IL 61832
Phone 217-446-1089

Invoice No. 010917

Name: ABC COMPANY
Address: 1 Main St.
Danville, IL 61832

Invoice Date: 12/31/2016
Due Date: Upon Receipt

QTY	Description	Claim Number	TOTAL
	Funding for payments issued from 12/01/16 – 12/31/16		\$ 540.00

Check #	Claimant	Claim Number	Claim Type	Date of Loss	Issue Date	Transaction Type	Comments	Trans Amount
Bank Account: ABC COMPANY Account # Ending with 2222								
1018	Smith, John	01U02L126028	Indemnity	11/1/2014	12/2/2016	MEDICAL WC	Check Voided by Adjuster	(\$19.00)
Check: 1018								Total: (\$19.00)
1024	Doe, Jane	01U02L126028	Indemnity	12/3/2015	12/2/2016	MEDICAL WC	Check Voided by Adjuster	(\$125.00)
1024	Doe, Jane	01U02L126028	Indemnity	12/3/2015	12/2/2016	INDEMNITY WC	Check Voided by Adjuster	(\$500.00)
Check: 1024								Total: (\$625.00)
1027	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC	Check Voided by Adjuster	(\$25.00)
1027	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC	Check Voided by Adjuster	(\$121.00)
1027	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC	Check Voided by Adjuster	(\$13.00)
1027	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC	Check Voided by Adjuster	(\$25.00)
Check: 1027								Total: (\$184.00)
50500545	Doe, Jane	01U02L126028	Indemnity	12/3/2015	12/5/2016	MEDICAL WC		\$1,000.00
Check: 50500545								Total: \$1,000.00
50500546	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC		\$26.00
50500546	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC		\$50.00
50500546	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC		\$50.00
50500546	Smith, John	01U02L129219	Indemnity	11/1/2014	12/5/2016	INDEMNITY WC		\$242.00
Check: 50500546								Total: \$368.00
Totals:			# Transactions:	12				
			# Checks:	3				
			# Epayments:	0				
			# Vouchers:	0				
			# Claims:	2				
			Total Trans Amt:	\$540.00				
Report Totals:			# Transactions:	12				
			# Checks:	3				
			# Epayments:	0				
			# Vouchers:	0				
			# Claims:	2				
			Total Trans Amt:	\$540.00				

PAYMENT INSTRUCTIONS

If initiating a Wire or ACH, please send to the following:

Bank Name: Bank of America
Routing Number: 071000039 ACH
Routing Number: 026009593 Wire
Account Number: 123456789
Account Name: CCMSI
Other Beneficiary Info: ABC COMPANY

If submitting a Check, please send to the following:

CCMSI
Att: Treasury Department
2 East Main St., Suite 208
Danville, IL 61832

REPORTS: EXHIBIT 2

CCMSI ACCOUNT RECONCILIATION FOR ABC COMPANY 123456789 31-Dec-16			
Bank Balance:			\$ 35,000.00
Outstanding Checks:			(5,540.00)
Outstanding Items:			
Adjusted Bank Balance:			\$ 29,460.00
Fund Balance:			\$ 29,460.00
Outstanding Deposits:			
Outstanding Items:			
Adjusted Fund Balance:			\$ 29,460.00
Adjusted Fund Balance:			\$ 29,460.00
Outstanding Items:			
	12/31/2016	December Claims Funding	540.00
Imprest Balance			\$ 30,000.00
			\$30,000.00

ABC COMPANY O/S CHECKS 12/1/16 - 12/31/16			
CHECK #	PAYEE	DATE	AMOUNT
1003	BACK CARE, INC	11/1/2016	3,382.00
1009	JOHN SMITH	11/15/2016	184.00
1015	JOHN SMITH	11/25/2016	184.00
1017	JANE DOE	11/28/2016	625.00
1025	ALIGN NETWORKS	11/29/2016	1,165.00
			5,540.00

Check #	Payee Name	Tran Date	Type	Check Amt.	Tran. Amt.
			Initial Balance:		\$25,000.00
	Bank Account: ABC COMPANY		Account # 123456789		
	SEPT 16 REPLENISHMENT	12/30/2016	Deposit		\$1,000.00
	OCT 16 REPLENISHMENT	12/30/2016	Deposit		\$2,000.00
	NOV 16 REPLENISHMENT	12/30/2016	Deposit		\$2,000.00
1018	BACK CARE, INC	12/2/2016	Check	(\$19.00)	
1024	JANE DOE	12/2/2016	Check	(\$625.00)	
1027	JOHN SMITH	12/5/2016	Check	(\$184.00)	
50500545	BACK CARE, INC	12/5/2016	Check	\$1,000.00	
50500546	JOHN SMITH	12/5/2016	Check	\$368.00	
Account Totals:	Checks: 3	Transactions: 5	EPayments: 2	\$540.00	\$5,000.00
			Ending Balance:		\$29,460.00

CCMSI CLIENT BANKING SET UP FORM

We will email you a form for you to complete. This form will indicate which escrow account type has been selected in addition to other set up details.

Please return to Marcie Bostwick mbostwick@ccmsi.com once completed so account set up can move forward.

CCMSI CLIENT BANKING SET UP FORM

PLEASE COMPLETE AND RETURN TO MBOSTWICK@CCMSI.COM

COMPANY NAME	
COMPANY ADDRESS	
FEDERAL TAX ID	
PRIMARY FUNDING CONTACT: Name, Title, Phone, Email SECONDARY FUNDING CONTACT: Name, Title, Phone, Email	
COMPANY NAME TO APPEAR ON CHECKS	CCMSI OBO _____
CLAIM ACCOUNT TYPE: Preferred: Full Service Preferred Escrow Other Available Options: Managed Escrow, Client Owned	
FUNDING FREQUENCY: Preferred: Monthly Other Available Options: Daily, Weekly	
PAYMENT MODE: Available Options: ACH, Check, Wire	
CLIENT OR CCMSI INITIATED IF ACH	
If CCMSI Initiates The ACH Please Provide The Following: <ul style="list-style-type: none"> • Funding Bank Name • Funding Bank Address • Funding Bank Account Number • Funding Bank Contact 	
Checks print and mail daily. If Other Arrangements Are Requested, Please Describe Here And Our Treasury Check Printing Supervisor Will Contact You For Further Discussion.	

CLIENT INFORMATION

Contact Marcie Bostwick with any questions or to set up an account.

Treasury Funding Manager: Marcie Bostwick, 217.444.1171 mbostwick@ccmsi.com



CCMSI

Exhibit 6: Implementation Overview & Plan





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New Client Notification

Please send the following information in an email to implementationteam@ccmsi.com

1. Client Name:
2. Effective date CCMSI will start handling business:
3. Estimated Revenue:
4. Is this a Multi-state client?
5. Policy type(s) to be serviced:
6. Conversion- yes or no:
7. Who is the current TPA?
8. Has the TPA been notified?
9. Current Carrier or Carriers:
10. Current Broker name and firm :
11. If CCMSI is handling run off claims, who are the Carriers on those claims?
12. Will the client be using Comp Mc for Bill Review and or Rx card services? if so please provide sold pricing
13. If you are not the acting Acct Manager, please identify who will be?

Phase 1 (Most Urgent)

Please send the following information in an email to CastRegionalCoordinator@ccmsi.com

General Information

1. Legal Business Name
2. Legal Corporate Address, City, State, Zip Code
3. FEIN Number
4. States of operations
5. Current Loss Run - preferably in Excel
6. Services CCMSI will be handling
7. Client Contact Information: Name, address, phone numbers, email address, and job title

RRE Setup

If the client has SIR or Fully Self-Insured policies, the client must complete an RRE application with CMS. Otherwise the client can use the carrier's RRE (information in carrier section below). See RRE Setup Document at <O:\CSU\Implementation\Implementation Docs> for AMs for more detail.

1. Client must select an Authorized Representative (must be a client employee)
2. The client (Authorized Rep) must register a new application on the cms website
3. Client must provide PIN and assigned RRE ID to CCMSI Compliance Dept (compliance@ccmsi.com)
4. Client must review, sign and return the profile report to the CMS EDI Representative, with a copy to compliance@ccmsi.com

Phase 1 (Most Urgent) Continued

Insurance Carrier

Send information to Castpolicy@ccmsi.com

1. Forward contact information for your current broker, including email, phone, and address
2. Policy info for claims years in which we will be handling including:
 - Policy Year(s)
 - Policy number
 - Carrier name and contact information (including email)
 - Address
 - Retention and policy type, i.e. deductible, SIR, dollar one, fully self-insured
3. Please provide a copy of all insurance policies for each policy period and coverages for which we will be handling claims.
4. Please provide RRE/CMS contact information at Carrier or a copy of the Carrier's RRE profile, if available. Contact CAST Policy to verify if RRE is already on file for a specific carrier.
5. Some carrier require 60, 90, or 120 day notice of change in TPA. Has the Carrier been notified of CCMSI as the new TPA? Is the notification timely?
6. If conversion, has the Carrier been notified? And timely?

Data Conversion

If CCMSI is handling take over files, provide the following information to carrierteam@ccmsi.com.

1. List TPA's we will be converting data from? 2. Point of contact with prior TPA(s)
3. Is it WC and/or liability?
4. Volume of takeover claims - Total and Open
5. Are image files coming over?

Banking

Send information to Marcie Bostwick, Treasury Manager / mbostwick@ccmsi.com

1. Please provide contact information for the individual with whom we will need to set up the loss fund banking account.
2. Please provide dollar amount paid for claims during past 12 months.

Client Information Request

Phase 2

General Information

Send information to CastRegionalCoordinator@ccmsi.com

1. Location listing including address for all locations
 - Please provide a hierarchy for reporting purposes with all locations, divisions etc, structured on how you want your reports formatted
 - Provide copies of all current RMIS reports
 - Please identify any additional reporting requirements
2. Please provide list of any attorneys you wish us to utilize
3. SIC numbers and/or NAICS
4. Unemployment ID numbers
5. Carrier or Self-Insured Number for each state (EDI and State purposes)

Insurance Carrier

Send information to CastRegionalCoordinator@ccmsi.com

1. Collect and provide claim reporting guidelines of the Carrier to CAST Regional Coordinator who will provide to CAST Policy, Carrier Team, and Claims Team.
2. Incorporate Carrier reporting guidelines into Client Servicing instructions

Information Technology

Send information to CastRegionalCoordinator@ccmsi.com

1. Walk through system setup/client service instructions - Client Overview (what do they do), Claim Intake, Reserve Approvals, Settlement Authority, Reimbursements, Bill Review, Pharmacy, Claim Extracts, Reports, Special Requests, etc.
2. For each of the users please identify their access level
 - Claim input ability only: yes or no
 - Full viewing of all divisions and locations or limited to specific division or locations? If so please list division, locations to which they should have access
3. How many people will need access to the system?
4. For each of the desired users please provide their name, email and phone number.
5. Are there any special data services we will be handling?
 - Export data requirements.
 - HR Feed intake.
6. Reports - Please provide copies of any reports you currently receive that you wish to receive from CCMSI. Please also provide indications of additional reports you would like to receive that you do not currently receive with a listing of fields, formats and structure.

OR, CCMSI can generate its normal month end reports and after reviewing these upon the first month end, you can determine if you want additional supplemental reports.

Client Information Request

Phase 2 Continued

Reports

The following reports will automatically be setup for your client during implementation and will appear on the Account Managers tab in MyReports:

- New WC Claims Last 7 Days - if daily is required, we can set up
- Loss Run All Claims
- Reimbursement Status Report - Over SIR/DED
- Transaction Register
- Incurred deductible/Retention detail
- Paid deductible retention report

Additional MyReports assistance is available:

- Email ClaimsReportFileRequest@ccmsi.com
- Include requirements or samples of report needing assistance with.

**Note all reports setup by Customer Service are transferred to the Account Manager id to maintain.*

Managed Care Services

If CompMC please send the following information to selliott@ccmsi.com

1. Rates for Bill Review (Fee Schedule/Usual & Customary Reductions)
2. Rates for PPO Reductions
3. Rates for Nurse Audit Review/Negotiations/Out of Network Specialty Repricing
4. A client location listing of states and any certified managed care programs currently being used (i.e. Texas HCN, California MPN, Illinois PPP)
5. Rates for Drug Card Program
6. Drug Card Activation Set Up - Manual by Adjuster or Automatic Upon Claim Opening
7. First Fill Card Contact Information

If not CompMC, please send the following information to CastRegionalCoordinator@ccmsi.com

1. Please provide the list of any outside firms you wish us to utilize for Nurse Case Management, UR, Voc Rehab etc.
2. Do you wish to issue a temporary Prescription card to injured workers' at the time the claim is reported? Yes or No
3. Please provide the contact information for all preferred medical providers including FEIN.

Client Information Request



Sample Implementation Plan

Stand Alone Client Implementation Plan					
Takeover Date: 7/1/2020					
Task	Start Date	Deadline	Completed	Owner	Status
Contract					
First contract draft				Client, SAE	
Revisions				Client, SAE	
Final draft distributed				Client, SAE	
Signatures				Client, SAE	
Information Requests					
Submit information request to client				SAE	
Contact current TPA submit information request				SAE, AM	
Broker name and Firm				Client	
Client to return Phase 1 Information				Client	
Client to return Phase 2 Information				Client	
Meetings/Communications					
Internal planning meeting				SAE, AM	
Create Implementation Plan				SAE	
Complete Client Profile				AM	
Set all client implementation meeting dates				AM, Client	
Follow up Implementation meetings schedule				SAE	
Site visits				AM	
Client/Broker to notify Excess carrier of TPA change				Client	
Client to notify all states of TPA change				CCMSI/Prior TPA	
Client notification to vendors, claimants, etc.				Client	
Final Implementation issues resolved				SAE, AM	

Sample Implementation Plan

Stand Alone Client Implementation Plan					
Takeover Date: 7/1/2020					
Task	Start Date	Deadline	Completed	Owner	Status
Staffing Plan					
Review staffing model				AM	
Service Team contact and distribute to client				AM	
Training of New Staff / Toolbar/ QSP/Best Practices				AM	
Quality Service Plan (QSP's)					
Create and send initial draft of QSP to client				AM	
QSP meeting				AM	
QSP finalized and distributed to client, internally				AM	
QSP Internal training				AM	
IT Implementation					
CCMSI Data Import/Export Transfer					
HR Feed				Client,AM	
Claim Input				Client,AM	
Claim Extract				Client,AM	
Infomational Documents Needed					
All WC & Liability Policies, Current and Prior				Client,AM	
Current Loss Run in Excel Format				Client,AM	
RRE Information if SIR policies				Client,AM	
Historical Data					
Notify IT and initialize set up				SAE, AM	
Initial contact prior TPA				AM	
Establish data conversion timeline				AM, IT	
Secure test data/mapping information from prior TPA				AM, IT	
Final live data feed from Prior TPA				AM, IT	
Complete final upload				AM, IT	

Sample Implementation Plan

Stand Alone Client Implementation Plan					
Takeover Date: 7/1/2020					
Task	Start Date	Deadline	Completed	Owner	Status
iCE Setup					
Review Client reporting needs				Client, AM, CSU	
Establish Policyholder Hierarchy				Client, AM, CSU	
Establish all codes to be used				Client, AM, CSU	
Establish client and internal ICE Login/passwords				Client, AM, CSU	
Finalize how to report a policyholder claim				Client, AM, CSU	
Client Training/Communication				Client, AM, CSU	
Reporting					
Client to provide list of standard reports / timeframes				Client, AM	
Create reporting requirements				AM	
Stewardship Report Requirements				Client, AM	
Develop any excess carrier data feeds				AM	
Claim File Transition					
Establish prior TPA cut off date				AM, Prior TPA	
Transfer plan developed for open physical files				AM, Prior TPA	
Actual physical file transfer				AM, Prior TPA	
Develop storage plan for closed files				AM	
TPA Change letter with checks to claimants				AM	
TPA Change letter to providers				AM	

Sample Implementation Plan

Stand Alone Client Implementation Plan					
Takeover Date: 7/1/2020					
Task	Start Date	Deadline	Completed	Owner	Status
Medical Management					
Notify comp mc and initialize set up, other than CompMC, Vendor information needed				AM	
Establish bill review cut off date				Prior TPA	
Client to provide list of all preferred medical providers				Client	
PPO Network mapping and establishment				AM	
Pharmacy set up				AM	
Coordination of Vendors					
Review and discuss workflow with 1-800 call in/triage provider				Client, AM	
Client to provide list of approved attorney's				Client, AM	
Client input on list of NCM, Surveillance, Outside Adj etc				Client, AM	
Determine if Client wants to utilize Bottomline - Legal Exchange				Client, AM	
Communicate to Vendor's of the change, follow up letter				Client, AM	

Client Information Request



Sample Implementation Plan

Stand Alone Client Implementation Plan					
Takeover Date: 7/1/2020					
Task	Start Date	Deadline	Completed	Owner	Status
Bank Account					
Finalize client funding arrangement				AM	
Fund account				Client	
Invoicing					
Forward contract to accounting				AM	
Establish invoicing protocol				Client, AM	
Invoice take over fees				AM	
Initial Invoice				AM	
Data Conversion Invoice				AM	
Other					
SAE - Senior Account Executive					
AM - Account Manager					
Client - Captive/PEO					
UW - CCMSI Underwriting					
CSU - CCMSI Customer Service Unit					
CCMSI Treasury					



Office of the Secretary of State

CERTIFICATE OF AUTHORITY OF

Cannon Cochran Management Services Inc.
Filing Number: 800331498

The undersigned, as Secretary of State of Texas, hereby certifies that an application of the above named corporation for a Certificate of Authority to transact business in this State under the Texas Business Corporation Act has been received in this office and has been found to conform to law.

ACCORDINGLY, the undersigned, as Secretary of State, and by virtue of the authority vested in the Secretary by law, hereby issues this Certificate of Authority to transact business in this State from and after this date for the purpose or purposes set forth in the application under the name of

Cannon Cochran Management Services Inc.

Dated: 04/19/2004

Effective: 04/19/2004



A handwritten signature in black ink, appearing to read "G. Connor".

Geoffrey S. Connor
Secretary of State

Texas Department of Insurance Certificate of Authority

Licensed as Third Party Administrator
License no. 2989674

Licensed since: 11-09-2007

Department Certification issued to:

CANNON COCHRAN MANAGEMENT SERVICES INC
Organized under the laws of Delaware

This entity has complied with the laws of the state of Texas applicable to the licensing of Third Party Administrators and is hereby authorized in accordance with **TEX. INS. CODE, Chapter 4151** to transact the business of:

ADMINISTRATOR

This certificate of authority is in full force and effect until it is revoked, canceled, or suspended according to law.

Given under my hand and official seal of office
in the city of Austin,

April 20, 2023

CASSIE BROWN
COMMISSIONER OF INSURANCE

BY


John Carter, Director

Company Licensing and Registration
Financial Regulation Division
Commissioner's order no. 3632



SERVICE AGREEMENT BETWEEN
_____ AND
CANNON COCHRAN MANAGEMENT SERVICES, INC.

THIS SERVICE AGREEMENT is made and entered into this ____ day of _____, 20__, by and between _____ (the "Client"), and Cannon Cochran Management Services, Inc. ("CCMSI"), a Delaware corporation. It is agreed between the parties hereto as follows:

- A. APPOINTMENT OF CCMSI.** The Client hereby appoints CCMSI, and CCMSI hereby agrees to serve, as Third Party Administrator ("Administrator") of the Client's insurance program as described within Exhibit A Fee and Payment Schedule ("Exhibit A"). All functions of CCMSI shall be performed until **[termination of this Agreement ("Life of Agreement") / closure of all claims that occur during the period of this Agreement ("Life of Claim")]**
- B. FUNCTIONS OF CCMSI.** During the term of this Agreement, the regular functions of CCMSI as the Client's Administrator shall include the following:
1. Claim Administration.
 - (a) Claim Management and Administration. In compliance with its Best Practices, CCMSI will manage and administer all claims of the Client that occur during the period of this Agreement. All claim payments shall be made with Client funds. CCMSI will act on behalf of Client in handling, monitoring, investigating, overseeing and adjusting all such actual and alleged claims.
 - (b) Claim Settlement. CCMSI will settle claims of the Client with Client funds.
 - (c) Claim Reserves. CCMSI will establish reserves for unpaid reported claims and unpaid claim expenses.
 - (d) Allocated Claim Expenses. CCMSI will pay, at market rates, all Allocated Claim Expenses with Client Funds. Allocated Claim Expenses are charges for services provided in connection with specific claims by persons or firms which are eligible claim expenses under the Client's program. Notwithstanding the foregoing, Allocated Claim Expenses will include all expenses incurred in connection with the custody, investigation, adjustment, settlement or defense of Client claims, even if such expenses are incurred by CCMSI. Allocated Claim Expenses will include, but not be limited to, charges for:
 - 1) Independent medical examinations of claimants;
 - 2) Managed care expenses, which may include the services provided by comp mc™, CCMSI's proprietary managed care program;
 - 3) Fraud detection expenses, which may include the services provided by FIRE, CCMSI's proprietary Special Investigation Unit (SIU), and other related expenses associated with

the surveillance, detection, reporting and prosecution of fraudulent claims, including legal fees;

- 4) Attorneys, experts, and special process servers;
- 5) Court costs, fees, interest and expenses;
- 6) Depositions, court reporters and recorded statements;
- 7) Independent adjusters and appraisers;
- 8) Index bureau and OFAC (Office of Foreign Assets Control) charges;
- 9) MMSEA/SCHIP compliance charges;
- 10) Electronic Data Interchanges (“EDI”) charges if required by state law;
- 11) CCMSI personnel, at their customary rate or charge, but only with respect to claims outside the state of their assigned office and only if such customary rate is communicated to the Client prior to incurring such cost;
- 12) Actual reasonable expenses incurred by CCMSI employees outside the state of their assigned office for meals, travel, and lodging in conjunction with claim management;
- 13) Police, weather and fire report charges that are related to claims being administered under Client’s program;
- 14) Charges associated with accident reconstruction, cause and origin investigations, etc.;
- 15) Charges for retrieval of medical records, personnel documents, and other documents necessary for adjudication of claims under Client’s program;
- 16) Charges associated with Medicare Set-Aside Allocations and other related MSP Services;
- 17) Legal bill review expenses, which include the services provided by CLEAR, CCMSI’s proprietary legal bill review program;
- 18) Other expenses normally recognized as Allocated Loss Adjustment Expenses (“ALAE”) by industry standards.

- (e) Subrogation. CCMSI will monitor claims for subrogation.
 - (f) Provision of Reports. CCMSI will provide reports to the Client as mutually agreed upon by the parties.
 - (g) Service Plan. CCMSI will cooperate with the Client in the drafting and periodic revision of a Quality Service Plan (QSP), claim handling instructions, or similar document if applicable that contains claim handling instructions, a schedule of reports, and other details of Client's insurance program as mutually agreed upon by the parties. The document shall be maintained in CCMSI's iCEBAR software application.
2. CLEAR Legal Bill Review Services. CCMSI will provide the Client with CLEAR Legal Bill Review Services upon mutual agreement of the parties and in exchange for payment of the applicable CLEAR fees stated in Exhibit A. The CLEAR Legal Bill Review Services shall include:
- (a) Audit of all legal invoices submitted by Client-approved law firms for adjudication in compliance with Client's Defense Counsel Billing Guidelines and generally accepted legal billing principles;
 - (b) Generation of an analysis report for each legal invoice reviewed. The report will be included with each check to the appropriate law firm and include details and supporting documentation for any deductions applied to the original billing; and
 - (c) Generation of periodic standard reports summarizing Client's overall savings results with metrics to analyze individual law firm performance.
3. comp mc™ Managed Care Services. CCMSI will provide the Client with comp mc™ managed care services upon mutual agreement of the parties and in exchange for payment of the applicable comp mc™ fees stated in Exhibit A. The comp mc™ Managed Care Services may include but not be limited to usual and customary medical bill re-pricing, state fee schedule medical bill re-pricing, preferred provider organization medical bill re-pricing, specialty medical and hospital bill negotiation, medical bill state reporting, pharmacy network services, field case management services, telephonic case management services, utilization review services, nurse triage services, and First Notice of Loss reporting services.
4. MMSEA/SCHIP Compliance Services. CCMSI, in conjunction with its reporting agent/MSP vendor, will comply with applicable MMSEA and Section 111 reporting requirements on behalf of the Client in exchange for payment of the applicable MMSEA/SCHIP fees stated in Exhibit A and conditioned upon Client's provision of an active Responsible Reporting Entity Number and written authority for CCMSI to report data on Client's behalf. The MMSEA/SCHIP Compliance Services shall include:
- (a) Querying of all qualifying claims to CMS for determination of Medicare eligibility on a monthly basis;

- (b) Collection of additional mandatory data regarding claims with verified Medicare eligibility; and
- (c) Reporting of all claims meeting CMS reporting guidelines.

C. CLIENT RESPONSIBILITIES. Client agrees to:

1. Report all claims, incidents, reports or correspondence relating to potential claims in a timely manner.
2. Reasonably cooperate in the disposition of all claims.
3. Claim Funding.
 - a. Provide Funds in a timely manner to pay all claims and expenses. **If utilizing an escrow account**, provide Funds on a periodic basis as mutually agreed upon per the Quality Service Plan, claim handling instructions, or similar document if applicable. Funds shall include those required to pay all claims and expenses covered by insurance carriers or other parties. CCMSI will work with Client to obtain timely reimbursement of such covered payments from insurance carriers or other parties but will not advance any such amounts.
 - b. **If utilizing an escrow account**, provide Funds in an amount that maintains a Claim Deposit equal to one and a half (1.5) times the average total of claim and expense payments for the previous six (6) months, adjusted for funding frequency. The required Claim Deposit will be monitored and adjusted as necessary per this calculation. The Claim Deposit is and shall remain the property of the Client. CCMSI will return excess Funds to Client in a timely manner upon recalculation of Claim Deposit or termination of the Agreement.
 - c. **If utilizing an escrow account**, provide advance funding (“Prefunding”) to pay all claim and expense transactions in excess of a mutually agreed upon amount per the Quality Service Plan, claim handling instructions, or similar document if applicable.
 - d. **If utilizing an escrow account**, provide all manner of Funds and Prefunding via Automated Clearing House (ACH) Electronic Funds Transfer (ETF).
4. Respond to reasonable information requests in a timely manner.
5. Identify in writing all insurance carriers applicable to CCMSI’s claim handling responsibilities contemplated in this Agreement that CCMSI will have claim or data reporting requirements. In this regard, Client agrees to provide CCMSI with a complete copy of the current excess or other insurance policies, including applicable endorsements and audits, applicable to Clients insurance program and this Agreement. CCMSI assumes no responsibility of any kind for not reporting an otherwise reportable claim to any carrier that Client has failed to disclose to CCMSI and/or provide CCMSI with a copy of the applicable insurance policy and reporting instructions relative to that carrier.

6. When applicable, obtain and provide CCMSI with an active Registered Reporting Entity (RRE) number through the Centers of Medicare & Medicaid Services that CCMSI is explicitly authorized to use for mandatory MMSEA Section 111 reporting. When applicable, client agrees to maintain this RRE # by fulfilling CMS's annual recertification process.
7. Pay any fees or costs charged by any carrier or prior Administrator of Client for the conversion of data associated with CCMSI handling run-off claims for Client, or for the general transfer of data to CCMSI's operating systems.
8. Promptly pay all fees to CCMSI as outlined in Exhibit A.

D. OPERATING EXPENSES. The Client agrees to be responsible for and pay all of its own operating expenses other than service obligations of CCMSI. Such operating expenses shall include but not be limited to charges for the following:

1. All costs associated with Client meeting its state security and licensing requirements;
2. Certified Public Accountants
3. Attorneys, other than provided for in Section B.1. (d) 3) and B.1. (d) 4) of this Agreement;
4. Outside consultants, actuarial services or studies and state audits;
5. Independent payroll audits;
6. Allocated Claims Expenses incurred pursuant to Section B. 1. (d) of this Agreement;
7. All applicable regulatory fees and taxes;
8. Educational and/or promotional material, industry-specific loss control material, customized forms and/or stationery, supplies and extraordinary postage, such as bulk mailing, express mail or messenger service.
9. National Council on Compensation Insurance, NCCI, charges;
10. Excess and other insurance premiums;
11. Costs associated with the development, record keeping and filing of fraud statistics and plans, but only if required by any state or regulatory authority having jurisdiction over Client;
12. Other operating costs as normally incurred by the Client.

E. BOOKS AND RECORDS.

1. (a) CCMSI shall maintain all claim information relating specifically to the Client which is necessary to the performance of CCMSI's obligations under this Agreement (the "Records"). The Records and implicated privileges shall remain at all times the sole property of the Client if self-insured or the Client's respective Carrier if subject to a deductible insurance policy.

(b) The Records shall not include any manuals, forms, files and reports, documents, customer lists, rights to solicit renewals, computer records and tapes, financial and strategic data, or information which documents CCMSI's processes, procedures and methods, or which CCMSI employs to administer programs other than the Client. The items specified in this Paragraph E. 1. (b) shall at all times be and remain the sole and exclusive property of CCMSI, and the Client shall not have any ownership, interest, right to duplicate or right to utilize these items except for the above documentation or information that relates solely to Client's program.

2. During the term of this Agreement, CCMSI shall provide the Client with copies of the Records, if so, requested by the Client. Any reasonable costs of reproduction of the Records shall be borne by the Client.

3. CCMSI shall make the Records available for inspection by any duly authorized representative of the Client, any governmental or regulatory authority having jurisdiction over CCMSI or the Client, or pursuant to court order.

F. NON-SOLICITATION OF EMPLOYEES. During the term of the Agreement and for two (2) years thereafter, the Client and CCMSI mutually agree not to recruit, solicit or hire any employee of the other without written permission.

G. OTHER INSURANCE. If CCMSI places any specific or aggregate excess insurance, reinsurance, or other insurance product associated with this Agreement, then customary commissions and fees will be retained by CCMSI.

H. TERM AND TERMINATION.

1. Term of Agreement. The first term of this Agreement shall be for _____ () years beginning on _____, 20__ and terminating on _____, 20__. Unless the Agreement is terminated as set forth in paragraph H. 2., it will automatically renew for successive _____ () year terms. At least ninety (90) days prior to the expiration of each _____ () year term of this Agreement, the parties shall enter into good-faith negotiations regarding any proposed change in Agreement terms or fees. If there are no changes requested by either party, then the Agreement will automatically renew under the same terms and fee arrangement as the prior term.

2. Termination of Agreement. This Agreement may be terminated:

- (a) By mutual agreement of the parties hereto;
- (b) Upon expiration of the current term of this Agreement if either party has given the other at least ninety (90) days written notice of its intention to terminate as set forth in paragraph H. 1.;
- (c) Upon dissolution of the Client's self-insurance program whether voluntary or due to cessation of Client's authority to self-insure;
- (d) Upon dissolution of the Client's self-insurance program due to Client insolvency or bankruptcy;
- (e) Upon ninety (90) days written notice by either party if the other party is in material breach of any term, covenant or condition contained herein; provided, however, that as a condition precedent to termination under this Section H. 2. (e), the terminating party shall give written notice to the other party, who shall have sixty (60) days from the date of such notice to cure or correct the grounds for termination. If the grounds of termination are not corrected or cured during the sixty (60) day period, this Agreement may be terminated on the termination date specified in the notice, but not prior to the expiration of the ninety (90) day period described herein.

3. Services Following Termination of Agreement. In the event that CCMSI's services are being provided on a Life of Agreement basis and this Agreement is terminated or non-renewed for any reason, CCMSI will cease providing services and turn over to the Client all Records in CCMSI's possession, which shall include all open and closed files.

Upon the Client's request and subject to agreement by CCMSI, CCMSI will be paid a reasonable negotiated fee to:

- (a) Provide for continued administration of the open claim files;
- (b) Cooperate with any successor Administrator in the orderly transfer of all functions, including providing a runoff listing of open claim files if desired by the Client and any other records reasonable and necessary for a successor administrator; and
- (c) Provide an electronic transfer of data if such is feasible, with the cost of providing such borne by the Client. The electronic transfer of data will be subject to a flat fee of \$10,000.

- I. **SERVICE FEE PAYMENTS.** The Client shall pay to CCMSI a service fee as outlined in the Fee and Payment Schedule attached hereto as Exhibit A.
- J. **ARBITRATION.** If an irreconcilable difference of opinion or claim should arise between the Client and CCMSI as the interpreters of any matter relating to this Agreement, such matter will be submitted to mediation and arbitration as the sole remedy available to both parties. Any such mediation or arbitration will take place in the City of _____, _____ and will be conducted in accordance with the then-current rules of the American Arbitration Association.
- K. **RELATIONSHIP OF PARTIES.** With respect to the services provided by CCMSI in this Agreement, CCMSI is considered an independent contractor. Nothing in this Agreement shall be construed to create a relationship of employer/employee, partners or joint ventures between the Client and CCMSI. This Agreement is non-exclusive, and CCMSI shall have the right to perform services on behalf of other individuals, firms, corporations and entities.
- L. **INDEMNIFICATION.**
1. **Indemnification by Client.** The Client agrees that it will indemnify and hold harmless CCMSI and CCMSI's directors, officers, employees, agents, shareholders, subsidiaries and other affiliates from and against any and all claims, losses, liability, costs, damages and reasonable attorney's fees incurred by CCMSI as a result of breach of this Agreement by the Client, explicit instruction by the Client, or alleged misconduct, error or omissions by the Client, or by any of the Client's trustees, directors, officers, employees, agents, shareholders, subsidiaries, or other affiliates in connection with the performance of this Agreement. Agents as used herein include third party vendors selected by Client.
 2. **Indemnification by CCMSI.** CCMSI agrees that it will indemnify and hold harmless the Client and the Client's trustees, directors, officers, employees, agents, shareholders, subsidiaries, members, or other affiliates from and against any and all claims, losses, liability, costs, damages and reasonable attorney's fees incurred by the Client as the result of breach of this Agreement by CCMSI or alleged misconduct, error or omissions by CCMSI, or by any of CCMSI's directors, officers, employees, agents, shareholders, subsidiaries or other affiliates in connection with the performance of this Agreement.
- M. **CHANGE IN CIRCUMSTANCES.** In the event the adoption of any statute, rule or regulation materially changes the nature of the relationship between the parties hereto or the legal or economic premises upon which this Agreement is based, the parties hereto shall undertake good faith negotiations to amend the terms of this Agreement to account for such changes in a reasonable manner. This includes the happening or development of a local, regional, national or global health situation, crisis, pandemic, or catastrophic event that would impact the volume and type of claims to be administered by CCMSI under this Agreement. In the event of any such occurrence, either party may contact the other in good faith and seek to amend the terms and / or service fees applicable to this Agreement.

N. SOFTWARE ACCESS. The Client may be provided with the right to use one or more CCMSI Applications in connection with the services provided by CCMSI in this Agreement. CCMSI Applications include iCE, MyReports, and Loss Control Resources. The right to use CCMSI Applications is non-exclusive, limited to the term of this Agreement per paragraph H.1., non-transferable and is solely for the internal business use of Client.

CCMSI owns and reserves all rights, title, and interest in and to the CCMSI Applications. Client has no right to receive a copy of the object code or source code to the CCMSI Applications. Client may not attempt to:

1. License, sell, lease or otherwise make the CCMSI Applications available to any other party. Client will not provide any access, passwords or other information regarding the CCMSI Applications to any third parties and/or competitors of CCMSI without the prior written consent of CCMSI;
2. Use the CCMSI Applications in any way that violates any law, regulation or mandate, or the term of this Agreement; or
3. Take any action that jeopardizes confidential or proprietary information held by CCMSI.

Client is responsible for any confidential or proprietary information accessed or downloaded by Client from the CCMSI Applications, including the implementation of appropriate information security controls surrounding such information.

Except as expressly provided in this Agreement, CCMSI Applications are provided "as-is". CCMSI disclaims all other warranties, express, implied, or statutory, including the implied warranties or merchantability, satisfactory quality, title, fitness for a particular purpose, non-infringement, compatibility, security, quiet enjoyment, or accuracy. Without limiting the foregoing, CCMSI does not warrant that access to or use of the CCMSI Applications will be uninterrupted or error-free. CCMSI will provide support for the CCMSI Applications in the two most recent two versions of the Internet Explorer, Chrome, Firefox and Safari browsers.

O. MISCELLANEOUS.

1. Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the State of [REDACTED] without regard to principles of conflicts of law.
2. Timing of Services. CCMSI may exercise its own reasonable judgment, within the parameters set forth herein and in compliance with state regulations, as to the time and manner in which it performs the services required hereunder. Additionally, CCMSI will be held to a standard of like administrators performing like services for customers such as Client.
3. Successors in Interest. This Agreement shall be binding upon, and inure to the benefit of, the successors in interest and permitted assigns of the parties hereto.
4. Severability. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if the invalid or unenforceable provision had been revised to the minimum extent necessary to make it valid and fully enforceable under applicable law.

5. Paragraph Headings. All paragraph headings in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
6. Waiver. The failure of any party to enforce any provisions of this Agreement shall not constitute a waiver by such party of any provision. A past waiver of a provision by either party shall not constitute a course of conduct or a waiver in the future with respect to that same provision.
7. Notice Provision. All notices, requests and other communications required under this Agreement shall be in writing and delivered by hand or mailed, registered or certified, return receipt requested, postage paid, or sent via a nationally recognized overnight courier to the other party at the following address:

Client:

Contact
Client Name
Address
City, State, Zip

CCMSI:

Cannon Cochran Management Services, Inc.
2 E. Main St.
Danville, IL 61832
Attn: Chief Financial Officer

8. File Destruction Policy. CCMSI will maintain electronic claim file records or hard copy files (where applicable) on behalf of Client for as long as necessary to protect the applicable statute of limitations and in accordance with CCMSI's Client Record Retention Policy.
9. Insurance. CCMSI will purchase and maintain insurance coverages for its performance of the services contemplated in this Agreement. Minimum policy limits are as follows:

Workers Compensation – Statutory
Professional - \$5,000,000
General Liability - \$1,000,000 / \$2,000,000
Umbrella - \$5,000,000
Cyber Coverage - \$5,000,000

10. Escheatment. CCMSI is responsible for complying with all applicable abandoned property or escheat laws, making any required payments, and filing any required reports on CCMSI escrow accounts.
11. Confidential Information. Confidential Information includes nonpublic information that is exchanged between the Client and CCMSI, including, without limitation, information relating to the business, financials, personnel, customer data and operating procedures. Confidential Information includes information whether in written, electronic, or oral form created and relating to services provided under the Agreement. All Confidential Information is proprietary. Client and CCMSI may use the other party's Confidential Information only for the purpose of this Agreement and will limit its disclosure to only those persons or entities reasonably necessary to perform under the Agreement.

- 12. Information Security. CCMSI is responsible for the protection of the confidentiality, availability, privacy and integrity of Client information in our custody. CCMSI has implemented an Information Security Policy that has been developed to comply with applicable federal and state laws or regulations and industry best practices. The Information Security Policy applies to all CCMSI personnel, including temporary employees, independent contractors and vendors with access to CCMSI systems.

- 13. Entire Agreement/Amendment. This Agreement sets forth the full and final understanding of the parties hereto with respect to the matters described herein and supersedes any and all prior agreements and understandings between them, whether written or oral. This Agreement may be amended only by written document executed by the Client and CCMSI.

Executed this ____ day of _____, 20__.

CANNON COCHRAN MANAGEMENT SERVICES, INC.

By: _____

John E. Kluth II

Its: Chief Financial Officer

CLIENT NAME

By: _____

It's: _____

EXHIBIT A
FEE AND PAYMENT SCHEDULE

**SERVICE AGREEMENT BETWEEN
FORT BEND COUNTY AND
CANNON COCHRAN MANAGEMENT SERVICES, INC.**

THIS SERVICE AGREEMENT is made and entered into this 1st day of February, 2026, by and between Fort Bend County (the "Client"), and Cannon Cochran Management Services, Inc. ("CCMSI"), a Delaware corporation. It is agreed between the parties hereto as follows:

- A. APPOINTMENT OF CCMSI.** The Client hereby appoints CCMSI, and CCMSI hereby agrees to serve, as Third Party Administrator ("Administrator") of the Client's insurance program as described within Exhibit A Fee and Payment Schedule ("Exhibit A"). All functions of CCMSI shall be performed until termination of this Agreement ("Life of Agreement").
- B. FUNCTIONS OF CCMSI.** During the term of this Agreement, the regular functions of CCMSI as the Client's Administrator shall include the following:
1. Claim Administration.
 - (a) Claim Management and Administration. In compliance with its Best Practices, CCMSI will manage and administer all claims of the Client that occur during the period of this Agreement. All claim payments shall be made with Client funds. CCMSI will act on behalf of Client in handling, monitoring, investigating, overseeing and adjusting all such actual and alleged claims.
 - (b) Claim Settlement. CCMSI will settle claims of the Client with Client funds.
 - (c) Claim Reserves. CCMSI will establish reserves for unpaid reported claims and unpaid claim expenses.
 - (d) Allocated Claim Expenses. CCMSI will pay, at market rates, all Allocated Claim Expenses with Client Funds. Allocated Claim Expenses are charges for services provided in connection with specific claims by persons or firms which are eligible claim expenses under the Client's program. Notwithstanding the foregoing, Allocated Claim Expenses will include all expenses incurred in connection with the custody, investigation, adjustment, settlement or defense of Client claims, even if such expenses are incurred by CCMSI. Allocated Claim Expenses will include, but not be limited to, charges for:
 - 1) Independent medical examinations of claimants;
 - 2) Managed care expenses, which may include the services provided by comp mc™, CCMSI's proprietary managed care program;
 - 3) Fraud detection expenses, which may include the services provided by FIRE, CCMSI's proprietary Special Investigation Unit (SIU), and other related expenses associated with

the surveillance, detection, reporting and prosecution of fraudulent claims, including legal fees;

- 4) Attorneys, experts, and special process servers;
 - 5) Court costs, fees, interest and expenses;
 - 6) Depositions, court reporters and recorded statements;
 - 7) Independent adjusters and appraisers;
 - 8) Index bureau and OFAC (Office of Foreign Assets Control) charges;
 - 9) MMSEA/SCHIP compliance charges;
 - 10) Electronic Data Interchanges ("EDI") charges if required by state law;
 - 11) CCMSI personnel, at their customary rate or charge, but only with respect to claims outside the state of their assigned office and only if such customary rate is communicated to the Client prior to incurring such cost;
 - 12) Actual reasonable expenses incurred by CCMSI employees outside the state of their assigned office for meals, travel, and lodging in conjunction with claim management;
 - 13) Police, weather and fire report charges that are related to claims being administered under Client's program;
 - 14) Charges associated with accident reconstruction, cause and origin investigations, etc.;
 - 15) Charges for retrieval of medical records, personnel documents, and other documents necessary for adjudication of claims under Client's program;
 - 16) Charges associated with Medicare Set-Aside Allocations and other related MSP Services;
 - 17) Other expenses normally recognized as Allocated Loss Adjustment Expenses ("ALAE") by industry standards.
- (e) Subrogation. CCMSI will monitor claims for subrogation.
- (f) Provision of Reports. CCMSI will provide reports to the Client as mutually agreed upon by the parties.
- (g) Service Plan. CCMSI will cooperate with the Client in the drafting and periodic revision of a Quality Service Plan (QSP), claim handling instructions, or similar document if applicable that contains claim handling instructions, a schedule of reports, and other details of Client's

insurance program as mutually agreed upon by the parties. The document shall be maintained in CCMSI's ICEBAR software application.

2. comp mc™ Managed Care Services. CCMSI will provide the Client with comp mc™ managed care services upon mutual agreement of the parties and in exchange for payment of the applicable comp mc™ fees stated in Exhibit A. The comp mc™ Managed Care Services may include but not be limited to usual and customary medical bill re-pricing, state fee schedule medical bill re-pricing, preferred provider organization medical bill re-pricing, specialty medical and hospital bill negotiation, medical bill state reporting, pharmacy network services, field case management services, telephonic case management services, utilization review services, nurse triage services, and First Notice of Loss reporting services.
3. MMSEA/SCHIP Compliance Services. CCMSI, in conjunction with its reporting agent/MSP vendor, will comply with applicable MMSEA and Section 111 reporting requirements on behalf of the Client in exchange for payment of the applicable MMSEA/SCHIP fees stated in Exhibit A and conditioned upon Client's provision of an active Responsible Reporting Entity Number and written authority for CCMSI to report data on Client's behalf. The MMSEA/SCHIP Compliance Services shall include:
 - (a) Querying of all qualifying claims to CMS for determination of Medicare eligibility on a monthly basis;
 - (b) Collection of additional mandatory data regarding claims with verified Medicare eligibility; and
 - (c) Reporting of all claims meeting CMS reporting guidelines.

C. CLIENT RESPONSIBILITIES. Client agrees to:

1. Report all claims, incidents, reports or correspondence relating to potential claims in a timely manner.
2. Reasonably cooperate in the disposition of all claims.
3. Claim Funding.
 - a. Provide Funds in a timely manner to pay all claims and expenses. **If utilizing an escrow account**, provide Funds on a periodic basis as mutually agreed upon per the Quality Service Plan, claim handling instructions, or similar document if applicable. Funds shall include those required to pay all claims and expenses covered by insurance carriers or other parties. CCMSI will work with Client to obtain timely reimbursement of such covered payments from insurance carriers or other parties but will not advance any such amounts.
 - b. **If utilizing an escrow account**, provide Funds in an amount that maintains a Claim Deposit equal to one and a half (1.5) times the average total of claim and expense payments for the

previous six (6) months, adjusted for funding frequency. The required Claim Deposit will be monitored and adjusted as necessary per this calculation. The Claim Deposit is and shall remain the property of the Client. CCMSI will return excess Funds to Client in a timely manner upon recalculation of Claim Deposit or termination of the Agreement.

- c. **If utilizing an escrow account**, provide advance funding ("Prefunding") to pay all claim and expense transactions in excess of a mutually agreed upon amount per the Quality Service Plan, claim handling instructions, or similar document if applicable.
- d. **If utilizing an escrow account**, provide all manner of Funds and Prefunding via Automated Clearing House (ACH) Electronic Funds Transfer (ETF).

- 4. Respond to reasonable information requests in a timely manner.
- 5. Identify in writing all insurance carriers applicable to CCMSI's claim handling responsibilities contemplated in this Agreement that CCMSI will have claim or data reporting requirements. In this regard, Client agrees to provide CCMSI with a complete copy of the current excess or other insurance policies, including applicable endorsements and audits, applicable to Clients insurance program and this Agreement. CCMSI assumes no responsibility of any kind for not reporting an otherwise reportable claim to any carrier that Client has failed to disclose to CCMSI and/or provide CCMSI with a copy of the applicable insurance policy and reporting instructions relative to that carrier.
- 6. When applicable, obtain and provide CCMSI with an active Registered Reporting Entity (RRE) number through the Centers of Medicare & Medicaid Services that CCMSI is explicitly authorized to use for mandatory MMSEA Section 111 reporting. When applicable, client agrees to maintain this RRE # by fulfilling CMS's annual recertification process.
- 7. Pay any fees or costs charged by any carrier or prior Administrator of Client for the conversion of data associated with CCMSI handling run-off claims for Client, or for the general transfer of data to CCMSI's operating systems.
- 8. Promptly pay all fees to CCMSI as outlined in Exhibit A.

D. OPERATING EXPENSES. The Client agrees to be responsible for and pay all of its own operating expenses other than service obligations of CCMSI. Such operating expenses shall include but not be limited to charges for the following:

- 1. All costs associated with Client meeting its state security and licensing requirements;
- 2. Certified Public Accountants
- 3. Attorneys, other than provided for in Section B.1. (d) 3) and B.1. (d) 4) of this Agreement;
- 4. Outside consultants, actuarial services or studies and state audits;

5. Independent payroll audits;
6. Allocated Claims Expenses incurred pursuant to Section B. 1. (d) of this Agreement;
7. All applicable regulatory fees and taxes;
8. Educational and/or promotional material, industry-specific loss control material, customized forms and/or stationery, supplies and extraordinary postage, such as bulk mailing, express mail or messenger service.
9. National Council on Compensation Insurance, NCCI, charges;
10. Excess and other insurance premiums;
11. Costs associated with the development, record keeping and filing of fraud statistics and plans, but only if required by any state or regulatory authority having jurisdiction over Client;
12. Other operating costs as normally incurred by the Client.

E. BOOKS AND RECORDS.

1. (a) CCMSI shall maintain all claim information relating specifically to the Client which is necessary to the performance of CCMSI's obligations under this Agreement (the "Records"). The Records and implicated privileges shall remain at all times the sole property of the Client if self-insured or the Client's respective Carrier if subject to a deductible insurance policy.

(b) The Records shall not include any manuals, forms, files and reports, documents, customer lists, rights to solicit renewals, computer records and tapes, financial and strategic data, or information which documents CCMSI's processes, procedures and methods, or which CCMSI employs to administer programs other than the Client. The items specified in this Paragraph E. 1. (b) shall at all times be and remain the sole and exclusive property of CCMSI, and the Client shall not have any ownership, interest, right to duplicate or right to utilize these items except for the above documentation or information that relates solely to Client's program.

2. During the term of this Agreement, CCMSI shall provide the Client with copies of the Records, if so, requested by the Client. Any reasonable costs of reproduction of the Records shall be borne by the Client.
3. CCMSI shall make the Records available for inspection by any duly authorized representative of the Client, any governmental or regulatory authority having jurisdiction over CCMSI or the Client, or pursuant to court order.

F. NON-SOLICITATION OF EMPLOYEES. During the term of the Agreement and for two (2) years thereafter, the Client and CCMSI mutually agree not to recruit, solicit or hire any employee of the other without written permission.

G. OTHER INSURANCE. If CCMSI places any specific or aggregate excess insurance, reinsurance, or other insurance product associated with this Agreement, then customary commissions and fees will be retained by CCMSI.

H. TERM AND TERMINATION.

1. Term of Agreement. The first term of this Agreement shall be for two (2) years beginning on February 1, 2026, and terminating on January 31, 2028. Unless the Agreement is terminated as set forth in paragraph H. 2., it will automatically renew for successive one (1) year terms. At least ninety (90) days prior to the expiration of each one (1) year term of this Agreement, the parties shall enter into good-faith negotiations regarding any proposed change in Agreement terms or fees. If there are no changes requested by either party, then the Agreement will automatically renew under the same terms and fee arrangement as the prior term.

2. Termination of Agreement. This Agreement may be terminated:
 - (a) By mutual agreement of the parties hereto;
 - (b) Upon expiration of the current term of this Agreement if either party has given the other at least ninety (90) days written notice of its intention to terminate as set forth in paragraph H. 1.;
 - (c) Upon dissolution of the Client's self-insurance program whether voluntary or due to cessation of Client's authority to self-insure;
 - (d) Upon dissolution of the Client's self-insurance program due to Client insolvency or bankruptcy;
 - (e) Upon ninety (90) days written notice by either party if the other party is in material breach of any term, covenant or condition contained herein; provided, however, that as a condition precedent to termination under this Section H. 2. (e), the terminating party shall give written notice to the other party, who shall have sixty (60) days from the date of such notice to cure or correct the grounds for termination. If the grounds of termination are not corrected or cured during the sixty (60) day period, this Agreement may be terminated on the termination date specified in the notice, but not prior to the expiration of the ninety (90) day period described herein.

3. Services Following Termination of Agreement. In the event that CCMSI's services are being provided on a Life of Agreement basis and this Agreement is terminated or non-renewed for any reason, CCMSI will cease providing services and turn over to the Client all Records in CCMSI's possession, which shall include all open and closed files.

Upon the Client's request and subject to agreement by CCMSI, CCMSI will be paid a reasonable negotiated fee to:

- (a) Provide for continued administration of the open claim files;

- (b) Cooperate with any successor Administrator in the orderly transfer of all functions, including providing a runoff listing of open claim files if desired by the Client and any other records reasonable and necessary for a successor administrator; and
- (c) Provide an electronic transfer of data if such is feasible, with the cost of providing such borne by the Client. The electronic transfer of data will be subject to a flat fee of \$10,000.

I. **SERVICE FEE PAYMENTS.** The Client shall pay to CCMSI a service fee as outlined in the Fee and Payment Schedule attached hereto as Exhibit A.

J. **ARBITRATION.** If an irreconcilable difference of opinion or claim should arise between the Client and CCMSI as the interpreters of any matter relating to this Agreement, such matter will be submitted to mediation and arbitration as the sole remedy available to both parties. Any such mediation or arbitration will take place in the City of Richmond, Texas, and will be conducted in accordance with the then-current rules of the American Arbitration Association.

K. **RELATIONSHIP OF PARTIES.** With respect to the services provided by CCMSI in this Agreement, CCMSI is considered an independent contractor. Nothing in this Agreement shall be construed to create a relationship of employer/employee, partners or joint ventures between the Client and CCMSI. This Agreement is non-exclusive, and CCMSI shall have the right to perform services on behalf of other individuals, firms, corporations and entities.

L. **INDEMNIFICATION.**

1. **Indemnification by Client.** The Client agrees that it will indemnify and hold harmless CCMSI and CCMSI's directors, officers, employees, agents, shareholders, subsidiaries and other affiliates from and against any and all claims, losses, liability, costs, damages and reasonable attorney's fees incurred by CCMSI as a result of breach of this Agreement by the Client, explicit instruction by the Client, or alleged misconduct, error or omissions by the Client, or by any of the Client's trustees, directors, officers, employees, agents, shareholders, subsidiaries, or other affiliates in connection with the performance of this Agreement. Agents as used herein include third party vendors selected by Client.

2. **Indemnification by CCMSI.** CCMSI agrees that it will indemnify and hold harmless the Client and the Client's trustees, directors, officers, employees, agents, shareholders, subsidiaries, members, or other affiliates from and against any and all claims, losses, liability, costs, damages and reasonable attorney's fees incurred by the Client as the result of breach of this Agreement by CCMSI or alleged misconduct, error or omissions by CCMSI, or by any of CCMSI's directors, officers, employees, agents, shareholders, subsidiaries or other affiliates in connection with the performance of this Agreement.

M. **CHANGE IN CIRCUMSTANCES.** In the event the adoption of any statute, rule or regulation materially changes the nature of the relationship between the parties hereto or the legal or economic premises upon which this Agreement is based, the parties hereto shall undertake good faith negotiations to amend the terms of this Agreement to account for such changes in a reasonable manner. This

includes the happening or development of a local, regional, national or global health situation, crisis, pandemic, or catastrophic event that would impact the volume and type of claims to be administered by CCMSI under this Agreement. In the event of any such occurrence, either party may contact the other in good faith and seek to amend the terms and / or service fees applicable to this Agreement.

- N. SOFTWARE ACCESS.** The Client may be provided with the right to use one or more CCMSI Applications in connection with the services provided by CCMSI in this Agreement. CCMSI Applications include ICE, MyReports, and Loss Control Resources. The right to use CCMSI Applications is non-exclusive, limited to the term of this Agreement per paragraph H.1., non-transferable and is solely for the internal business use of Client.

CCMSI owns and reserves all rights, title, and interest in and to the CCMSI Applications. Client has no right to receive a copy of the object code or source code to the CCMSI Applications. Client may not attempt to:

1. License, sell, lease or otherwise make the CCMSI Applications available to any other party. Client will not provide any access, passwords or other information regarding the CCMSI Applications to any third parties and/or competitors of CCMSI without the prior written consent of CCMSI;
2. Use the CCMSI Applications in any way that violates any law, regulation or mandate, or the term of this Agreement; or
3. Take any action that jeopardizes confidential or proprietary information held by CCMSI.

Client is responsible for any confidential or proprietary information accessed or downloaded by Client from the CCMSI Applications, including the implementation of appropriate information security controls surrounding such information.

Except as expressly provided in this Agreement, CCMSI Applications are provided "as-is". CCMSI disclaims all other warranties, express, implied, or statutory, including the implied warranties or merchantability, satisfactory quality, title, fitness for a particular purpose, non-infringement, compatibility, security, quiet enjoyment, or accuracy. Without limiting the foregoing, CCMSI does not warrant that access to or use of the CCMSI Applications will be uninterrupted or error-free. CCMSI will provide support for the CCMSI Applications in the two most recent two versions of the Internet Explorer, Chrome, Firefox and Safari browsers.

O. MISCELLANEOUS.

1. Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Texas without regard to principles of conflicts of law.
2. Timing of Services. CCMSI may exercise its own reasonable judgment, within the parameters set forth herein and in compliance with state regulations, as to the time and manner in which it performs the services required hereunder. Additionally, CCMSI will be held to a standard of like administrators performing like services for customers such as Client.
3. Successors in Interest. This Agreement shall be binding upon, and inure to the benefit of, the successors in interest and permitted assigns of the parties hereto.

4. Severability. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if the invalid or unenforceable provision had been revised to the minimum extent necessary to make it valid and fully enforceable under applicable law.
5. Paragraph Headings. All paragraph headings in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
6. Waiver. The failure of any party to enforce any provisions of this Agreement shall not constitute a waiver by such party of any provision. A past waiver of a provision by either party shall not constitute a course of conduct or a waiver in the future with respect to that same provision.
7. Notice Provision. All notices, requests and other communications required under this Agreement shall be in writing and delivered by hand or mailed, registered or certified, return receipt requested, postage paid, or sent via a nationally recognized overnight courier to the other party at the following address:

Client: Wyatt Scott
Fort Bend County
301 Jackson St.
Richmond, TX 77496

CCMSI: Cannon Cochran Management Services, Inc.
2 E. Main St.
Danville, IL 61832
Attn: Chief Financial Officer

8. File Destruction Policy. CCMSI will maintain electronic claim file records or hard copy files (where applicable) on behalf of Client for as long as necessary to protect the applicable statute of limitations and in accordance with CCMSI's Client Record Retention Policy.
9. Insurance. CCMSI will purchase and maintain insurance coverages for its performance of the services contemplated in this Agreement. Minimum policy limits are as follows:

Workers Compensation – Statutory
Professional - \$5,000,000
General Liability - \$1,000,000 / \$2,000,000
Umbrella - \$5,000,000
Cyber Coverage - \$5,000,000

10. Escheatment. CCMSI is responsible for complying with all applicable abandoned property or escheat laws, making any required payments, and filing any required reports on CCMSI escrow accounts.
11. Confidential Information. Confidential Information includes nonpublic information that is exchanged between the Client and CCMSI, including, without limitation, information relating to the business, financials, personnel, customer data and operating procedures. Confidential

Information includes information whether in written, electronic, or oral form created and relating to services provided under the Agreement. All Confidential Information is proprietary. Client and CCMSI may use the other party's Confidential Information only for the purpose of this Agreement and will limit its disclosure to only those persons or entities reasonably necessary to perform under the Agreement.

12. Information Security. CCMSI is responsible for the protection of the confidentiality, availability, privacy and integrity of Client information in our custody. CCMSI has implemented an Information Security Policy that has been developed to comply with applicable federal and state laws or regulations and industry best practices. The Information Security Policy applies to all CCMSI personnel, including temporary employees, independent contractors and vendors with access to CCMSI systems.
13. Entire Agreement/Amendment. This Agreement sets forth the full and final understanding of the parties hereto with respect to the matters described herein and supersedes any and all prior agreements and understandings between them, whether written or oral. This Agreement may be amended only by written document executed by the Client and CCMSI.

Executed this ____ day of _____, 20__.

CANNON COCHRAN MANAGEMENT SERVICES, INC.

By: _____
John E. Kluth II

Its: Chief Financial Officer

FORT BEND COUNTY

By: _____
Wyatt Scott

It's: Risk Management Director

EXHIBIT A
FEE AND PAYMENT SCHEDULE

Service Agreement Term: <u>2/1/2026 – 1/31/2028</u>	
Services	Fees
Claims Administration	
<p>CCMSI will manage all claims for the Life of Agreement for a fee as follows:</p> <ul style="list-style-type: none"> • First Year: \$340,000 <i>(Includes all lines of coverage for run-in¹ and new claim data provided in the RFP, Annual Administration Fee, Account Setup, Data Transition, and RMIS)</i> • Second Year: \$317,296 • Third Year: \$328,388 • Fourth Year: \$339,924 • Fifth Year: \$351,921 <p>¹ Run-in quoted in the First Year includes liability and a portion of Workers' Compensation (WC). The remaining WC run-in will be billed in Years 2–5. In Run-in WC indemnity and liability claims that remain open longer than twelve (12) months will be billed at a rate of \$55 per claim, per month, capped at \$500.</p> <p><u>Annual Increases:</u></p> <p>A 4% annual increase in Claim Administration Fees is included in the fees stated above.</p> <p><u>Workers' Compensation Claim Definitions</u></p> <ul style="list-style-type: none"> ▪ Indemnity Claims – Claims involving lost-time, questionable compensability, legal involvement/client attorney representation, subrogation, second injury fund, probable permanent impairment, jurisdictional issues, coverage issues and complex medical issues that are assigned or transferred to indemnity adjusters for claims handling. ▪ Medical Only Claims – Claims which have no issues of lost time, no evidence of other indemnity benefit exposure, no obvious question of compensability, no evidence of potential subrogation or second injury recovery, no evidence of problematic medical issues and no requirement 	

<p>or need for any formal statements (3-point or 2-point verbal contact is not required).</p> <ul style="list-style-type: none"> ▪ Complex/Enhanced Medical Only – Medical only claims that have 6 or more paid medical transactions and total paid dollars greater than \$2,500. ▪ Incident Only Claims – Reported claims which require only input into RMIS system and requires no claims management activity. 	
<p>Annual Administration Fee</p> <ul style="list-style-type: none"> • Dedicated client service team • Development of specific client service requirements • Monthly loss reporting • Quarterly claim reviews at client’s request • Issuance of 1099’s • Assistance in filing all required state forms including state mandated assessments. <ul style="list-style-type: none"> ○ If Client has directed CCMSI to utilize a third-party vendor selected by Client for the provision of services, then such assistance will be the responsibility of the third-party vendor. • Preparation for, compliance with and response to regulatory audits • Account Management and Administration 	<p>10% of Claim Administration Fees (Included in flat fee)</p>
<p>Subrogation Fee</p>	<p>15% of recovery with a cap of \$50,000 per claim.</p>
<p>comp mc™ Managed Care Service Fees</p>	
<p>Fee Schedule, Usual & Customary Re-pricing</p>	<p>\$9.00 per bill</p>
<p>PPO Network Access</p>	<p>25% of savings below state fee schedule</p>
<p>Hospital/Specialty Review</p>	<p>25% of savings below state fee schedule</p>
<p>Pharmacy Benefit Program</p>	<p>25% of savings</p>
<p>Field Case Management</p>	<p>Market Rate</p>

Telephonic Case Management	Market Rate
Utilization Review Current - \$105 (Nurse), \$250 (Physician)	Market Rate
FNOL Reporting / Nurse Triage	Market Rate
Medical Bill State Reporting (for applicable medical bills to reportable state)	\$1.50
Ancillary Fees	
State Reporting / EDI Fees Current - \$15.00 per Initial Report, \$10.00 per Subsequent Report	Market Rate
Index Bureau Current - \$20.00 per Index	Market Rate
MMSEA/SCHIP Compliance Fee Current - \$25.00 per Claim.	Market Rate
Annual RMIS Fees Risk Management Information System (iCE) cost to include: 5 User ID's (each additional user is \$200 per user per year). Internet access to claim files; the ability to email your adjuster and Account Manager; access to our library of template risk management reports together with initial training and ongoing support.	\$2,500 <i>(Included in flat fee, up to 5 users)</i>
Other Fees	
Account Set-up (One-time Fee) <u>Initial set-up meeting to review and establish the following:</u> <ul style="list-style-type: none"> • Computer Set-up • Banking and Funding • Reports • Special Claim Handling Guidelines • All Other Miscellaneous Start-up Issues 	\$5,000 <i>(Included in flat fee)</i>
Data Conversion Fee (One-Time Fee) Includes the transfer of claim data from the prior TPA(s) claim system to CCMSI (if applicable).	\$15,000 <i>(Included in flat fee)</i>



<p>Data Feeds CCMSI will provide data feeds as requested by Client. CCMSI will provide an estimate of one-time and ongoing charges before any work is done.</p> <ul style="list-style-type: none"> • First Notice of Loss to CCMSI via API - \$3,500 (setup fee – no monthly or annual fees) • Data Extract from CCMSI via SFTP - \$2,500 (setup fee – no monthly or annual fees) 	
<p>Carrier Fees If applicable, Client will be responsible for payment of any carrier fees associated with the transition of claim handling responsibilities to CCMSI.</p>	<p>TBD</p>
<p>Billing Schedule First Year claim administration fees will be invoiced monthly at \$28,333 beginning 2/1/2026.</p>	

Exhibit B

COUNTY PURCHASING AGENT
Fort Bend County, Texas



Brooke Lindemann
County Purchasing Agent

(281) 341-8640
Fax (281) 341-8645

September 18, 2025

TO: All Prospective Bidders

RE: Addendum No.1 – Fort Bend County RFP 26-001 – Property and Casualty Claims Third Party Administration Services

Addendum 1:

Addendum 1 has been posted to the County’s website. Vendors are to use Addendum 1 documents while preparing their proposal. Submission due date and tentative schedule have been updated. Q&A documents will be posted soon.

Immediately upon your receipt of this addendum, please fill out the following information and email this page to Amy Blevins at Amy.Blevins@fortbendcountytexas.gov .

Company Name

Signature of person receiving addendum

Date

If you have any questions, please contact this office.

Sincerely,

Cheryl Krejci
Assistant Purchasing Agent

** AMENDED 9/18/25*

**Fort Bend County, Texas
Request for Proposals**



**Property and Casualty Claims Third Party Administration Services
RFP 26-001**

SUBMIT SEALED PROPOSALS TO:

Fort Bend County
Purchasing Department
Travis Annex
301 Jackson, Suite 201
Richmond, TX 77469

Note: All correspondence must include the term
“Purchasing Department” in address to assist in
proper delivery.

SUBMIT NO LATER THAN:

*Tuesday, September 30 23, 2025
2:00 PM (Central)

LABEL SEALED ENVELOPE/BOX:

RFP 26-001
Property & Casualty 3rd Party Admin
Srvs

***ALL RFPs MUST BE RECEIVED IN AND TIME/DATE STAMPED BY THE PURCHASING OFFICE
OF FORT BEND COUNTY ON OR BEFORE THE SPECIFIED TIME/DATE STATED ABOVE.***

RFPs RECEIVED AS REQUIRED WILL THEN BE OPENED AND NAMES PUBLICLY READ.

RFPs RECEIVED AFTER THE SPECIFIED TIME, WILL BE RETURNED UNOPENED.

Result will be provided after final,
agreement is approved by Commissioners
Court.

Requests for information must be in
writing and directed to:
Cheryl Krejci, CPPB
Assistant County Purchasing Agent
Cheryl.Krejci@fortbendcountytexas.gov

Vendor Responsibilities:

- Download and complete any addendums. (Addendums will be posted on the Fort Bend County website no Later than 48 hours prior to bid opening)
- Submit response in accordance with requirements stated on the cover of this document.
- DO NOT submit responses via email or fax.



COUNTY PURCHASING AGENT
Fort Bend County, Texas

Vendor Information

Brooke Lindemann
Purchasing Agent

Office (281) 341-8640

Legal Company Name (top line of W9)				
Business Name (if different from legal name)				
Type of Business	Corporation/LLC Sole Proprietor/Individual	Partnership Tax Exempt	Age in Business?	
Federal ID # or S.S. #	SAM.gov Unique Entity ID #			
SAM.gov CAGE / NCAGE				
Publicly Traded Business	___ No ___ Yes Ticker Symbol _____			
Remittance Address				
City/State/Zip				
Physical Address				
City/State/Zip				
Phone Number				
E-mail				
Contact Person				
Check all that apply to the company listed above and provide certification number.	DBE-Disadvantaged Business Enterprise ___	Certification # _____	<u>Cert Date</u>	<u>Exp Date</u>
	SBE-Small Business Enterprise ___	Certification # _____	_____	_____
	HUB-Texas Historically Underutilized Business ___	Certification # _____	_____	_____
	WBE-Women's Business Enterprise ___	Certification # _____	_____	_____
Company's gross annual receipts	<\$500,000 _____	\$500,000-\$4,999,999 _____		
	\$5,000,000-\$16,999,999 ___	\$17,000,000-\$22,399,999 _____	>\$22,400,000 _____	
NAICs codes (Please enter all that apply)				
Signature of Authorized Representative				
Printed Name				
Title				
Date				

THIS FORM MUST BE SUBMITTED WITH THE SOLICITATION RESPONSE

1.0 INTRODUCTION:

Fort Bend County, Texas (hereafter referred to as the (“County”)) seeks sealed Proposals (“Proposals” or “RFP”) for selection of firm (“Respondent”) to provide Third Party Administration Services for the Fort Bend County Property and Casualty Insurance Program (“Project”) in accordance with the terms, conditions and requirements set forth in this RFP.

2.0 GUIDELINES:

By virtue of submitting a proposal, interested parties are acknowledging:

- 2.1 The County reserves the right to reject any or all proposals if it determines that select proposals are not responsive to the RFP. The County reserves the right to reconsider any proposal submitted at any phase of the procurement. It also reserves the right to meet with select Respondents at any time to gather additional information. Furthermore, the County reserves the right to delete or add scope up until the final contract signing.
- 2.2 All Respondents submitting proposals agree that their pricing is valid for a minimum of ninety (90) days after proposal submission to the County. Furthermore, the County is by statute exempt from the State Sales Tax and Federal Excise Tax; therefore, proposal prices shall not include taxes.
- 2.3 This Proposal does not commit the County to award nor does it constitute an offer of employment or a contract for services. Costs incurred in the submission of this proposal, or in making necessary studies or designs for the preparation thereof, are the sole responsibility of the Respondents. Further, no reimbursable cost may be incurred in the anticipation of award. Proposals containing elaborate artwork, expensive paper and binding and expensive visual or other presentations are neither necessary nor desired.
- 2.4 In an effort to maintain fairness in the process, all inquiries concerning this procurement are to be directed only to the County’s Purchasing Agent in writing. Attempts to contact any members of the County’s Commissioners’ Court or any other County employee to influence the procurement decision may lead to immediate elimination from further consideration.
- 2.5 When responding to this Proposal, follow all instructions carefully. Submit proposal contents according to the outline specified and submit all hard copy and electronic documents according to the instructions. Failure to follow these instructions may be considered a non-responsive proposal and may result in immediate elimination from further consideration.

3.0 PROPOSAL CONTACT:

This Proposal is being issued by the County Purchasing Agent on behalf of Fort Bend County, Texas. Thus, responses should be directed to the Assistant Purchasing Agent, as outlined below. **Respondents are specifically directed NOT to contact any County personnel for meetings, conferences or technical discussions that are related to this Proposal other than specified herein. Unauthorized contact of any County personnel will likely be cause for rejection of the Respondent's proposal. All communications regarding the Proposal shall be directed to the County's Proposal Contact.** Communication with the Proposal Contact is permitted via email, facsimile, or written correspondence.

PROPOSAL CONTACT:

Cheryl Krejci, CPPB
Assistant County Purchasing Agent
Fort Bend County Travis Annex
301 Jackson, Suite 201
Richmond, Texas 77469
Cheryl.Krejci@fortbendcountytexas.gov

*4.0 SUBMISSION REQUIREMENTS:

4.1 Submission requirements: one (1) original proposal, eight (8) paper copies, and one (1) electronic response on a labeled flash drive are required by RFP opening time of **2:00 PM on Tuesday, September 30 23, 2025**. Flash drive must contain only one (1) file in PDF format and must match written/original/paper response identically. Failure to provide proper flash drive is cause for disqualification. Proposal shall be submitted to the address shown below. Proposal shall be signed by a person having the authority to bind the firm in a contract.

Fort Bend County
Purchasing Department
301 Jackson, Suite 201
Richmond, Texas 77469

Proposal Number: R26-001
Due Date: Tuesday, September 30 23, 2025
Time: 2:00 PM (CST)
For: Property & Casualty Claims Third Party
Administration Services

4.2 Respondents may submit their proposal any time prior to the Opening Date and time. The Respondent's name and address as well as a distinct reference to the Proposal number above shall be marked clearly on the submission. All proposals are time-stamped upon receipt and are securely kept, unopened, until the Opening Date. No responsibility will attach to the County, or any official or employee thereof, for the pre-opening of, post-opening of, or the failure to open a proposal not properly addressed and identified. No oral, telegraphic, telephonic, or facsimile proposals will be considered.

- 4.3 Proposals may be modified or withdrawn prior to the established opening date by delivering written notice to the proposal contact. Any alteration made prior to opening date and time shall be initialed by the signer of the proposal, guaranteeing authenticity.
- 4.4 Proposals time-stamped after the due date and time will not be considered and will be returned to the Respondent unopened. Regardless of the method used for delivery, respondents shall be wholly responsible for the timely delivery of submitted proposals.
- 4.5 The Respondent's name and address shall be clearly marked on all copies of the proposal.

5.0 INCURRED COSTS:

Those submitting proposals do so entirely at their expense. There is no expressed or implied obligation by the County to reimburse any individual or firm for any costs incurred in preparing or submitting proposals, for providing additional information when requested by the County or for participating in any selection interviews, including discovery (pre-contract negotiations) and contract negotiations.

6.0 ACCEPTANCE:

- 6.1 Submission of any proposal indicates a Respondent's acceptance of the conditions contained in this Proposal unless clearly and specifically noted otherwise in their proposal.
- 6.2 Furthermore, the County is not bound to accept a proposal on the basis of lowest price, and further, the County has the sole discretion and reserves the right to cancel this Proposal, to reject any and all proposals, to waive any and all informalities and or irregularities, or to re-advertise with either the identical or revised specifications, if it is deemed to be in the County's best interests. The County reserves the right to accept or reject any or all of the items in the proposal, and to award the contract in whole or in part and/or negotiate any or all items with individual Respondents if it is deemed in the County's best interest.
- 6.3 Although Fort Bend County desires to negotiate toward a contract with a selected Respondent, the Commissioners' Court may award the contract on the basis of the initial proposals received, without discussions. Therefore, each initial proposal should contain the Respondent's best terms.

7.0 INTERPRETATIONS, DISCREPANCIES, AND OMISSIONS:

- 7.1 It is incumbent upon each potential Respondent to carefully examine these specifications, terms, and conditions. Should any potential Respondent find discrepancies, omissions or ambiguities in this Proposal, the Respondent shall at

once request in writing an interpretation from the County's Proposal Contact. Any inquiries, suggestions, or requests concerning interpretation, clarification or additional information shall be made in writing via e-mail only to the County's Proposal Contact, as specified in Section 3.0. Deadline for submission of questions and/or clarification is no later than **Tuesday, September 9, 2025 at 10:00 AM. (central)**. Requests received after the deadline will not be responded to due to the time constraints of this Proposal process.

- 7.2 The issuance of a written addendum is the only official method by which interpretation, clarification or additional information will be given by the County. Only questions answered by formal written addenda will be binding. Oral and other interpretations or clarification will be without legal effect. If it becomes necessary to revise or amend any part of this Proposal, notice will be given by the County Purchasing Agent to all prospective Respondents who were sent a Proposal. The Respondent in their proposal shall acknowledge receipts of amendments. Each Respondent shall ensure that they have received all addenda and amendments to this Proposal before submitting their proposals.

8.0 CONTRACTUAL OBLIGATIONS:

This Request for Proposal, response and associated documentation, any negotiations and final contract, when properly accepted by Fort Bend County, shall constitute a contract equally binding between the contractor and Fort Bend County.

9.0 RETENTION OF RESPONDENT'S MATERIAL:

The County reserves the right to retain all proposals regardless of which response is selected. All proposals and accompanying documents become the property of the County.

10.0 ASSIGNMENT:

The Respondent may not sell, assign, transfer or convey the contract resulting from this Proposal, in whole or in part, without the prior written approval from Fort Bend County Commissioners' Court.

11.0 CERTIFICATE OF INDEPENDENT PRICE DETERMINATION:

By submission of a proposal, each Respondent certifies, that in connection with this procurement:

- 11.1 The prices in this proposal have been arrived at independently, without consultation, communication, or agreement with any other Respondent; with any competitor; or with any County employee(s) or consultant(s) for the purpose of restricting competition on any matter relating to this Proposal.
- 11.2 Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by the Respondent and will not

knowingly be disclosed by the Respondent prior to award directly or indirectly to any other Respondent or to any competitor; and;

- 11.3 No attempt has been made or will be made by the Respondent to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

12.0 CONFIDENTIAL MATTERS:

- 12.1 All data and information gathered by the Respondent and its agents, including this Proposal and all reports, recommendations, specifications, and data shall be treated by the Respondent and its agents as confidential. The Respondent and its agents shall not disclose or communicate the aforesaid matters to a third party or use them in advertising, publicity, propaganda, and/or in another job or jobs, unless written consent is obtained from the County.
- 12.2 Proposals will be publicly received and acknowledged only so as to avoid disclosure of the contents to competing Respondents and kept confidential during negotiation. However, all proposals shall be open for public inspection after the contract is awarded. Trade secrets and any material that is considered to be confidential information contained in the proposal and identified by Respondent as such will be treated as confidential to the extent allowable in the Open Records Act. Respondents are to clearly mark confidential pages/information in red ink/type.
- 12.3 By submitting a Proposal, Respondent acknowledges and agrees that County is subject to the Texas Public Information Act, TEX. GOV'T CODE ANN. § 552.001 et seq., as amended, and County will make any information related to the Proposal, or otherwise, available to third parties in accordance with the Texas Public Information Act. Any proprietary or confidential information marked as such and provided to County by Respondent shall not be disclosed to any third party, except as directed by the Texas Attorney General in response to a request for such under the Texas Public Information Act, which provides for notice to the owner of such marked information and the opportunity for the owner of such information to notify the Attorney General of the reasons why such information should not be disclosed.

The terms and conditions of any Agreement, or amendment thereto, entered into between the chosen Respondent and the County are not proprietary or confidential information.

- 12.4 Respondent in providing all services hereunder agrees to abide by the provisions of any applicable Federal or State Data Privacy Act.

13.0 LIMITS OF SUBCONTRACTORS:

- 13.1 The County has approval rights over the use and/or removal of all subcontractors and/or vendor(s). Subcontractors shall conform to all County policies.

- 13.2 Any dispute between the Respondent and subcontractors, including any payment dispute, will be promptly remedied by the Respondent. Failure to promptly remedy or to make prompt payment to subcontractor may result in the withholding of funds from the Respondent by the County for any payments owed to the subcontractor.

14.0 JURISDICTION, VENUE, CHOICE OF LAW:

This Proposal and any contract resulting there from shall be governed by and construed according to the laws of the State of Texas. Should any portion of any contract be in conflict with the laws of the State of Texas, the State laws shall invalidate only that portion. The remaining portion of the contract(s) shall remain in effect. Any lawsuit shall be governed by Texas law and Fort Bend County, Texas shall be the venue for any action or proceeding that may be brought or arise out of, in connection with or by reason of this Proposal process and resulting Agreements.

15.0 INDEPENDENT CONTRACTOR:

The Respondent is an independent contractor and no employee or agent of the Respondent shall be deemed for any reason to be an employee or agent of the County.

16.0 AMERICANS WITH DISABILITIES ACT (ADA)

Proposals shall comply with all federal, state, county, and local laws concerning this type of products/service/equipment/project and the fulfillment of all ADA requirements.

17.0 DRUG-FREE WORKPLACE:

All Respondents shall provide any and all notices as may be required under the Drug-Free Workplace Act of 1988, 28 CFR Part 67, Subpart F, to their employees and all sub-contractors to insure that the County maintains a drug-free workplace.

18.0 PERFORMANCE AND PAYMENT BOND:

No performance nor payment bond is required for this project.

19.0 POWER OF ATTORNEY:

An attorney-in-fact who signs a bid bond, performance bond or payment bond must file with each bond a certified and effectively dated copy of his or her power of attorney.

20.0 TEXAS ETHICS COMMISSION FORM 1295:

- 20.1 Effective January 1, 2016 all contracts executed by Commissioners Court, regardless of the dollar amount, will require completion of Form 1295 "Certificate of Interested Parties", per the new Government Code Statute §2252.908. All firms submitting a response to a formal Bid, RFP, SOQ or any contracts, contract amendments, renewals or change orders are required to complete the

Form 1295 online through the State of Texas Ethics Commission website. Please visit:

<https://www.ethics.state.tx.us/File/>

20.2 On-line instructions:

20.2.1 Name of governmental entity is to read: Fort Bend County.

20.2.2 Identification number use: RFP 26-001.

20.2.3 Description is: Property & Casualty Insurance Program Third Party Administration Services.

20.3 Highest evaluated vendor will be required to provide the Form 1295 within three (3) calendar days from notification; however, if your company is publicly traded you are not required to complete this form.

21.0 INSURANCE:

21.1 All respondents shall submit, with RFP, a current certificate of insurance indicating coverage in the amounts stated below. In lieu of submitting a certificate of insurance, respondents may submit, with RFP, a notarized statement from an Insurance company, authorized to conduct business in the State of Texas, and acceptable to Fort Bend County, guaranteeing the issuance of an insurance policy, with the coverage stated below, to the firm named therein, if successful, upon award of this Contract.

21.2 At contract execution, contractor shall furnish County with properly executed certificates of insurance, which shall evidence all insurance required and provide that such insurance shall not be canceled, except on 30 days prior written notice to County. Contractor shall provide certified copies of insurance endorsements and/or policies if requested by County. Contractor shall maintain such insurance coverage from the time Services commence until Services are completed and provide replacement certificates, policies and/or endorsements for any such insurance expiring prior to completion of Services. Contractor shall obtain such insurance written on an Occurrence form (or a Claims Made form for Professional Liability insurance) from such companies having Best's rating of A/VII or better, licensed or approved to transact business in the State of Texas, and shall obtain such insurance of the following types and minimum limits:

21.2.1 Workers' Compensation insurance. Substitutes to genuine Workers' Compensation Insurance will not be allowed.

21.2.2 Employers' Liability insurance with limits of not less than \$1,000,000 per injury by accident, \$1,000,000 per injury by disease, and \$1,000,000 per bodily injury by disease.

- 21.2.3 Commercial general liability insurance with a limit of not less than \$1,000,000 each occurrence and \$2,000,000 in the annual aggregate. Policy shall cover liability for bodily injury, personal injury, and property damage and products/completed operations arising out of the business operations of the policyholder.
- 21.2.4 Professional Liability (Errors & Omissions) Insurance with limits of not less than \$1,000,000 each occurrence, \$2,000,000 aggregate. Such insurance will cover all Work performed by or on behalf of Contractor and its subcontractors under this Agreement. No Professional Liability policy written on an occurrence form will include a sunset or similar clause that limits coverage unless such clause provides coverage for at least twenty-four (24) months after the expiration or termination of this Agreement for any reason.
- 21.3 County and the members of Commissioners Court shall be named as additional insured on a Primary and Non-Contributory basis to all required coverage except for Workers' Compensation and Professional Liability (Medical Malpractice) Insurance. All Liability policies including Workers' Compensation written on behalf of contractor, shall contain a waiver of subrogation in favor of County and members of Commissioners Court.
- 21.4 If required coverage is written on a claims-made basis, contractor warrants that any retroactive date applicable to coverage under the policy precedes the effective date of the contract; and that continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning from the time that work under the agreement is completed.

22.0 INDEMNIFICATION:

Respondent shall save harmless County from and against all claims, liability, and expenses, including reasonable attorney's fees, arising from activities of Respondent, its agents, servants or employees, performed under this agreement that result from the negligent act, error, or omission of Respondent or any of Respondent's agents, servants or employees.

- 22.1 Respondent shall timely report all such matters to Fort Bend County and shall, upon the receipt of any such claim, demand, suit, action, proceeding, lien or judgment, not later than the fifteenth day of each month; provide Fort Bend County with a written report on each such matter, setting forth the status of each matter, the schedule or planned proceedings with respect to each matter and the cooperation or assistance, if any, of Fort Bend County required by Respondent in the defense of each matter.
- 22.2 Respondent's duty to defend, indemnify and hold Fort Bend County harmless shall be absolute. It shall not abate or end by reason of the expiration or termination of any contract unless otherwise agreed by Fort Bend County in writing. The provisions of this section shall survive the termination of the contract and shall

remain in full force and effect with respect to all such matters no matter when they arise.

- 22.3 In the event of any dispute between the parties as to whether a claim, demand, suit, action, proceeding, lien or judgment appears to have been caused by or appears to have arisen out of or in connection with acts or omissions of Respondent, Respondent shall never-the-less fully defend such claim, demand, suit, action, proceeding, lien or judgment until and unless there is a determination by a court of competent jurisdiction that the acts and omissions of Respondent are not at issue in the matter.
- 22.4 Respondent's indemnification shall cover, and Respondent agrees to indemnify Fort Bend County, in the event Fort Bend County is found to have been negligent for having selected Respondent to perform the work described in this request.
- 22.5 The provision by Respondent of insurance shall not limit the liability of Respondent under an agreement.
- 22.6 Respondent shall cause all trade contractors and any other contractor who may have a contract to perform construction or installation work in the area where work will be performed under this request, to agree to indemnify Fort Bend County and to hold it harmless from all claims for bodily injury and property damage that arise may from said Respondent's operations. Such provisions shall be in form satisfactory to Fort Bend County.
- 22.7 Loss Deduction Clause - Fort Bend County shall be exempt from, and in no way liable for, any sums of money which may represent a deductible in any insurance policy. The payment of deductibles shall be the sole responsibility of Respondent and/or trade contractor providing such insurance.

23.0 STATE LAW REQUIREMENTS FOR CONTRACTS:

The contents of this section are required by Texas Law and are included by County regardless of content.

- 23.1 Agreement to Not Boycott Israel Chapter 2271 Texas Government Code: Contractor verifies that if Contractor employs ten (10) or more full-time employees and this Agreement has a value of \$100,000 or more, Contractor does not boycott Israel and will not boycott Israel during the term of this Agreement.
- 23.2 Texas Government Code Section 2251.152 Acknowledgment: By signature on vendor form, Contractor represents pursuant to Section 2252.152 of the Texas Government Code, that Contractor is not listed on the website of the Comptroller of the State of Texas concerning the listing of companies that are identified under Section 806.051, Section 807.051 or Section 2253.153.

24.0 HUMAN TRAFFICKING:

By acceptance of this contract, Contractor acknowledges that Fort Bend County is opposed to human trafficking and that no County funds will be used in support of services or activities that violate human trafficking laws.

***25.0 TENTATIVE SCHEDULE:**

Release of RFP:	August 31, 2025
Deadline for Questions:	September 9, 2025
Submission Due Date:	September 30 23 , 2025
Evaluation of Submissions:	Week of October 7, 2025
Commissioners Court Permission to Negotiate:	October 14, 2025
Negotiations:	Begin October 15, 2025
Final Contract Approval Commissioners Court:	November 25, 2025

26.0 PRE-RFP CONFERENCE:

There is no Pre-RFP meeting for this solicitation.

27.0 EVALUATION CRITERIA:

In order to facilitate the analysis of responses to this Proposal, Respondents are required to prepare their proposals in accordance with the instructions outlined in this part. Proposals should be prepared as simply as possible and provide a straightforward, concise description of the Respondent’s capabilities to satisfy the requirements of the Proposal. Emphasis should be concentrated on accuracy, completeness, and clarity of content. All parts, pages, figures, and tables should be numbered and clearly labeled.

27.1 Respondents are required to follow the outline below when preparing their proposals:

Tab	Title
	Title Page
	Table of Contents
	Executive Summary
1	Understanding Requirements
2	Qualifications/Experience/References
3	Price
4	Required forms and overall completeness of submission

27.2 Any exceptions to the Proposal requirements shall be identified in the applicable section.

27.3 Executive Summary - This section should be limited to a brief narrative highlighting the company’s background and experience. Narrative should clearly

demonstrate compliance with Respondent's qualifications listed in the RFP specifications. Include length of time the company has been in business and provide examples of past/current projects. Provide a list of newly awarded contracts and pending contracts.

27.4 Respondents will be evaluated utilizing the factors, as weighted below:

Tab 1

Understanding Requirements (weight factor = 25%)

- Provide response to all questions in Attachment 1.

Tab 2

Qualifications/Experience/References (weight factor = 35%)

- Provide the following information: Length of time respondent has been in the business of Third Party Administration; current and recent history of past performance by the Respondent of a similar nature to the performance offered in response to the RFP; any evidence submitted (letters of reference) or readily attainable regarding the quality of past performance and the reliability of responsiveness of the Respondent; the apparent capabilities of the Respondent to perform well in the execution of its obligations under a contract with the County as evidenced by its leadership and management personnel, size of organization, length of time in business, past performance, and other current contractual obligations defining the Respondents capability to undertake and successfully fulfill the obligations proposed to be undertaken by its submission of a proposal in response to this RFP. Respondent should outline experience with clients of the same size and/or same vicinity/state as this County.

Tab 3

Price (weight factor = 35%)

- Provide all pricing in Attachment 2.

Tab 4

Required forms and overall completeness of submission (weight factor = 5%)

- Proof of Insurance

- Completed Respondent forms
- Completed W9 form
- Completed debt form

28.0 AWARD:

RFP will be evaluated by a committee comprised of County staff. The committee will review Request for Qualifications submitted and may develop a short list of not more than four (4) firms. These firms may be requested to submit additional information and may be invited for a presentation with the Committee. Based on further review after the interviews, the committee will forward their recommendations to the Fort Bend County Commissioners Court.

29.0 TERM OF CONTRACT:

The term of this contract is for a period of twenty-four (24) months, commencing on January 1, 2026, and ending at the close of business on December 31, 2027, with three (3) additional one-year renewal options under the same terms and conditions if mutually agreeable to both parties. Either party for any reason may terminate this contract by giving thirty (30) days written notice of the intent to terminate.

30.0 REQUIRED FORMS:

All respondents submitting are required to complete the attached/included and return with submission:

- 30.1 Vendor Form
- 30.2 W9 Form
- 30.3 Tax Form/Debt/Residence Certification
- 30.4 Proof of Insurance

31.0 ATTACHMENTS:

- 31.1 Attachment 1: General Questionnaire
- 31.2 Attachment 2: Pricing

ATTACHMENT 1: GENERAL QUESTIONNAIRE

A. Location and Personnel

1. List the location of your firm's main office and the locations of offices in the State of Texas. Provide the address of the office location that will service the County.
2. Identify the person directly responsible as the Account Coordinator on behalf of the County and provide contact information for that person and include a brief description of the representative's background, experience and qualification, as well as an explanation of the representative's role and responsibilities for the firm.
 - a. What are the responsibilities of this position?
 - b. What additional duties may be required of this individual besides that of account coordinator?
 - c. What authority does this individual have to affect action and changes on behalf of the County?
 - d. How is the account coordinator monitored and evaluated? By whom and how frequently?
 - e. Is the account coordinator's compensation related to performance?
 - f. Please provide a resume of the Account Coordinator recommended for the County's program. Please include prior experience in this position.
 - g. From which office is this person based?

B. Designated Adjusters

1. If you designate an adjuster, or a team, will this person handle more than one jurisdiction? If so, how many jurisdictions and which ones?
2. What training or development is provided to adjusters who manage claims for multiple jurisdictions?
3. Please provide resumes of the adjusters who are recommended to be assigned to the County account. Please include the jurisdictions with which they currently work and length of experience with each jurisdiction.
4. What are adjuster turnover rates, nationally and by branch?
5. What are adjuster caseloads, nationally and by branch?
6. What is the maximum adjuster caseload allowed?
7. Will adjusters work from a company office or from home?

C. Firm Overview

1. Provide an overview of the firm, including the full legal name of the institution, state of organization and supervisory and regulatory authorities that oversee the institution.
2. Provide a summary of the ownership and management of the firm. Describe any significant changes in the management and/or structure of your firm, including mergers that have occurred during the past three years. Does your firm foresee or anticipate any organizational changes in the next 24 months?
3. Provide an annual report or other information describing your business, its scope, size and structure.
4. When was your business started and how long has it provided claims administration services?
5. How many clients do you support and what is the average size of the clients business?
6. Does your firm carry Errors and Omissions coverage for its staff? Who is covered?

D. Claim Office Structure

1. What is the structure of each claim office?
2. What is the supervisor to adjuster ratio? What are the specific supervisory duties and responsibilities? Do supervisors supervise any staff other than adjusters?
3. Do supervisors manage claims? If so, what is their caseload?
4. How are supervisors monitored and evaluated, how frequently and by whom? Is compensation related to performance?
5. What internal audit functions does your company perform, either at the home office or claim office level?

E. Volume of Business.

1. Provide a summary of the firm's claim volume for each of the past three years by the following categories: commercial property, general liability, commercial umbrella and commercial automobile, public official liability and bond, and workers' compensation.
2. If the office that will service the County's account is a branch or subsidiary of a national or regional firm, the above information should be provided for both the office providing services to the County and the entire firm.

F. References.

1. Provide a list of at least three clients with insurance adjusting needs similar to the County which may include public schools, city, county or state governmental entities.
2. Describe your firm's specific experience providing services to each of those clients.
3. Describe your experience, if any, providing third party claims administration services to counties in the State of Texas
4. Describe any issues or problems that have impacted any of the client accounts described in this section.
5. Identify ways in which you added unique value or problem solving to any of the client accounts.
6. Provide contact information to enable the County to contact those accounts as references.
7. Identify any new accounts for governmental entities obtained in the past three years and any such accounts that the firm has lost. Provide an explanation for the lost accounts.

G. Customer Support.

1. Describe and discuss your staff available to support the County.
2. How much of that staff is located in the state of Texas?
3. How many dedicated claims support staff does the firm maintain?
4. What portion of the claims support staff is located in the state of Texas?
5. How many claims support staff are located in the office that will service the County?
6. Identify the average number of claims support staff per customer account and the average number of claims handled by each claims support staff member each year.
7. Identify any technology or related tools available from your firm and describe the advantages those tools offer the County.
8. What are your internal quality assurance processes? Please provide your company's service standards or best practices?
9. How are adjusters monitored and/or compensated to ensure compliance with your internal service standards or best practices with the County's client service instructions?

10. Describe your risk management information system (RMIS). What controls are in place to ensure data integrity?
11. Describe what type of access and training you will be offering the County to your RMIS

H. Claim Notes

1. What information is required to be included in the claim notes?
2. What are the supervisory file review criteria? What supervisory note documentation is required?
3. Are medical case manager notes included?
4. Who else enters claim notes?

I. Reserving Practices

1. What is your company's reserving philosophy?
2. When are initial reserves established?
3. When and how do you communicate reserve information to the client?
4. When do supervisors review initial reserves, reserve changes and conduct periodic reserve reviews?
5. What subjective information and/or objective tools are used by your company to establish reserves?
6. Does your company use an automated reserving program to establish reserves?

J. Diary System

1. What automatic system diary notices are provided, to whom and when?
2. How frequently do supervisors monitor/review claims?
3. How frequently are adjusters expected to review a claim? Other diary notices.

K. Subrogation

1. The County does not allow subrogation to be pursued without County approval.
2. Describe your subrogation services. What criteria are used for exploring cases with potential subrogation? Do you use resources from outside your organization for this service? How does this affect pricing?
3. Please discuss in detail any additional fees required for these services.

L. Litigation Management Strategies

1. What are your litigation management practices?
2. What is the procedure for assigning defense counsel to a claim?
3. What is the adjuster and supervisor involvement in a litigated claim?
4. Describe your process for coordinating with County counsel.
5. Do you have an approved outside counsel list? Will you add our preferred attorneys to the list?

M. Allocated Loss Adjustment Expenses (ALAE)

1. What do you define as ALAE?
2. What are the adjuster's responsibilities?

N. Client Instructions

1. How are client service instructions made available to adjusters?
2. Is there a gate-keeping system that will require the adjuster to complete or comply with all items of the client special handling instructions?
3. How do supervisors ensure adjuster's compliance with client service instructions?
4. Please confirm that TPA is agreeable to weekly call with FBC RM department personnel to verify claims are being setup and investigated properly.
5. Please confirm if TPA is agreeable to considering using Dean Pappas and Associates as a FBC preferred WC defense counsel for any hearing or litigation needs.

O. Claim Review Meetings

1. Claim review meetings will be conducted with the County on a quarterly basis.
2. What are your recommendations for scheduling and accomplishing the quarterly claim review meetings?
3. Please confirm that TPA has the ability to prepare detailed AL/GL/WC/Claim Status Reports prior to each Quarterly Claim Review (current status, financials and action plan going forward)
4. What fees are assessed for this service, if any?

P. Claim Reporting Options

1. What options are available to the County for reporting new losses to your company?
2. How are new losses disbursed to claim offices? What is the guaranteed time frame?
3. What are the internal service standards for establishing a claim file for a new loss?

4. County currently has a proprietary incident reporting system. After September (2023) incident reporting will be available through Origami. Can County system or Origami interface with your RMIS to upload incident reports to you? Is there a cost for this service?
5. Please provide pricing options.

Q. Centralized Medical Only Claim Handling

1. Please provide a detailed description of your capabilities relative to the administration of medical only claims.
2. If so, please provide details of locations, personnel, and best practices.

R. Billing/Funding

1. What billing options are available to the County? How are fees estimated if billed on a per-claim basis?
2. What banking arrangements are available to the County?
3. How is the imprest/escrow fund determined?
4. Please outline your internal procedures to ensure security of claim checks.
5. Are benefit checks issued from the claim office or from a central facility?

S. Carrier Protocols

1. How is claim data transferred to an excess insurance carrier? Is there a cost associated with this service?
2. How are claims with excess insurance potential identified?
3. How are claims with excess insurance potential reported?
4. When, and how, is the client notified of these types of claims?
5. The County is self-insured and has its' own RMIS for internally-handled claims, to review third party administered claims and to run combined reports of internally/externally handled claims. Does your system have the ability to interface with the County's RMIS (Origami) to include notes, reserves, financial transactions, photos, accident investigative reports, incident reports, etc.? Is there a cost for this interface or data transfer service? If so, please include pricing in your quote.

T. Implementation Plan

1. Please provide a management plan and timeline for the implementation of the County's program.
2. Please firm that your RMIS is compatible with Origami (currently the FBC RMIS system).
3. Please indicate if your system and IT group are able to complete transfer of data between your system and Origami and to set up an ongoing interface to transfer claims file data within a 6-8 week setup and implementation period.
4. Please include who will be responsible for each activity.

U. Cost Reduction Results

1. Please provide your average cost per claim for workers' compensation medical only and lost time claims, auto liability bodily injury and general liability bodily injury claims.
2. Please provide the average number of days a workers' compensation medical only and lost time, auto liability bodily injury and general liability bodily injury claim is in an open status.
3. Please provide the average number of days your claimants are on temporary total disability.
4. Please provide details on your temporary transitional assignment (modified duty) process for compensable injured employees on workers compensation.
5. Please provide additional information that reflects your company's cost reduction outcomes.
6. Please confirm that TPA is willing to unbundle Medical Cost Containment and if so, use a FBC preferred MCC Vendor partner (include in your bid your MCC solutions).

V. Legal, Regulatory and Ethics Actions

1. Provide a summary of any litigation, arbitration and regulatory proceedings, pending, adjudicated or settled that your firm has been subject to within the last three years involving services your firm provided as a third party claims administrator.
2. Please describe each regulatory proceeding in detail and any litigation or arbitration proceeding resulting in judgments, settlements or damage claims.

W. Licenses

1. Provide evidence that the third party administrator and persons performing the work for the County maintain all Texas licenses in order to provide the service insurance sought pursuant to this RFP/Q relating to third party administration.

X. OTHER

1. What are your standard procedures with regard to the termination of an account? Describe your procedures for moving both physical files and electronic data. Specifically address your position on transfer of adjuster notes in the electronic information. Provide details on fees associated with transfer of both paper and electronic files. Include information on pricing and terms for claims handling after termination. Finally, include your policy on access to electronic system upon termination of account – including pricing.
2. Discuss your procedures for participation in workers' compensation hearings. Please define roles and responsibilities of in-house resources versus outside representatives – including legal counsel. What is the experience level of hearing representatives?
3. Please describe in detail the various banking options for bill payment that are available to Client. Be sure to include information on any paid loss deposit or claim service fee fund requirements, large loss funding thresholds and wire transfer payment options. Include information on the process of actually producing checks including information on checkstock, options or procedure relating to creating, maintenance, and funding of the necessary bank accounts and other related items. Describe the process of managing and reconciling these accounts.
4. Please provide a sample contract.

Print Name and Title of person completing this form: _____.

Name of Agency/Company: _____.

Signature: _____.

ATTACHMENT 2: PRICING

Please fill in a rate or dollar amount and check mark where applicable in the appropriate column. Please fill in your estimate of claims. Only fill in areas that apply to your proposal. Should you need to explain a fee/charge that was not addressed, use the bottom of the page, and you may go into greater detail in your individual proposal. Please attach this page to the section of your proposal including pricing.

Full Legal Name of Firm/Entity:

Name of Person(s) Completing this form:

	Incurred 2024	Incurred 2025 as of 7/1/2025	Open claims as of 7/1/2025
Workers Compensation	350	175	150
Medical only	100	120	80
Indemnity	40	50	70
AL/GL	359	185	150
Property Damage Non litigated	139	77	20
Bodily Injury Non litigated	11	3	10
Bodily Injury Litigated	0	0	7
Law Enforcement Liability Litigated (Civil Rights)	6	1	11
Employment Practices Liability Litigated	5	1	10
Subrogation for Property Damage	7	2	6
Subrogation for Workers' Compensation	15	10	
Subrogation for GL/AL	61	29	50

All lines of Coverage Flat Fee			
Attending TDI Hearings Other			
Data Conversion			
On-Line Computer Services (Incident Reporting)			
RMIS System and Services – Annual Administration Fee (Interfaces and other fees)			
Run-Off Costs			
Run IN costs			
Field Services/Investigation			
Designated Doctor review			
RME Coordination			

**INSURANCE COMPANY ADMINISTRATION, THIRD PARTY ADMINISTRATION
AND COST CONTAINMENT ADMINISTRATION**

	Flat Fee	Fee per Review	Fee per Hour	Fee per Bill	T/E mileage				
Hospital Bill Audit									
Physician Peer-Review									
Chiropractic Peer-Review									
Pre- Authorization									
Utilization Review									
Medical/Rx Bill Audits									
Use of PPO Networks									
Rehabilitation Services									
Vocational Case Management									
Impairment Rating review									
	Other Charges/Fees Explanation:								
	Other Charges/Fees Explanation:								
	Other Charges/ Fees Explanation:								
	Other Charges/Fees Explanation:								
	Do you require any deposits? Y / N If yes, please explain purpose and dollar amounts:								
	Does your proposal offer multi-year pricing? Y / N If yes, explain how long pricing is in effect:								
	State your guaranteed annual flat fee:								
	State your estimated annual fee including all charges:								
	Name/Signature:								
	Company/Agency:								



COUNTY PURCHASING AGENT
Fort Bend County, Texas

Vendor Information

Brooke Lindemann
Interim Purchasing Agent

Office (281) 341-8640

Legal Company Name (top line of W9)				
Business Name (if different from legal name)				
Type of Business	Corporation/LLC Sole Proprietor/Individual	Partnership Tax Exempt	Age in Business?	
Federal ID # or S.S. #	SAM.gov Unique Entity ID #			
SAM.gov CAGE / NCAGE				
Publicly Traded Business	___ No ___ Yes Ticker Symbol _____			
Remittance Address				
City/State/Zip				
Physical Address				
City/State/Zip				
Phone Number				
E-mail				
Contact Person				
Check all that apply to the company listed above and provide certification number.	DBE-Disadvantaged Business Enterprise ___	Certification # _____	Cert Date _____	Exp Date _____
	SBE-Small Business Enterprise ___			
	HUB-Texas Historically Underutilized Business ___	Certification # _____	_____	_____
	WBE-Women's Business Enterprise ___	Certification # _____	_____	_____
Company's gross annual receipts	<\$500,000 _____	\$500,000-\$4,999,999 _____		
	\$5,000,000-\$16,999,999 ___	\$17,000,000-\$22,399,999 _____	>\$22,400,000 _____	
NAICs codes (Please enter all that apply)				
Signature of Authorized Representative				
Printed Name				
Title				
Date				

THIS FORM MUST BE SUBMITTED WITH THE SOLICITATION RESPONSE

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

**Give form to the
 requester. Do not
 send to the IRS.**

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See <i>Specific Instructions</i> on page 3.	1	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)		
	2	Business name/disregarded entity name, if different from above.		
	3a	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes.		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
	<input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate		Exempt payee code (if any) _____	
	<input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____ Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.		Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____	
	<input type="checkbox"/> Other (see instructions) _____		<i>(Applies to accounts maintained outside the United States.)</i>	
	3b	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions <input type="checkbox"/>		
5	Address (number, street, and apt. or suite no.). See instructions.		Requester's name and address (optional)	
6	City, state, and ZIP code			
7	List account number(s) here (optional)			

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Social security number											
					-			-			
or											
Employer identification number											
					-						

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they







Fort Bend County Contract_2.1.26 12

Final Audit Report

2026-01-09

Created:	2026-01-09
By:	Mary Bushong (mary.bushong@ccmsi.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAw8XsQJXpbWumURm6ZB0f2igwOaDiitiV

"Fort Bend County Contract_2.1.26 12" History

-  Document created by Mary Bushong (mary.bushong@ccmsi.com)
2026-01-09 - 4:45:52 PM GMT
-  Document emailed to John Kluth (jkluth@ccmsi.com) for signature
2026-01-09 - 4:45:56 PM GMT
-  Email viewed by John Kluth (jkluth@ccmsi.com)
2026-01-09 - 4:46:38 PM GMT
-  Signer John Kluth (jkluth@ccmsi.com) entered name at signing as John E. Kluth II
2026-01-09 - 4:47:22 PM GMT
-  Document e-signed by John E. Kluth II (jkluth@ccmsi.com)
Signature Date: 2026-01-09 - 4:47:24 PM GMT - Time Source: server
-  Agreement completed.
2026-01-09 - 4:47:24 PM GMT