Exhibit E

PROPOSAL RESPONSE FORM – SIGNATURE PAGE

(Submit this form with your proposal)

TO: City of Gainesville, Florida
200 East University Avenue
Gainesville, Florida 32601

PROJECT: **Third Party Claims Adjusting Services**

RFP/RFQ#: RMDX-160031-DD

RFP/RFQ DUE DATE: July 7, 2016 @ 3:00 P.M.

Proposer's Legal Name: **Preferred Governmental Claim Solutions**

Proposer's Alias/DBA: **Preferred Governmental Claim Services (PGCS)**

Proposer's Address **615 Crescent Executive Court, Suite 600, Lake Mary, FL 32746**

PROPOSER'S REPRESENTATIVE (to be contacted for additional information on this proposal)

Name: **Kenneth Picton, Vice President** Telephone Number **321-832-1400 ext 4035**

Date: June 30, 2016 Fax Number **321-832-1448**

Email address **kpicton@pgcs-tpa.com**

ADDENDA

The Proposer hereby acknowledges receipt of Addenda No.'s **1&2** to these Specifications.

TAXES

The Proposer agrees that any applicable Federal, State and Local sales and use taxes, which are to be paid by City of Gainesville, are included in the stated bid prices. Since often the City of Gainesville is exempt from taxes for equipment, materials and services, it is the responsibility of the Contractor to determine whether sales taxes are applicable. The Contractor is liable for any applicable taxes which are not included in the stated bid prices.

LOCAL PREFERENCE (check one)

Local Preference requested: YES **X** NO

A copy of your Business tax receipt and Zoning Compliance Permit should be submitted with your bid if a local preference is requested.

Exhibit E

QUALIFIED LOCAL SMALL BUSINESS STATUS (check one)

Is your business qualified as a Local Small Business in accordance with the City of Gainesville Small Business Procurement Program? (Refer to Definitions) YES **X** NO

SERVICE-DISABLED VETERANS' BUSINESS (check one)

Is your business certified as a service-disabled veterans' business? YES **X** NO

LIVING WAGE COMPLIANCE

X See Living Wage Decision Tree (Exhibit C

hereto) **Check One:**

X Living Wage Ordinance does not apply (check all that apply)

Not a covered service

Contract does not exceed $100,000

Not a for-profit individual, business entity, corporation, partnership, limited liability company, joint venture, or similar business, who or which employees 50 or more persons, but not including employees of any subsidiaries, affiliates or parent businesses.

Located within the City of Gainesville enterprise zone.

☐ Living Wage Ordinance applies and the completed Certification of Compliance with Living Wage is included with this bid.

NOTE: If Contractor has stated Living Wage Ordinance does not apply and it is later determined Living Wage Ordinance does apply, Contractor will be required to comply with the provision of the City of Gainesville's living wage requirements, as applicable, without any adjustment to the bid price.

SIGNATURE ACKNOWLEDGES THAT: (check one)

X Proposal is in full compliance with the Specifications.

Proposal is in full compliance with specifications except as specifically stated and attached hereto.

Signature also acknowledges that Proposer has read the current City of Gainesville Debarment/Suspension/Termination Procedures and agrees that the provisions thereof shall apply to this RFP.

(CORPORATE SEAL)

ATTEST:

Signature

By: Anthony Robinson

Title: V.P. / Assistant Secretary

PROPOSER:

Signature

By: **Kenneth Picton**

Title: **Vice President**

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LETTER OF INTEREST

July 5, 2016

Mr. Doug Drymon
Senior Buyer
City of Gainesville Purchasing
200 East University Avenue, Room 339
Gainesville, Florida 32601

Dear Mr. Drymon:

PGCS Claim Services appreciates the opportunity to submit this proposal to provide Third Party Administrative Services for Workers' Compensation Claims for the City of Gainesville. As a true partner to the City, PGCS will customize a program to meet your unique needs, backed by the resources, leadership team, and financial stability that PGCS offers.

Here are some key elements that differentiate us from other providers and ultimately, position us to be the best partner for the City:

Public Entity Expertise

PGCS's client base is comprised solely of public entities. We understand the nuances of handling claims in the public sector. Our unique approach, combined with a 24/7 nurse triage program, proactively addresses potentially complex claims at the onset of the injury. This significantly impacts our clients' programs and reduces their total cost of risk.

Local Service

PGCS will manage the City's claims from our Lake Mary, Florida office. The service team we assign to manage the City's claims brings expertise in the nuances of your local jurisdiction and will offer a high level of customer service as a result of their proximity. The City can take advantage of the opportunity to conduct in-person file reviews to discuss complex or high dollar cases and strategize opportunities to resolve claims.

Integrated Services Through AmeriSys

PGCS partners with AmeriSys to provide managed care services. Since medical costs account for approximately 60 cents of each dollar spent on workers' compensation claims, medical management services play an enormous role in the City's overall cost of risk. PGCS is proposing integrated third party

administration and medical management services because we believe this approach allows for the greatest efficiency and enables claims examining staff to assert more control over the outcome of the file, resulting in lower cost of claims.

Innovative, State-of-the-Art Risk & Claims Management System

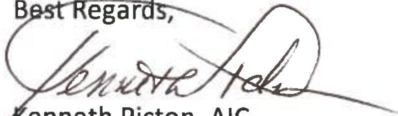
PGCS offers the City an innovative front end system, RiskMaster, which is a powerful, yet easy-to-use, risk management tool that will give you instant access to the information you want, exactly the way you want to see it. RiskMaster, via our website, provides data visualization, and an expanding library of customizable reports and interactive tools which transform volumes of data into useful, impactful information that can be understood at a glance. Available on all data platforms – tablets, mobile devices, and PC's – it is simple, intuitive and engaging to use.

RiskMaster is central to our ability to manage the City's program in an efficient cost-effective manner. Our paperless process is fully integrated with our managed care system, thereby enabling our adjusters to operate efficiently and dedicate their attention to reducing claims costs and providing outstanding customer service to the City.

Our goal is to adapt our structure and process to become a seamless extension of the City's risk management program so that we can meet your unique needs.

The undersigned is the designated contact person for PGCS.

Best Regards,



Kenneth Picton, AIC
Vice President of PGCS

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Introduction To PGCS

CITY OF GAINESVILLE

Mission Statement

Preferred Governmental Claims Solutions, Inc. (PGCS) is a lean, highly competitive service organization comprised of people of the highest integrity and quality, bound together by clearly defined goals and prideful relationships.

Our mission is to serve our customers, employees and society by providing a broad range of services.

We will develop innovative programs which meet the needs of our clients and contribute to their success.

We will foster an environment which stimulates professional excellence and encourages contribution by all employees.

We will demonstrate good corporate citizenship through the ethical conduct of our business.

Executive Summary

- Premier governmental third party claims administrator (TPA) in Florida since 1956
- Division of Brown & Brown Insurance
- Provides third party claims administration services to over 450 governmental entities including schools, cities, towns, counties, community development districts, and fire districts.

Executive Summary - continued

Professional, Experienced Staff

- Fifty-One (51) claims, IT, and accounting professionals
  - ✓ Workers' Compensation
  - ✓ General Liability
  - ✓ Property
  - ✓ Auto Liability
  - ✓ Catastrophic Adjusting Team for hurricanes and other natural and man-made disasters

PGCS Specialty Services

- Subrogation Unit
  - ✓ Recovery rate is sixty-eight and a half percent (68.5%) of the claim costs expended
- Excess Reporting & Recovery Unit
- SCHIP Compliance Unit
- EDI Compliance Unit

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PGCS Organization

Ken Picton
Vice President

Cheryl Riley — Workers' Compensation Claims Manager

- Sheila Kraft — Assistant Claims Manager
  - Angela Looney — Sr. Claim Specialist
  - Pam Dyke — Sr. Claim Specialist
  - Lynn Bowen — Sr. Claim Specialistl
  - Lynn Owens — Claim Specialist II
  - Nancee Hache — Sr. Claim Specialist
- Paula Humphreys — Excess and Subrogation Supervisor
  - Christen Swint — Excess Specialist
  - Rhonda Humphreys — Excess Claims Specialist I
  - Cheryl Jordan — Sr. Excess Specialist
  - Dorris Gonzalez — Sr. Subrogation Specialist
- Wendy Hall — WC PGIT Supervisor
  - Jennifer Bowling — Sr. Claim Specialist
  - Lisa Battershall — Sr. Claim Specialist
  - Cathy Meeks — Sr. Claim Specialist
  - Holly Davis — Sr. Claim Specialist
  - Nicole Ashcraft — Claim Specialist I
- Jacque Harris — M/O & Support Services Supervisor
  - Evelyn Asencio-Villa — Claim Specialist I
  - Maria Beahm — Claim Specialist I
  - Martha Turner — Claim Specialist I
  - Karen Maxwell — Mail Room Coordinator
  - Cathy Amberson — WC Claim Assistant
  - Marlene Harjo — WC Claim Assistant
  - Eva Toro — WC Intake Coordinator
  - Wendy Insley — PGIT WC Intake & WC Claim Assistant
  - Deni Sugg — Receptionist

Julius Hajas — Liability Claims Manager

- Natalie Bowen — Liability Claims Supervisor
  - Rachel Kelly — Claim Specialist II
  - Jane Lee — Claim Specialist I
  - Kara Wilkins — Claim Specialist I
  - Krysta Bann — Liability Intake Coordinator
  - Carol Thomas — Liability Claim Assistant
- William Ritzmann III — Liability Claims Supervisor
  - David Smyth — Sr. Claim Specialist
  - Paul Dennis — Sr. Claim Specialist
  - Linda Fouche — Sr. Claim Specialist
  - Monika Coleman — Sr. Claim Specialist
  - Jeffery Liberto — Sr. Claim Specialist
  - Stephen Scholfield — Sr. Claim Specialist

Gail Couchman — Director of I.T.

- Melissa Yates — Data Administrator
- Amber Gilmour — EDI Specialist

Heather Payne — Accounting Leader

- Rachael Mountford — Accounting Assistant
- TBD — Check Processor

Gail Stearman — Executive Assistant

PGCS Leadership Team

Kenneth Picton – Executive Vice President

- Responsible for the day to day management of PGCS
- Graduate of Bradley University
- 40 years insurance claims adjusting & claims management experience
- Carrier and TPA experience
- Extensive experience in litigation management

Julius Hajas – Manager, Liability & Property

- Responsible for the overall management of the PGCS Liability and Property Divisions
- Graduate of Marist College
- Actively licensed as an adjuster with multi-state experience
- 38 years insurance claims adjusting & claims management experience

Cheryl Riley – Manager, Workers' Compensation

- Responsible for the overall management of the PGCS Workers' Compensation Division
- 32 years insurance claims experience
- Carrier & TPA experience

PGCS Leadership Team

Heather Payne – PGCS Accounting Leader

- PGCS Accounting Leader
- Holds AAI, ARM and CEBS designations
- Graduate of the University of Central Florida
- 10 years experience in Finance & Accounting

Sheila Kraft – Assistant Manager, Workers' Compensation

- Responsible for the administration of the PGCS Self-Insured Workers' Compensation units
- Responsible for continuing education and licensing
- Holds a Florida Claims Adjuster license
- 26 years of workers' compensation claims handling experience

Jacques Harris – Supervisor, Workers' Compensation

- Responsible for oversight of the Medical Only unit
- Holds a Florida Claims Adjuster license
- 39 years of workers' compensation claims handling experience

PGCS Leadership Team

Wendy Hall – Supervisor, Workers' Compensation

- Responsible for the supervision of the Preferred Governmental Insurance Trust Workers' Compensation Unit
- Holds a Florida Claims Adjuster License and a Board Certification designation
- 32 years insurance claims experience

Paula Humphreys – Supervisor, Excess Claims Unit

- Responsible for the supervision of the Excess Claims Unit
- Holds a Florida Claims Adjuster License and a Board Certification designation
- 29 years of insurance claims experience

Bill Ritzmann – Supervisor, Professional Liability

- Responsible for the supervision of the Professional Liability Claims Unit
- Responsible for continuing education and licensing
- Holds a Florida Claims Adjuster License
- 24 years of insurance claims experience

PGCS Leadership Team

Natalie Bowen – Liability Claims Supervisor

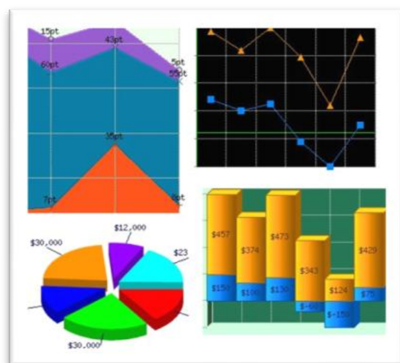
- Responsible for the supervision of the Liability and Property Claims Unit
- Graduate of University of Central Florida
- Holds a Florida Claims Adjuster License
- 24 years of insurance claims experience

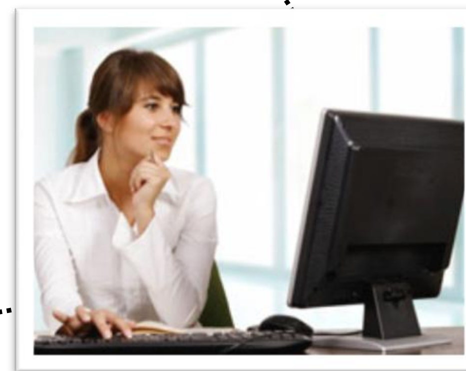
Gail Couchman – Director, Information Technology Services

- Responsible for IT operations, claims data management, reporting, and claims EDI
- Extensive experience in system administration, data management, compliance, and software development across a broad range of industries
- 28 years Information Technology experience

Information Technology

Responsible for website maintenance/development;
750 ad hoc reports issued annually; **1,140** loss runs produced.



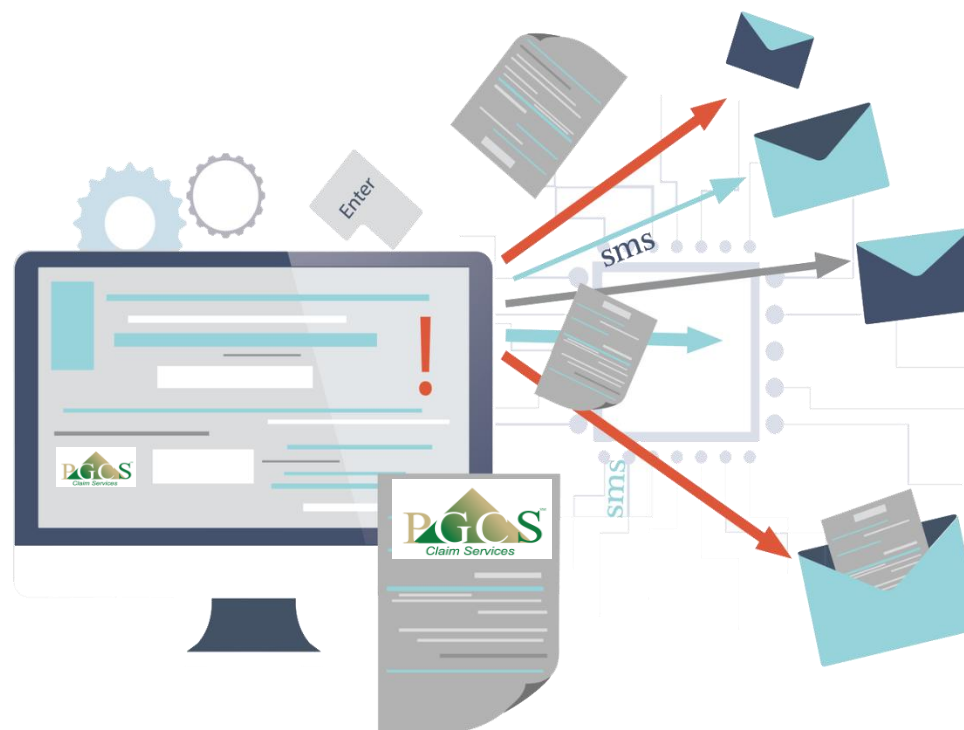


Finance

96,922 payments (claim checks) issued annually;
31 self insured loss funds managed.

Mail Room

85,676 pieces of mail processed annually;
50,832 documents scanned annually.



Average Annual

Claims

9,987 claims processed

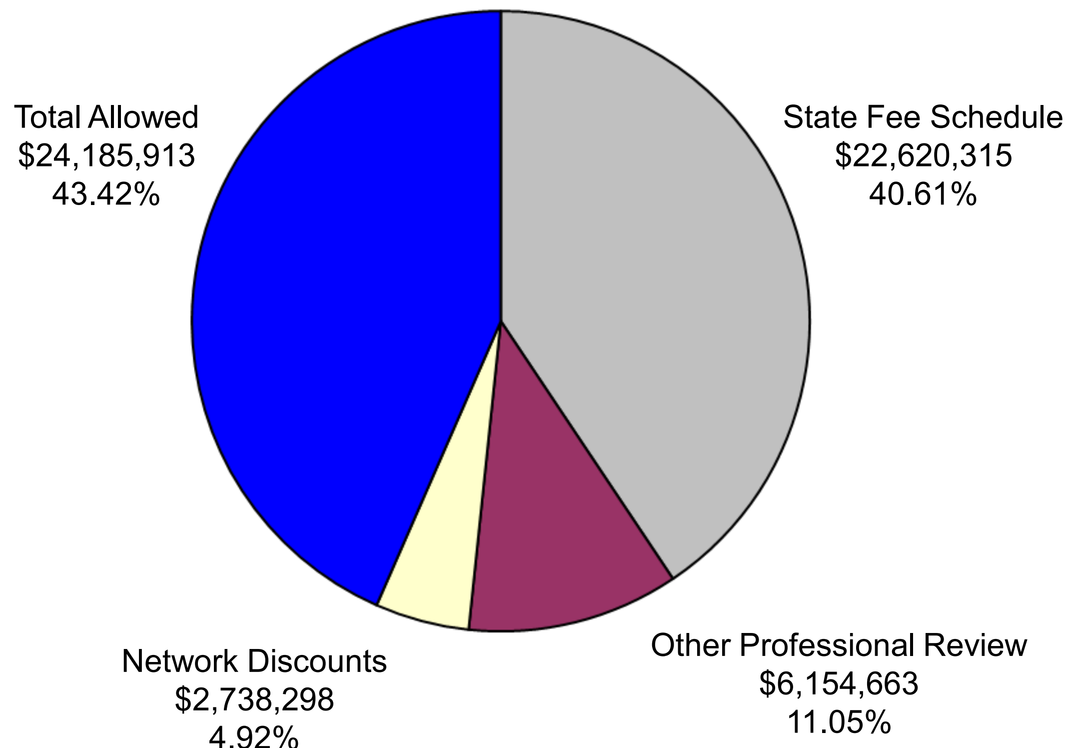
Subrogation

68.5% collected

Excess

4,000 reports submitted;

$10,163,937 recovered.



General Administration

Location

- PGCS maintains locations in Lake Mary & West Palm Beach, Florida

Experience

- In a calendar year, PGCS handled 9,987 liability and workers' compensation claims.
- 60 Years experience in Florida Claims Administration

Staff

- Licensed adjusters
- Case loads for Lost Time Adjusters limited to 120
- Medical Only Adjusters 300 case load

Supervision

- Monitors and notes all files on a scheduled basis
- Closely assesses promptness in handling and severity of cases
- Assures adjuster case loads are balanced to maintain a high level of quality service

Claims Handling

- No contract adjusters are utilized for claim administration

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General Administration – continued

Duties include, but are not limited to:

Set-up and maintain records and files as well as receive reporting for all claims.

- Email
- Phone
- Internet
- Fax

Prepare, maintain and file all records and reports as required by legal authorities.

- EDI
- SCHIP Compliant
- DFS
- OSHA 300

General Administration – continued

- Prepare, maintain and file statistical or other records and reports as required by excess insurers.
- Provide monthly loss reports.
- Provide quarterly report on all claims with a total incurred in excess of an agreed upon amount.

PGCS Claim Best Practices

ATTITUDE

FRAUD

DIARY/DOCUMENTATION

RESERVES

CUSTOMER SERVICE

LARGE LOSS REPORTING

SUBROGATION

RETURN-TO-WORK

QUALITY/COMPLIANCE

SUPERVISION

RESOLUTION

INVESTIGATION

INJURY/ACCIDENT REPORTING

Customer Commitments

- No commissions or overrides
- Flexible in tailoring a program to suit client requirements
- Adequate resources committed to ensure success of program
- Client retains ultimate authority in the handling of the claim
- Excellent relationship with excess carriers
- SCHIP compliant
- Other resources available – educational & legal seminars
- On site client training

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PUBLIC ENTITY CLIENT LIST

Brevard County BOCC

Charlotte County BOCC

City of Altamonte Springs

City of Bradenton

City of Cape Coral

City of Deerfield Beach

City of Delray Beach

City of Ft. Myers

City of Hallandale Beach

City of Homestead

City of Kissimmee

City of Leesburg

City of Naples

City of Plantation

City of Titusville

Leon County BOCC

Leon County School Board

Memorial Healthcare Systems

Osceola County BOCC

Palm Beach County BOCC

District School Board of Pasco County

Preferred Governmental Insurance Trust

Town of Palm Beach

Town of Davie

ADMINISTRATIVE SERVICES

Upon award of contract, PGCS shall:

Provide an Account Manager that will act as liaison between the City and PGCS.

Execute the Implementation Plan provided under Section 5-F – Implementation Plan.

Prepare and file with the appropriate state agencies all applications, bonds, documentation and data required, on behalf of the City and in accordance with state mandated time frames, for implementation and continuance of the program.

Prepare, maintain and file all records and reports on behalf of the City as may be required by any local, state and federal legal authorities within the mandated time frames.

Prepare, maintain and file statistical or other records and reports as required by the City's excess insurer(s). Report claims to the City's excess insurer(s) in accordance with the applicable policy requirements and provide the City with a copy of all reports submitted. All applicable notification, investigative and reporting procedures shall be followed.

In accordance with state mandated time frames, prepare, maintain and file statistical information required by the State, workers' compensation rating bureaus and, as applicable, Centers for Medicare and Medicaid Services or other appropriate agencies.

Information shall include, but not be limited to, Electronic Data Interchange (EDI) and data necessary for the promulgation of experience modifications and self-insurance assessments.

Comply fully with all rules, regulations, guidelines or procedures established by the City, the State of Florida, and CMS Medicare Secondary Payor requirements to maintain the legal operation of the City's self-insurance program.

Regularly keep the City informed of any significant regulatory or industry changes that may impact the City or its workers' compensation program.

Prepare and distribute all required 1099 forms.

Reimburse City for payment of any fines, penalties or assessments assigned by the State of Florida for failure to comply with rules and regulations, including but not limited to EDI reporting, associated with the performance or responsibility of PGCS.

Cooperate with any audits of PGCS's files and procedures conducted by or on behalf of the City. The City shall have the right to audit during the contract period and for five (5) years following the termination of the agreement. No additional fees shall be due PGCS for cooperation with such audits.

Annually provide the City with a SSAE 16 Type II report as required by the City financial auditors.

Establish procedures acceptable to the City for the payment of compensable claims. Procedures will include periodic funding requests submitted to the City with detailed backup information. Funds will be provided by the City following review and approval of the funding requests.

Upon request, provide formal classroom-style training and education to City staff regarding topics of interest to the City such as case law updates, regulatory or rule changes, claims management best practices and medical consumerism.

FIRST NOTICE OF INJURY REPORTING SERVICES

Upon Award of Contract, PGCS will:

Assist the City in establishing custom claim reporting procedures compatible with the needs and structure of the City.

PGCS currently provides its clients 24-hour telephonic and internet based claim reporting and intake capabilities via our website at www.pgcs-tpa.com.

Send First Notice of Injury to the State of Florida in a timely manner in compliance with proscribed statutory requirements. PGCS will accept responsibility for penalties for late notice to the State when caused by reason other than delay by the City.

PGCS provides a toll-free phone line, 800-237-6617 for claims reporting, inquiries and after-hour access.

Other reporting capabilities include email at workerscompensationclaims@pgcs.tpa.com, facsimile at (321) 832-1438, or by DropBox.

PGCS will coordinate data between first report of injury and RiskMaster.

WORKERS' COMPENSATION CLAIMS SERVICES

Upon award of contract, PGCS shall:

Establish claim and/or loss files for each report claim and/or loss. Such files will be subject to review and audit by the City at any reasonable time.

Establish reporting procedures which are compatible with the needs and organizational structure of the City.

Provide necessary forms and instructions for use. Such forms will include appropriate First Reports of Injury with mailing address of primary recipients preprinted thereon.

Receive and examine on behalf of the City reports of employee injury claims.

Accept or deny reported claims for employee injuries on behalf of the City in accordance with applicable Workers' Compensation Laws. If it appears that the final value of any claim settlement will exceed a discretionary limit of $5,000 or may be of a nature that is sensitive to the City, the final decision to accept or deny shall rest with the City or its respective designees.

Conduct such investigation as the exercise of professional judgment would deem necessary.

Subject to the prior approval of and at the expense of the City, employ outside professionals such as private detectives and expert witnesses to assist in the investigation and adjustment of claims.

Review for reasonable and conformity to appropriate medical and surgical fee schedules all medical bills and other services for which a claim is being made.

Subject to prior approval for claims valued in excess of $5,000 or claims expected to be of a sensitive nature to the City and in the exercise of professional judgment, adjust and settle all reported claims. Such settlement is to include preparation and actuation of all necessary compromise and release agreements.

Prepare and maintain files necessary for legal defense of claims and/or litigation (such as actions for subrogation) or other proceedings.

Where appropriate or desirable, attend hearings, depositions, and other proceedings.

Subject to the foregoing provisions, pay in accordance with state regulations or, lacking that, in a timely fashion all claims and expenses.

At the request of the City, or their respective designees, provide a complete copy of all files involving litigation, subrogation, or recovery from special or second injury funds.

Aggressively pursue all possibilities of subrogation with City approval, contribution, indemnity and/or recovery from special or second injury funds on behalf of the City.

Periodically as appropriate, but at least every six months, prepare a written report of the value of all open cases and if requested, review in person with the designated representative of the City.

Provide assistance in providing rehabilitation of injured employees in consultation, retraining, or reassignment of employees with limited physical performance arising out of covered injuries.

Consult with and refer to the City or its respective designees all questionable or contested cases and those with an estimated value in excess of $5,000.

Maintain a current roster of preferred physicians and other medical professionals for treatment of covered injuries on a first aid and specialized basis as well as maintaining procedures for establishing close liaison with the treating physicians and other medical professionals.

LIABILITY CLAIMS SERVICES

Upon award of contract, PGCS shall:

Make available adjuster on a 24 hour basis to respond to an accident scene at the request of the City. After hours, the adjuster will be available via cell phone.

Establish reporting procedures which are compatible with the needs and organization structure of the City.

Provide necessary forms and instructions for use. Such forms will include appropriate accident reports with the mailing address of PGCS preprinted thereon.

Receive and examine on behalf of the City all third party claim reports.

Accept or deny all third party claims on behalf of the City. If it appears that the final value of any claim will exceed $5000 or is of a potentially sensitive nature, the decision to accept or deny shall rest with the City or its designees.

Conduct such investigation as in the exercise of professional judgment would seem necessary.

Subject to the prior approval of, and at the expense of the City, employ outside professionals such as private detectives, or expert witnesses to assist in the investigation and adjustment of claims.

Review for reasonableness all medical bills and other services for which a claim is being made.

Subject to prior approval for claims valued in excess of $5000 or claims of a potentially sensitive nature and in the exercise of professional judgment, adjust and settle all reported claims. Such settlement will include preparation and actuation of all necessary compromise and release agreements.

Prepare and maintain files necessary for legal defense and/or litigation such as actions for subrogation or other proceedings.

Attend hearings, depositions, and other proceedings where appropriate or desirable.

Subject to the foregoing provisions, pay in a timely fashion all claims and expenses.

Aggressively pursue all possibilities of subrogation, contribution, or indemnity on behalf of the City.

Periodically as appropriate, but at least every six months, prepare a written report of the value of all open cases in person with the designated representative of the City.

At the request of the City or its respective designees, provide a complete copy of all files involving litigation, subrogation, contribution, or indemnity.

Consult with and refer to the City or its respective designees all questionable or contested cases and those with an estimated settlement value in excess of $5000.

LOSS STATISTICS SERVICES

PGCS will provide the City, at no additional cost, the ability to access comprehensive, real-time online electronic claim, financial and reporting data and information. The City would like data reportable by Fiscal Year vs. Calendar year reporting. In addition, the Contractor shall provide the City regularly scheduled statistical and loss reports as agreed upon by the parties in an acceptable format to the City. Data capabilities should include:

Loss runs will be provided on a monthly basis sorted separately by policy year and department/location. Loss runs should list each claim separately. Specific summary reports also will be provided. The following reports are required and will be provided:

Claims listing by Department
Check register
Cumulative report by line of coverage by year
Annual summary reports
Large loss or severity report
Excess insurance report
Litigation report
Legal payments report
Pharmacy Penetration report
Care Management report
Ability to identify costs and claim data by department
Open claim data including payments and reserves paid
Ability to identify any claimants on restricted duty
Real time data on current payments, reserves
Monthly reports by department showing fiscal year monthly and to date payments
Other reports as requested including, but not limited to:

a. Loss experience
b. Summary of claim and loss experience, broken down by injury type, injury cause,
c. Department and location of injury
d. Cost, frequency and severity report
e. Claim activity summary (new, re-open/closed/controverted, etc.)
f. Claim master file listing
g. Detail list of claimants including current and prior claim activity
h. Retention level analysis
i. Reserve analysis detailing rationale and total cost
j. Average cost by medical provider
k. Number of Days from DOA Date to MMI Date
l. Lost Time Analysis

m. OSHA 300 Log
n. Assist City in determining anticipated budget based on claim payments and reserves

PGCS will provide the City real-time, online access to all claim files, including adjuster notes, supervisory notes, case management notes, diary items, payment records, medical bills and expense bills in an electronic format with internet based access via our website at www.pgcs-tpa.com

PGCS will provide reporting capabilities to evaluate the success of the program and whether the Contractor's staff, medical clinicians, associated services vendor(s), and contracted entities are performing services and achieving the best possible outcomes in an effective and efficient manner.

PGCS will provide City with data and reports to comply with its annual audit and actuarial requirements no later than October 10th of each calendar year.

PGCS utilizes the RiskMaster claim processing system. Following is a description of the system and its capabilities:

RISKMASTER

RiskMaster is an occurrence/event based system which can track claims around a central occurrence/event and track financials at both claim & event level. It captures a myriad of data elements ranging from type of accident, locations, NCCI coding for workers' compensation claims, all claimant information, litigation management, vehicle information, etc. RiskMaster processes, manages and analyzes critical claims data for:

- General Liability
- Property and Casualty
- Workers' Compensation
- Automotive Liability
- Incident/Occurrence Administration
- First Reports of Injury (FROI)
- OSHA Compliance
- Insurance Policies
- Actuarial Reporting
- Adjuster/Case Management
- Funds Management
- EDI

For all claim types, the following information is tracked, but is not limited to:

- Persons involved (drivers, employees, witnesses, etc.)
- Adjuster information (including multiples)
- Litigation information
- Defendant information
- Claimant information (including attorney information)
- Location of incident
- Cause of incident
- All financial information across several lines

For vehicle accident claims, additional information is tracked:

- Accident type
- Accident description (coded types)
- Vehicle information linked to fleet information provided

For workers' compensation claims, additional information tracked is as follows:

- Dependents
- Restricted or work loss information
- Employment information
- OSHA information
- All NCCI information

Also note that information not tracked can be built into various types of supplemental fields on any type of screen (event, claim, provider, payment, etc.). Examples would be a W/C claim supplemental built to track presumption claims. Also another GL/Prop claim screen supplemental built to track catastrophe name.

Some additional important features to note:

- There are virtually hundreds of code tables, all of which are user-defined And can be added or changed as needed.
- An extensive organizational hierarchy would allow 5 levels of customer-defined data to be used. Events are attached at the lowest level so reporting can be done at any level needed.
- Multiple bank accounts can be setup at various levels in the organizational hierarchy.
- All claims are attached to policies which are entered to show every level of retention from the ground up or deductible up for each organization.
- Integration to outside systems for bill review, importing date, etc.
- 1099 processing done seamlessly on each customer utilizing data from all Or just certain bank accounts.

Reports can be generated to fit individual client needs. PGCS does offer some standard reports, however, most are tailored to the client's requests and the loss reports can be custom tailored to include just about every field.

HARDWARE AND SOFTWARE CONFIGURATION

The following is the system currently in use by PGCS. We have just completed the implementation of a new computer system as follows. This system is used to perform date processing, storage services and provide remote connectivity for all accounts. It is housed directly in our office located in Lake Mary, Florida.

HARDWARE

Server/CPU

1. Dell Poweredge 2500 – Dual Pentium III 933 Megahertz, 25K Cache, 3GB Ram
2. Dell Poweredge 2600 – Dual Xeon 3.6 Mhz 2 MB Cache 8GB Ram
3. Dell Poweredge 1850 – Dual Xeon 3.0 Mhz 1MB Cache 2GB Ram

Printers

1. HP LaserJet 4200 (35 Pages per minute)
2. Two (2) Ricoh Laser AP2600 (26 pages per minute)

Disk Storage

1. Three (3) 72GB SCSI Drive in a RAID 5 configuration with a total storage capacity of 14GB. There is also a standard CD-ROM Drive and 3.5" Floppy Drive.

2. Three (3) 146GB 10K RPM Ultra 320 SCSI Hard Drive in a RAID 5 configuration with a total storage capacity of 292 MB. There is also a standard CD-ROM Drive and 3.5" Floppy Drive.
3. Two (2) 36GB 10K RPM Ultra 320 SCSI Hard Drives in a RAID 1 configuration with a total storage capacity of 36 GB. There is also a Standard CD-ROM Drive and 3.5" Floppy Drive.

Tape Drives — Del PV110T, LTO 2 200/400 internal tape drive in server 2. Server 1 and 3 are backed up to Server 2.

SOFTWARE

PGCS currently utilizes the RiskMaster system for all administration for both the workers' compensation and property & liability claims. This system is accessed by means of a PC connection through our LAN. All PC's are equipped with at least Windows XP SP1, but most are Windows XP SP2.

SECURITY MECHANISMS

The following is a summary of some steps we have taken to protect and safeguard our data and equipment.

PHYSICAL SECURITY

The Lake Mary location is monitored by ADT through a digital alarm system of which only certain users have access to the password. In addition, the computer room is in a secured environment and the entire office is located on a secured floor.

DATA AND APPLICATION SECURITY

Every user of the system is explicitly identified to the computer and has their own unique password, which they use to gain access to the computer. Passwords are changed every 90 days by each user. This system is utilized for all layers of network access from e-mail to file management. In addition, the RiskMaster system has a complete set of security based on 8 digit passwords.

A user can only run those functions for which they have explicit authority. Currently, the technical service staff, upon an approved written request, grants the necessary authority for a user to perform a certain task. Since work is done via the functions of programs, no user is ever authorized direct access to the data files.

Security is enforced at the System/486 level and through application menus. The operating system allows technical services to protect the actual files and programs while the application menus limit a person to specific options on the menu.

The in-house developed applications use various on-line and batch edits to ensure that the data entered is valid or reasonable. As a result the data files are kept more accurate.

DATA BACKUP AND RECOVERY

All systems are backed-up nightly. Back up is the process of copying the on-line (disk) information onto magnetic tape. The magnetic tape is then stored off-site and can be used at a later time to recreate the information as it was at the time it was copied.

Our current back-up strategy included daily, monthly and yearly full backups. These backups will allow us to recover the system to within one day's processing. Back up tapes are then stored onsite on a fire proof safe until transported to a safety deposit box at a local area bank.

DATA INTEGRITY

Application development is performed on separate test files. As a result, the chance that damage could occur to production data files due to programmer testing is minimal.

ORGANIZATION AND STAFF

OPERATIONS

The operations staff is responsible for the day to day running of the system. They monitor the system, record any problems encountered, print and distribute reports and perform backup and archival activities.

PROGRAMMING

The programming group is responsible for all application software design, development and maintenance. The programmers work directly with the users to determine what the application is to do and implement those functions using a third generation programming language.

TECHNICAL SERVICES

The technical service staff is responsible for the hardware and system software configuration and maintenance. In addition, technical services provide a single place where users can call if they are having any problems with the system.

FILE MAINTENANCE AND REPORTS

All internal files and reports are maintained directly by RiskMaster for the workers' compensation and property & liability system. There are several hundred internal files which comprise the entire system. They range from the policy administration side (groups, employers, policy years, rates, etc.) to the claims side (employee demographics, claim history, payment information, etc.) This system is supported directly by CSC during normal business hours should the need arise.

Reports include but are not limited to:

- Employers Experience Reports
- Check Registers
- Recovery Registers
- Excess Reimbursement Reports

Copies of certain reports are included as well as additional specialized reports which give a better "picture" of claims activity for any time period.

LOSS FUND MANAGEMENT SERVICES

The City's claim funding account will be maintained at a financial institution chosen by the City. All interest earned or service credits generated will accrue to the benefit of the City.

The City may establish an escrow amount to facilitate the payment of claims. PGCS will comply with Florida laws F.S. 237.211(6) and F.S. 280 Security of Public Deposits.

All claims or expense payments will be made by PGCS on checks drawn on the City's claim funding account. It is understood and agreed upon that all funds in this account are the City's funds and shall be returned to the City upon request or termination of any agreement resulting from this RFP. No payments due to PGCS for administrative fees or reimbursable expenses will be deducted from these funds.

PGCS will submit weekly invoices for reimbursement for checks issued for claims the previous week. A check register that includes at the minimum the check date, check number, check amount, and payee should be included as backup to the invoice. Also, the City's fiscal year end cut off of Sept. 30 will be observed for reimbursement invoicing.

PGCS administrative fees will be billed monthly on a separate invoice to the City.

PGCS will be responsible for monthly reconciliation of the City's claim funding account. The reconciliation statement submitted by PGCS to the City will include the following:

- Balance at inception of statement period
- All disbursements which cleared, by date, amount, claimant, payee, claim number, check number, and City department
- All credits/reimbursements
- Balance at close of statement period
- A list of all checks issued and outstanding

PGCS will cooperate fully with any audit of the City's claim funding account by either the City or City authorized independent auditor.

Medical Bill Review & Audit

AmeriSys

MEDICAL BILL REVIEW AND AUDIT SERVICES

AmeriSys has an excellent rapport with the Florida Division of Financial Services. We have consulted with the organization on multiple occasions in addressing challenging situations along with attending workshops and hearings where we have a vested interest and the outcome could benefit our customers. Along with the Division of Financial Services, AmeriSys has maintained an excellent standing with AHCA. During our last four audits we were found to have zero deficiencies and it was communicated that our policy and procedure format has been utilized in instructing new organizations to Managed Care as to the proper way to set up their protocols.

AmeriSys developed proprietary software, Corrus, for bill review. Fee schedules are maintained via downloads from Optum (formerly Ingenix), Usual & Customary fees from Context Healthcare, and Medicare Fee Schedules from CMS. State rules are coded into the rules engine of the system for use during adjudication.

Unique Corrus Features:

- **Provider EOB Search**
  The AmeriSys web-based Provider EOBR Search has given providers the ability to track their bills from data entry through payment without waiting on the phone and repeating claim info while a bill review clerical researches the bill. This has also demonstrably cut down on incoming requests and time spent on the part of AmeriSys staff and claims adjusters, thus increased productivity in the number of bills completed per day, ensuring faster payment to providers.

  This feature is available from our website
  https://corrus.amerisys-info.com/ProviderEob

- **Unique paperless scanning bills**
  AmeriSys programmer/analysts are continually developing and enhancing the Corrus application to speed up, simplify and improve performance of the processes involved in medical bill review. An example is the unique approach made to the paperless system where bills that are scanned automatically create a bill record, case note with attached documents, diaries to the adjuster or TCM and a built in mechanism for authorization/denial of the bill. All of these functions are inter-related and tied together via unique identifiers for tracking purposes.

- **eBilling -** utilizing the IAIABC X12 5010 standards
  AmeriSys has implemented eBilling utilizing the IAIABC X12 5010 standards, which duplicates all the processes listed above for the scanned bill as the eBill is imported. This eBilling capability places us in a leadership position amongst our peers in preparation for the future regulatory mandates that are presented to us by the healthcare industry.

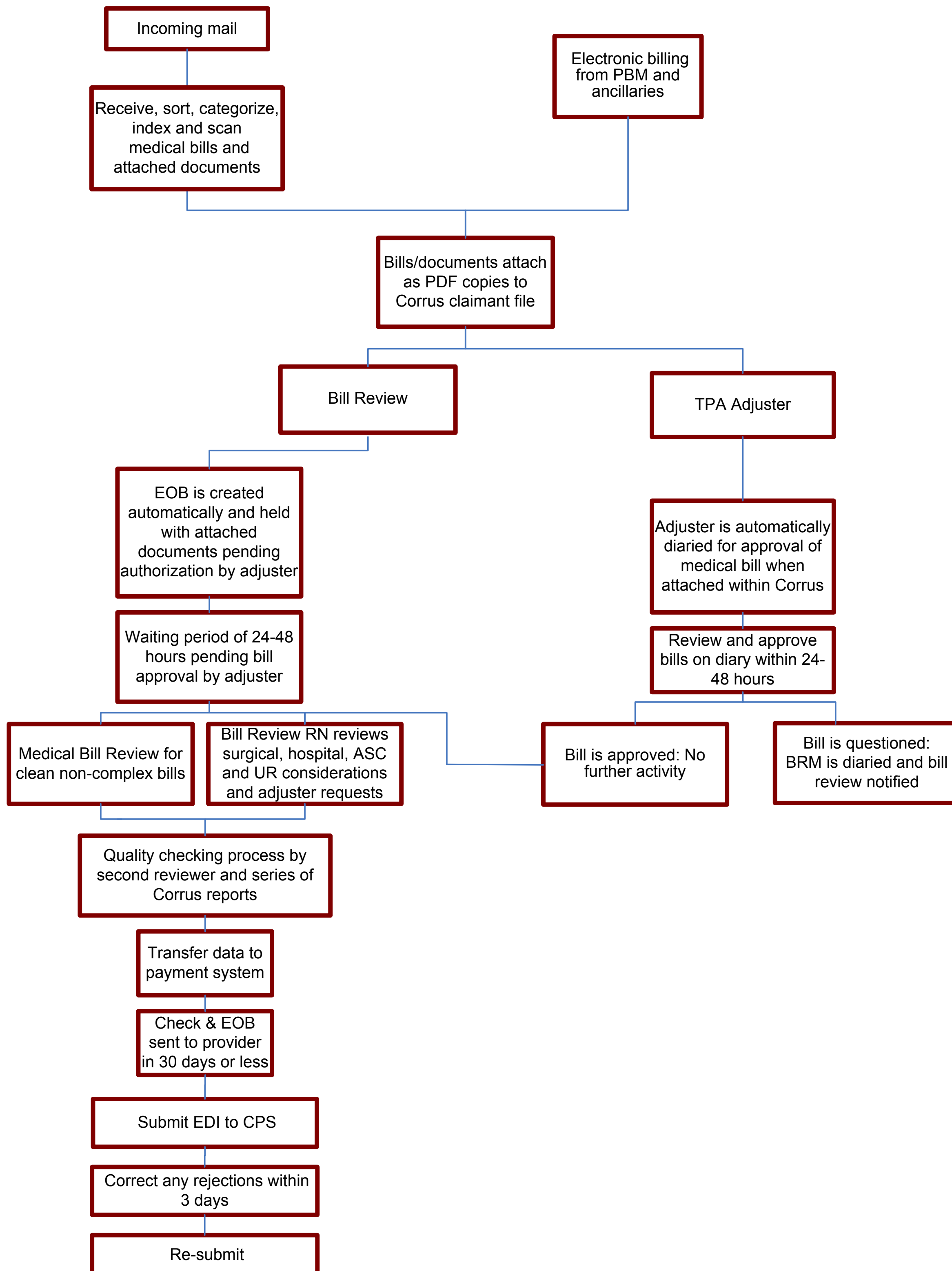
The following is our current Medical Bill Review process which meets all statutory guidelines. This process can and will be customized to meet the specific needs of the City of Gainesville.

Upon receipt of paper billings, the bills, along with any corresponding documentation, are scanned and attached to individual claimant files within the Corrus system. Medical bills may also be submitted electronically via HIPAA compliant X12 5010 standard files. A bill record is then created corresponding to the scanned/imported document/bill. Simultaneously the adjuster is diaried as to the presence of the bill for electronic review and approval. After a definitive period of time (generally 3 days) to allow proper review/approval by the adjuster, the bill record, along with scanned document/bill, is transferred to a user bill list for the bill reviewer to examine and prompt the system adjudication to apply fee schedule limitations/rulings and MRA. As the adjudication system validates data, the bill review analyst must respond to any “Review Messages” prior to finalizing the bill. During this process the bill review staff will also be alerted to any reimbursement issues identified from the TCM/adjuster review via Corrus notes that are accessible by all parties involved with the claim.

The Corrus system allows bill review staff to explicitly note the file by adding a flashing comment to the screen to show controverted or denied claims, which ensures non-payment.

Please reference the following Medical Bill Review Flow Chart. Procedures can be changed to accommodate the City of Gainesville's processes.

Life of a Medical Bill



During the review process the following actions are taken:

- The date of service is noted in relationship to the date of injury.
- The ICD-9-CM diagnosis code is noted and compared to the description of the injury recorded in the computer.
- The CPT code and description of services rendered is compared with the description of the injury and the diagnosis for relatedness and appropriateness.
- All bills are reviewed for appropriate coding, bundling and unbundling of CPT codes, application of fee schedule limitations/rulings and MRA, and contractual agreements.
- All fee schedules are accessed through our bill review platform, Corrus, and appropriate rates are applied based on the jurisdiction of the claim or where services are rendered. If there are inconsistencies or errors noted, additional information may be requested from the provider or the employer, or payment for services may be denied.
- An EOBR is then created corresponding to the scanned document/bill.
- If payment is denied, the EOBR will state the reason for denial (i.e. services rendered prior to date of injury, treatment is not related to injury, etc.).
- All bills that meet the focused review screens (such as those with a -22 modifier, those with an MRA listed as "By Report", those without established allowances, and others as identified by the U.R. Committee) are forwarded to a utilization review nurse for review prior to processing.

Bills are also reviewed against pre-determined criteria, which indicate that a more in-depth review is indicated. These criteria include:

- Hospital bills which indicate inpatient stays for procedures normally performed on an outpatient basis
- Hospital bills with lengths of stay which exceed the 50th percentile of the normal length of stay
- Hospital bills which show multiple diagnostic tests or diagnostic tests not usually related to the injury
- Hospital bills which contain unidentified detail charges
- Hospital bills which contain duplicate charges, data entry errors, or unidentified charges posted after the discharge date
- Hospital bills which note unrelated diagnosis or procedures on the UB-04
- Provider bills which meet the indicators of potential abuse (double billing, common referrals, cross billing, fragmented billing, missing modifiers, over-charging, over-itemization, over-prescribing, overutilization, prolonged follow-up, self-referrals, services not rendered, substandard care, or upcoding)
- Provider bills which indicate more than four modalities of therapy per visit
- Provider bills which show an excessive number of diagnoses for the same condition/injury
- Provider bills accompanied by narratives which do not meet CPT guidelines, or appear to be duplicates or computer-generated

- Provider bills which show an excessive amount of surgical or other supplies or medications

Those bills filed incorrectly or not in compliance with the guidelines printed in the Reimbursement Manual, those bills which are incomplete, or those bills which lack enough information to determine relatedness, appropriateness, or necessity are returned to the provider prior to payment. A letter is generated requesting the additional information or corrections needed. These letters are recorded in the computer and the information is tracked for statistical purposes and to provide data for analysis for focused retrospective review. A nurse and/or medical consultant forwards bills which meet these criteria for focused review and determination of appropriateness and/or medical necessity. Some of the items contained in the history which may indicate the need for further review at client's discretion include:

- Treatment extending beyond three months or exceeding 20 office visits with no improvement in condition
- Excessive x-ray and repeat x-ray procedures
- Treatment which begins six months after the date of occurrence
- Excessive diagnosis listed for the same condition
- Two or more physicians treating the same condition/area at the same time
- Multiple consecutive providers
- Previous bills submitted for services rendered the same day by the same/different providers
- More than one initial visit per provider
- More than one consultation per specialty per diagnosis per injury
- Charges for same services previously paid or denied
- Anesthesia charges without corresponding surgical charges
- Diagnostic testing interpretation charges without corresponding technical components
- Total medical payments exceeding $5,000
- Yearly provider visits with no interim charges

The Medical Fee schedule is updated in our Corrus system in accordance with State revisions. We are notified of the pending revision via e-mail and are able to accommodate changes in fees based on date of service. These updates and bill review services are administered from a centralized office.

All manual reviews of medical bills are done by staff oriented and trained in bill review coding in compliance with the State's rules and regulations, and AmeriSys policy and procedure. Please reference to the job description for a Medical Bill Reviewer.

Job Description

USIS/AmeriSys Job Title		Medical Bill Reviewer	Dept #/name	250 AmeriSys Bill Review
Reports to: (mgr/supv)		Supervisor/Bill Review Manager/Utilization Mgmt		
Office Location:		Major Blvd, Oviedo		
B&B Job Title	Admin II		B&B Job Code	ADM II

General Description:
Review Workers' Compensation provider medical bills via the system for cost containment purposes. Analyze, review and recommend payment to medical providers, hospitals, ancillary medical providers, rehabilitation services and pharmacies and significantly reduce costs to clients. Via system entry and software, process Workers' Compensation medical bills for payment according to state Workers' Compensation fee schedule and beyond.

Primary/Essential Duties:

- Accurate data entry and adjudication of provider bills in the Corrus computer system according to state Workers' Compensation Fee Schedule rules, with satisfactory volume and error ratio
- Analyze, review and recommend payment to medical providers based upon statutory rules or guidelines and/or provider reimbursement contract amounts to achieve maximum cost savings, to the level appropriate in terms of:
  - ✓ Medical necessity
  - ✓ Treatment actually rendered
  - ✓ Adjuster authorizations
  - ✓ Usual or reasonable and customary charges
  - ✓ Utilization practices
  - ✓ Applicable fee schedules
  - ✓ Contracted agreements
- Ensure timely payments to providers meet statutory regulations on the type and amount of reimbursement and significantly reduce costs
- Handling of provider and customer phone calls
- Training on an on-going basis to increase knowledge with State Fee Schedule, medical terminology, use of reference materials, eg. CPT, ICD-9, HCPCS
- Perform other duties as needed.

Knowledge, Abilities and Skills:
Typing 60 wpm/10-key by touch. Heavy numerical data entry with high ratio of accuracy
Experienced in Florida Workers' Compensation Fee Schedule, medical terminology, CPT, ICD-9, HCPCS coding
Medical terminology knowledge
Ability to work under and accomplish production standards
Experience dealing with medical provider offices
Data entry proficiency and computer skills –Word, Excel
Excellent organizational skills
Detail orientated and motivated
Ability to effectively operate a personal computer and related claims and business software
Good communication skills, both oral and written. Team player. Good attendance. Good customer service skills.

Minimum Qualifications:
High school diploma
Experienced in Florida Workers' Compensation Fee Schedule, medical terminology, CPT, ICD-9, HCPCS coding
1-2 years medical terminology/medical office experience
Typing 60 wpm. Heavy numerical data entry with high ratio of accuracy.

Additional Notes:
Heavy data entry. Fast paced. Production standards monitored.

This job description is not intended to be all-inclusive. Employee may perform other related duties as necessary to meet the ongoing needs of the organization.

USIS employee(s): (name/dept)

Additional Corrus system information

At present AmeriSys is using the Corrus software to interface with several different systems as well as producing EDI extracts. Importing claims history into the system and exporting current data is a daily function handled by interfaces at all of our locations.

- Software Availability
  Access to our system is available through several means:
  1. Direct internet connection to our secured web site allows for viewing and entering of Case Notes and Diaries, viewing bills, running reports, and more.
  2. TSWeb connection to a specified computer via a VPN allows full access to the system
  3. VPN/ODBC connection allows for full usage of the system if our software is installed at the remote site.

- SFTP Site (Secure File Transfer Protocol)
  A FTP site will be hosted and maintained by AmeriSys to allow transfers of data and or/reports required by client. The site will be accessible by client with proper authorizations.

- Hardware Availability
  Our systems are secured both externally with multiple firewalls and internally with Kaspersky Antivirus and multiple layer security on all software. We operate with firewalls, routers and server banks at each of our locations that are integrated via MPLS and Metro Ethernet. Our equipment is constantly evaluated and upgraded or replaced as needed and we audit compliance with all software licensing agreements. Our systems operate in Windows platforms with relational databases in MS SQL and Sybase SQL.

  External customers have access to websites for Corrus INet, Provider EOBR Search, AmeriSys SharePoint sites, secure FTP site for data transfers and Citrix connections into the Corrus Case Management and Bill Review system.

AmeriSys Provider EOB Search

Last updated at 10/05/2012 5:50 AM. Includes bills from 10/5/2010.

Provider: Align Networks, Inc - Ancillary

Change Provider Admin Home FAQ

Required Search Fields

Date of Accident 8/4/2012

Claimant Last Name

Last 4 digits of SSN 7426 or Claim Number

Optional Search Fields

Begin Service Date

End Service Date

Search Print Search Rules

Bills

Status	The EOBR has been entered into the bill review system. payment schedule...					Adjuster					
Site	ASI (407)949-3100	EOBR Number	L12J00B8	Last Name		First Name		DoB		SSN	xxx-xx-7426
Claim Nbr	3-5788A01-21	Fed Tax Id	043821114	Claim Date	8/4/2012	Rcv Date	10/3/2012	From Date	8/31/2012	To Date	8/31/2012
Payer Name		Payment Date	n/a	Payment Ref	n/a	Payment Amt	n/a	Billed Total	94.00	Allowed Total	39.25

Status	The EOBR has been entered into the bill review system. payment schedule...					Adjuster					
Site	ASI (407)949-3100	EOBR Number	L12J00B2	Last Name		First Name		DoB		SSN	xxx-xx-7426
Claim Nbr	3-5788A01-21	Fed Tax Id	043821114	Claim Date	8/4/2012	Rcv Date	10/3/2012	From Date	8/27/2012	To Date	8/27/2012
Payer Name		Payment Date	n/a	Payment Ref	n/a	Payment Amt	n/a	Billed Total	188.00	Allowed Total	112.25

Our Information Technology staff is internal. USIS/AmeriSys has the following staff:

- Eight (8) Programmers
- Two (2) System Technicians
- Four (4) System Operators and Reporting Technicians

For further information you may request a copy of the IT Guidelines, schematics of our topology or specific details regarding equipment.

- Reports

  AmeriSys has reports that can be customized per the client and delivered in most common formats Adobe .PDF and Excel.

  Below are a list of reports that can be customized for you.

  1. Bill Review Note
  2. Explanation of Bill Review
  3. Savings Report
  4. Case Manager Savings by Payer and Claim
  5. RTW Savings Report
  6. Medical Bill Review Activity Report
  7. Network Hits Report by Employer
  8. Network Penetration Report
  9. Sales Journal by Payer by Product with Source
  10. Sales Journal by Payer by Product
  11. Medical Payment Exception Version 1
  12. Medical Payment Exception Version 2
  13. EOB Payment Status Report
  14. EOB Reconsideration History
  15. EOB Status Report
  16. Provider Utilization
  17. Outcomes by Provider
  18. Provider/Diagnosis Analysis
  19. Top DME Providers - 2013
  20. Top Prescribers Report - 2013
  21. Provider Bills by Specialty
  22. Top Prescriptions Report by Count
  23. Top Prescriptions Report by Cost
  24. Ancillary Provider e-billing Accept /Reject Reports

If clients desire to receive standard monthly or quarterly spreadsheets that currently monopolize a great deal of your time every month-end or quarter-end, there is likely a process that can be built for it to be downloadable the 1st day after any month-end.

Duplicate billings

Identification of duplicate billings as well as possible duplicates.
Duplicates are identified to the bill review staff in two ways:

Exact duplicates which match all criteria including same FEIN, date of service, coding and billed amount – an exact duplicate cannot be reimbursed without a system override by a supervisor.

Possible duplicates are also identified which would alert the reviewer to a previously paid bill that only has the same coding and date of service. We find this is particularly important as provider services are often billed under a separate FEIN when a billing service is utilized, or multiple providers are attempting to bill for the same service such as diagnostic interpretation. The notification of "possible duplication" would allow the reviewer to question the charges thoroughly prior to reimbursement

Unbundling of charges

Identify unbundling of outpatient, surgical, laboratory, or diagnostic procedures
The UR Nurse Specialist identifies procedures codes that are individually billed that are included or should be billed using a single procedure code. The codes are verified if they are included in other CPT codes and should not be billed separately. This procedure is consistent with outpatient, surgical, laboratory and diagnostic procedures. If additional documentation is needed it is requested.

Upcoding of charges

Identify upcoding
Bills are reviewed and verified by the UR Nurse Specialist to determine the correct use of procedure codes based on the reports and medical documentation. Upon review and verification by our expert professional we provide additional cost savings to the account.

Approval and appropriate precertification

Verification of precertification criteria and/or length of stay
The precertification process is initiated by the UR Nurse Specialist using nationally accepted criteria. If the procedure does not meet the criteria, the procedure is reviewed by a Board Certified MD of the same specialty or the Medical Director, and the length of stay is also addressed at that time.

Review all medical bills that:

(i) Are not subject to fee schedule coding
Identification of Usual and Customary rates
In cases where no statutory fee schedule exists, AmeriSys' Bill Review Dept can analyze the provider's charge against a database to find out if the fees charged are comparable to like services within the same geographical area.

(ii) Are for services not specifically addressed in the fee schedule
'By report' (BR) procedures are those without an assigned value, or per the Fee Schedule are not listed but available in the materials adopted by the State.

However, unless negotiated for an agreed payment, we use CMS (Miami * 1.4) to reimburse (BR) procedures or those procedures not listed in the fee schedule but valid in 2009 CPT edition.

When a health care provider performs a procedure or service which is not listed in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition, the provider must use a code contained in the CPT®-2009, CDT-2009/2010 or HCPCS-2009 as specified in this section.

(iii) Need an in-depth medical interpretation of the rules and regulations
Identification of unnecessary services/procedures
The UR Nurse Specialist reviews all claimant injury information, medical documentation to verify the specific compensable body part prior to processing a procedure. There is collaboration with the claims representative to verify and clarify any questions on compensability. Medical necessity is requested for the identified procedures that are not compensable or related to the injury.

(iv) In the exercise of professional judgment, specifically warrant review.
Specialty Bill Review
The AmeriSys Bill Reviewers in collaboration with the Utilization Review Nurses are trained to identify those situations that review is warranted by the professional expertise. In keeping with all statutory requirements, supporting documentation is requested to complete a thorough review. Criteria may be agreed with our customers that trigger the bill review for these unique circumstances.

Process, pay and mail bills within 20 days of receipt.

- **Application of State Fee Schedule**
  A statutory medical fee schedule sets a maximum amount that a medical

provider is reimbursed for rendering medical services to a person injured at work. Many state fee schedules have complex rules that require expertise in the application of the rules for provider bill payment. AmeriSys has trained analysts who apply the rules with the assistance of our Corrus system. Our system adjudicates the medical provider's charges to those allowed under the statutory medical fee schedule, and is equipped with a rules engine that assists in navigating the complexities of limits and rules in bill review. Additionally, the accuracy of the CPT codes, unbundling, and the level of service are verified. The diagnosis is checked for relatedness to the reported injury and all applicable claims information is reported to the Division as required.

- **Identification of PPO discounts**
  AmeriSys has a one step process that allows for the PPO reduction to be applied to the mandatory fee schedule or the usual and customary amount. AmeriSys has the ability to utilize multiple PPO networks or can accommodate custom networks, payment modules or negotiated rates on an individual clinician level.

- **Adjudication of payment, denial or requests for additional information within 20 days**
  The normal turnaround time for provider bills received by AmeriSys not only meets but is significantly less than the statutory requirements. AmeriSys agrees to the 20-day turnaround.

  Our processing and payment standard is within the State Mandated Guidelines for timely payment. This being said, our customary turnaround for bill review only, (not payment), is 5-7 business days. We would anticipate this timeframe unless there are some extenuating or other circumstances. Currently from bill receipt to payment is running 12-16 days for other than hospital bills. Hospitals undergo more stringent scrutiny which increases the reviews and payment timeframes.

Please reference the following PGCS Turnaround Report Sample:

4th Quarter 2013 Bill Review Turn Around Report

Bill Type	Bill Count		Average Days from PGCS Receipt to ASI Receipt	Average Days from ASI Receipt to Posted	Average Days from Bill Review Receipt to Export	Average Days from Received to Paid
Hospitals	450		8.6	8.3	8.4	21.5
Pharmacy	3045		0.6	2.0	2.6	6.4
All Other	11255		6.6	5.9	6.3	16.3

Overpayments

AmeriSys understands that it is our responsibility and would reimburse within 30 days of identification of overpayment. An overpayment report will be provided to the City quarterly.

While this is a rare occurrence, if an overpayment or erroneous payment is identified in Bill Review (via provider, adjuster or overall random checking), AmeriSys corresponds by letter to the provider (expanding or changing reasons as needed.) See example below.

DEAR PROVIDER:

Account:	*[PAYER NAME]*
Tax #:	*[PAYER BILLING FEIN]*
Claimant:	*[CLAIMANT NAME]*
Claim date:	*[DATE OF ACCIDENT]*
Claim Number:	*[CLAIM NUMBER]*

A review of our file indicates that the attached payment was made in error.
Please refund, at your earliest convenience $

Please make check payable to ________ and send to:

Client Name
c/o AmeriSys
P O Box 616648
Orlando FL 32861-6648

(We will be unable to accept your remittance if not made payable to the account as referenced above.)
Please include a copy of this letter in your return and/or reference our claim number:

A copy of the letter is retained in the file with any supporting documentation saved as a case note.
A copy of the letter with any attachments is given to a clerical assistant for follow up as needed.

Once a refund is received, it is logged and given to the Accounting Coordinator to be entered. The Accounting Coordinator enters the refund into the appropriate claim and scans a copy of the check into the file with a note documenting the refund entry. The original check is then forwarded to a designated representative for the client with a letter detailing the claim information for the refund.

myMatrixx™ good medicine for business

Pharmacy Program

Background

Amerisys has partnered with myMatrixx, a leading Pharmacy Benefit Management (PBM) organization. Amerisys is fully integrated with myMatrixx through a seamless approach which will provide a strong pharmacy solution for The City of Gainesville specific to custom needs and the most cost-effective treatment for injured workers.

MyMatrixx provides pharmacy benefit management services to over 100 governmental agencies including state funds, municipalities, cities and towns, school boards, police and fire departments and other local public entities. myMatrixx has created unique formularies and clinical programs based on specific needs for the these entities and their requirements.

For Purposes of this proposal, myMatrixx is to be considered as Amerisys subcontractor; Pharmacy Benefit Management: myMatrixx, 5706 Benjamin Center Drive, Tampa, FL 33634

Retail Pharmacy Network

The myMatrixx® pharmacy network consists of over 64,000 participating pharmacies nationwide, which includes over 4600 in the state of Florida. We partner with these pharmacies through various programs including electronic connectivity and telephonic support to ensure the highest levels of in-network penetration. Our help desk is answered by a live team member and is available 24 hours a day 7 days a week for both pharmacists and injured workers. We constantly monitor transactions for clinical appropriateness through our prospective drug utilization review at the point of sale, which includes, but not limited to a review of the following: early and/or excessive use of opioids, unrelated medications, early refills, duplicate therapies, unauthorized physicians, excessive dosages, contra-indicated medications, high dollar drug costs, over/under utilization and additional specialized flags for medications like OxyContin®.

Pharmacy Cards

myMatrixx pharmacy program combines the benefits of BOTH a card and card-less program. Although clients may elect to choose between card and/or a card-less program, clients choosing a combined approach typically realize 80% to 90% in network penetration. Therefore, we recommend a combined approach.

Cards can be activated or deactivated via the daily eligibility file and can also controlled manually in the myMatrixx web-portal (real time). This security protocol and other proprietary techniques ensure strong utilization by the correct individual. Card verbiage can be customized to fit your specific needs. The nine closest network pharmacies will print on the myMatrixx pharmacy material, and an attached card will be sent to your injured worker for a smooth transition.

First Fill Cards

The myMatrixx First Fill program allows newly injured workers that have not been added to the myMatrixx system to receive a limited fill of their prescription until compensability can be established. Our programs have significantly reduced the risk of pharmacies sending a particular script to a third party biller, i.e. Stone River. myMatrixx, in conjunction with our partner Amerisys, will work to establish a specific workflow and days supply parameters prior to the implementation of the program. Each employer/client can have custom rules!

Custom First Fill forms are available to employers, physicians and/or HR departments for the injured worker at the time of injury. First Fill forms are available as a PDF via the myMatrixx Web Portal and can be printed easily. Restrictions can include (limited day supply, formulary, and physician network), first fill reports are monitored daily. Our Customer Service team is also available for questions 24/7.

Out of Network Program

myMatrixx has created a proprietary process to deal with out-of-network transactions. Less than 18% of our transactions are processed through third party billers and directly through physician dispensing programs. For those retail pharmacy transactions that are presented via paper bills, we immediately begin a process of re-indexing, providing appropriate billing information and communicating with the injured worker to educate them on the use of our pharmacy cards.

This comprehensive process includes a phone contact with each pharmacy within 48 hours of receipt when an out-of-network bill is received. The pharmacy is given myMatrixx's billing information which educates them on the correct billing process for all future prescriptions and myMatrixx sends an automated fax directly to the pharmacy which provides the same billing information in writing. myMatrixx also sends a new pharmacy card to the injured worker along with an outbound phone call.

For those transactions that are processed via physician dispensing programs, myMatrixx currently has three programs in use by existing clients:

1) myMatrixx has created another proprietary process utilizing your contract rates to re-process bills that are presented with a repackaged National Drug Code (NDC). These NDCs are re-priced using a proprietary algorithm which yields savings as high as 45%.
2) myMatrixx has contracted with physician dispensing networks to process your bills at a negotiated rate based on the source AWP of the dispensed product as opposed to the inflated re-packaged AWP.
3) myMatrixx has also contracted with physician dispensing clinics to process prescriptions on-line in a manner similar to retail pharmacies to ensure formulary compliance and contract adherence at the time of dispensing.

Each of these programs may be used solely or in conjunction with either or both of the other two programs.

Note: myMatrixx uses all available data – on-line retail pharmacy transactions, paper bills, third-party processor bills, physician dispensing data - as part of our clinical programs. This helps drive out unnecessary medications and ensures clinical protocols are constantly mapped against a given claim.

myMatrixx™ good medicine for business

Formulary Development

The myMatrixx workers' compensation formulary was developed by our experienced clinical pharmacists and dynamic data analysis tools. We are skilled and experienced in supporting customized formularies that adjust in response to pharmaceutical market changes, generic introductions, brand drug innovations and new drug entities.

myMatrixx will work to establish a default formulary at the plan level but our formularies can be tailored to a specific department or claim.

CATEGORY	CODE	DESCRIPTION	EXAMPLES
PAIN			
	H3A	**ANALGESICS, NARCOTICS**	Ultram, Vicodin, Percocet, Morphine, Dilaudid, Methadone Oxycontin
	H3D	**ANALGESICS, SALICYLATES**	Disaldid, Fiorinal, Esgic, Dolobid
	H3E	**ANALGESIC/ANTIPYRETICS, NON-SALICYLATE**	Esgic Plus, Fioricet
	H3N	**ANALGESICS, NARCOTICS**	Ibuprofen/Hydrocodone BIT, Hydrocodone BT-Ibuprofen, Vicoprofen
SKELETAL MUSCLE RELAXANTS			
	H6H	**SKELETAL MUSCLE RELAXANTS**	Norflex, Zanaflex, Robaxin, Flexeril, Soma, Skelaxin, Baclofen
ANTI-INFLAMMATORY			
	S2B	**NSAIDS/ANTI-INFLAMMATORY AGENTS**	Daypro, Bextra, Relafen, Voltaren, Celebrex, Motrin, Lodine
	Q5P	**TOPICAL ANTI-INFAMMATORY, STEROIDAL**	Hydrocort, Topicort, Temovate, Valisone, Triam, Halog
	Q6P	**EYE ANTI-INFLAMMATORY AGENTS**	Pred Forte, FML,Voltaren,Lotemax

Additionally, ad-hoc reporting by our clinical team will also be provided when our clinical review identifies potential costly anomalies and will make recommendations to formularies and/or approval processes.

Any drug class can be added to your formulary upon request. Any specific medication can be removed from an approved drug class upon request.

Generic or single-source brand drugs will be used unless brand is specified by an authorized treating physician.

Quarterly maintenance will be performed on the formulary; any additions, deletions or updates are completed at this time. Any new medications that become available under formulary drug classes or medications that are removed from the market will be addressed upon myMatrixx' receipt of any updates from the FDA.

Reporting

All myMatrixx reports are available real-time through our web portal. Each quarter specific reports will be emailed automatically by your account manager at no additional charge. The standard management reporting packages as well as the utilization reports is referenced below:

Standard Management Reports

- Group Savings (See Example)
- Payer Savings
- Employer Savings
- Brand Savings
- Generic Savings
- Rejection Savings
- Top Prescriptions by Cost
- Top Prescribers by Cost
- Top Pharmacies by Cost

Standard Utilization Reports

- Patient Review Savings
- Patient Review Savings Monthly
- Third Party Biller Savings
- Pharmacy Paper Bill Summary
- Prescriber History
- Prescriber Summary
- Prescriber Therapeutic Comparison
- Narcotics Utilization
- Medication History
- Multiple Pharmacy
- Duplicate Therapy
- Early Refill
- Mail Order Candidates
- Brand/Generic Efficiency
- Therapeutic Comparison
- Top Therapeutic Detail

In addition, please refer to the attached myMatrixx Reporting Guide.

Clinical Program

Get Ahead of the Claim™

This is both a program and philosophy where myMatrixx ensures our entire team works in partnership with our clients, pharmacists, physicians and any other appropriate entity. Together we focus on a claim from the onset. It is critical that we provide the necessary level of clinical oversight and advice to ensure appropriate protocols from the day we begin to manage a claim. Not when an injured patient approaches eligibility for an MSA settlement. We provide comprehensive clinical oversight – ALL THE TIME.

We do what's right in reviewing every transaction including electronic retail and mail service scripts, paper bills, rejections, and other transactions against an injured worker's history - the full claim.

We do this regardless of the injured worker's age or the age of a claim. This allows for early and immediate intervention with the treating physician(s) by our clinical pharmacists at a point in time where we can significantly decrease inappropriate medication use and ultimately a reduction in drug spend; regardless of the opportunity for a potential settlement. We focus on drug mix, lower cost alternatives, and appropriateness. Thus our clients save on their injured worker's drug spend from the time a claim is active vs. gaining expert clinical advice at the end of a claim's lifecycle when it's too late.

Drug Therapy Management

As part of our clinical pharmacy program, myMatrixx provides a Comprehensive Drug Therapy Management (DTM) program which includes:

- Alert, Review and Manage (ARM) program
    - Opioid Management Program
    - Drug Utilization Review (DUR)
        - prospective Drug Utilization Review (pDUR)
        - retrospective Drug Utilization Review (rDUR)
    - Targeted Intervention Program (TIPs)
- basic Drug Regimen Review (basic DRR)
- detailed Drug Regimen Review (DRR)
- Pharmacy and Therapeutics (P&T) Committee

All of these programs are driven by a modification of our ARM program. Several points throughout the program make it easy to refer a patient to Case Management. These "refer to case management triggers" may be automated or manual depending on the client's specifications.

Alert, Review, Manage (ARM)™

General Overview of the Alert, Review, Manage (ARM) Program

Because of the unique nature of pain management, the myMatrixx ARM program is a highly flexible, customizable program in which the client may work directly with our clinical staff to modify existing ARM alerts (ARMs) and to develop unique ARMs that target specific areas of concern for that client's employee base. Furthermore, although the ARM program is definitely a component of the myMatrixx Clinical Pharmacy Program, it must be understood that ARMs may be comprised of clinical concerns, financial concerns, and Fraud, Waste and Abuse (FWA) concerns – or any combination of these three areas.

In general, each ARM is tied to one or more measurable actions. Typically these actions will be represented by a Targeted Intervention Letter to the physician and any combination of the remainder:

- Target Intervention Letter to the physician
- Companion Inform Letter to the pharmacist
- Educational Letter to the patient
- Copy of letter(s) to the adjuster (via e-mail)
- Recommendation for referral to Case Management

Each letter will be accompanied by an optional survey response form to ascertain the usefulness of that particular letter.

The action associated with an ARM must be initiated after review by a pharmacist. The action is not intended to be an automated response.

In addition, the ARM program offers the following unique features:

- Track and measure the impact of the TIP
- Identify change in prescribing, including date of change
- Measure pre- and post-intervention change in spending for that particular therapy
- Measure change in spending for non-intervention patients
- Report on changes at the patient, client and global level

Track and measure baseline changes in drug spending (at the client and global levels), including:

- Changes in Drug Spending Intensity
- Inflation over a specified period of time
- Impact of new generic introductions
- Impact of new uses for existing drugs
- Impact of new drugs in market
- Average cost per diagnosis at the ICD-9 level

Existing ARMs:

- **Excessive Number of Skeletal Muscle Relaxants** where more than one transaction has HIC = H6H, NDC[1] of Drug A ≠ NDC of Drug B and multiple DOS exist for Drug A that are < and > DOS of Drug B during a specified date range.

- **Excessive Duration of Skeletal Muscle Relaxant Therapy** where multiple transactions exist with HIC = H6H and with same NDC where last DOS minus initial DOS is ≥ 180 days.

Opioid Management Program

Opioid therapy represents a significant and necessary component of Pain Management. Yet at the same time, opioids and other narcotic medications represent an area with significant potential for fraud and abuse. Because of this fact, myMatrixx treats Opioid Management as a special subset of our ARM protocols.

Among the myriad of newer, more powerful and more expensive narcotic medications to treat pain are relatively few clinical advantages that warrant the use of these medications outside of their approved and limited use in areas such as end-stage cancer pain. Via its ARM program, myMatrixx has developed a series of specific, customizable triggers that alert us to review prescribing patterns that indicate when opioid use in a chronic pain case is not optimally managed.

Examples of these triggers include:

- Appropriateness of use: Actiq/Fentora (oral transmucosal fentanyl citrate or OTFC) identify the use of OTFC within the first “x” days post DOA.

- Appropriateness of use: Oxycontin or Long-Acting Opioids identify any long-acting opioid prescribed within the first “x” days post DOA.
- Prescription for an Opioid with a Substance Abuse Diagnosis
- Injectable Opioids for Non-Cancer Patients
- Chronic Use of Demerol – Brand Only
- Chronic Use of Propoxyphene
- Chronic Use of Talwin

Following review, these cases are managed in a manner that is consistent with the Office of Disability Guidelines (ODG), and alert our clients when a patient should be referred for case management, drug screening, detailed Drug Regimen Review and/or ‘Narcotic Contracts’.

Drug Utilization Review (DUR)

Drug Utilization Review (DUR) has been defined as a process used to assess the appropriateness of drug therapy against predefined criteria through the evaluation of drug therapy. Its role is primarily to help limit less-than-appropriate use of drugs, adverse consequences for patients, and potentially Amerisys health care costs.

Two types of DUR are retrospective and prospective. Retrospective DUR is typically conducted after the medication is dispensed and should focus on population pattern analysis. Prospective DUR is typically conducted during or before dispensing and can detect drug-specific problems such as drug-drug interactions, dosage problems, or duration issues.

The ultimate goal of DUR is to engage educational interventions with the physician and patient to improve prescribing and drug use.

Prospective Drug Utilization Review (pDUR)

DUR will be performed at the time of dispensing on all prescriptions either by the dispensing retail network pharmacist or by a member of the pharmacist staff at the myMatrixx Mail Service Pharmacy. pDUR will include:

- Drug Interactions
- Duplication of Drug Therapy
- Therapeutic Class Overlap
- Compliance Monitoring
- Dose Limitations

Retrospective Drug Utilization Review (rDUR)

- Drug-drug interaction
- Drug-disease interaction
- Drug over-utilization
- Drug under-utilization
- Drug-pregnancy alert
- Therapeutic duplication
- Addictive substances
- Drug-patient interaction
- Drug-age interaction

- Multiple physicians
- Multiple pharmacies

Basic Drug Regimen Review (Basic DRR)

The basic DRR will include:

- A listing of all the drugs that a patient has received. This comprehensive list will include the brand and generic name of the drug, the drug class as defined by the American Hospital Formulary Service (ASHP), and the FDA-approved indications for the drug.
- A description of off-label use of medication applicable to pain management,
- A proposed rationale for the use of particular medications in pain management or Workers Compensation, and
- A review of contraindications, side effects and warnings

Detailed Drug Regimen Review (DRR)

Designed for those situations in which detailed information and professional evaluation and commentary regarding a patient's possible outcome is required, the detailed DRR includes all the information available via the basic DRR plus:

- A recommendation for improvements in therapy,
- An evaluation of the Official Disability Guidelines (ODG) where appropriate,
- A review of any TIPs that may have already been performed on behalf of this patient and recommendations for next steps, and
- An indication that case management is advisable for the particular patient under review.

Pharmacy and Therapeutics (P&T) Committee

The myMatrixx P&T Committee has been created to act in an advisory capacity to the clients of myMatrixx with regard to the selection of drugs and drug classes to be included on a list of recommended drugs for coverage under Workers' Compensation and other entities. Recommendations from the committee must be approved by an individual client, and such recommendations and/or formularies are in no way intended to detract from the customizable approach that myMatrixx has always applied to its formularies and the prior authorization process.

Furthermore, the myMatrixx P&T Committee will periodically review Official Disability Guidelines (ODG) to maintain an ODG formulary that is in compliance with ODG and therefore offers a mechanism that allows clients that must comply with the Texas Department of Insurance Division of Workers' Compensation (TDI-DWC) to maintain such compliance. Until such regulation regarding the ODG formulary and prior authorization is approved and made final by the TDI-DWC, the myMatrixx P&T Committee shall review the proposed regulations and offer forward such recommendations to the TDI-DWC that the committee feels will facilitate the process and provide its clients with a workable solution to administer the ODG formulary and guidelines. For those myMatrixx clients that are not bound by the TDI-DWC, adoption of the ODG formulary and guidelines is entirely voluntary, but the committee feels that its review of said guidelines will allow those clients to exercise due diligence in the adoption or rejections of all or part of the guidelines.

The myMatrixx P&T Committee shall also recommend prior authorization guidelines for non-preferred or non-covered drug entities. For those clients bound by the TDI-DWC regulations, such prior authorization guidelines shall be in compliance with TDI-DWC regulations governing

other areas such as Utilization Review. For all clients, the prior authorization process is intended to provide a process that allows coverage determination supported by evidence-based guidelines.

The myMatrixx clinical staff will provide both clinical and financial analyses to assist the committee in its decision making process. At times, additional expertise may be required from member organizations or outside institutions. Acceptance of such expertise will be at the discretion of the committee.

The committee is composed of physicians, nurses, pharmacists and lay persons that have a familiarity with Workers' Compensation and/or injury state management. Other experts and/or specialists may be invited to participate in a non-voting capacity on an as needed basis.

The committee meets on a quarterly basis at a minimum, and may convene more often if a majority of the committee deems it necessary. Between meetings, different analyses, evaluations and/or reviews may be required to be completed prior to the next meeting. The membership is encouraged to meet in person as often as possible, but it is recognized that various members may at times have to participate telephonically. However, at least one annual meeting will be held in which the entire membership must be present in person.

In accordance with guidelines established by both the Academy of Managed Care Pharmacy and the American Society of Health-System Pharmacists, the myMatrixx P&T Committee shall make decisions based on clinical effectiveness. Business decisions shall only play a role in the decision making process when more than one drug provides the same clinical efficacy. In those cases, such as generic substitution, the committee will always make fiscally responsible decisions.

Pricing

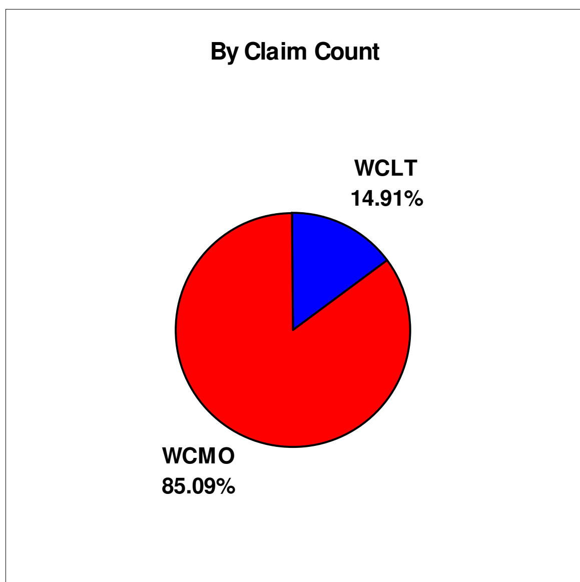
	Brand	**Generic**	**Dispensing Fee**
Retail	AWP – X%	AWP – XX%	$
Mail Service	AWP – X%	AWP – XX%	$

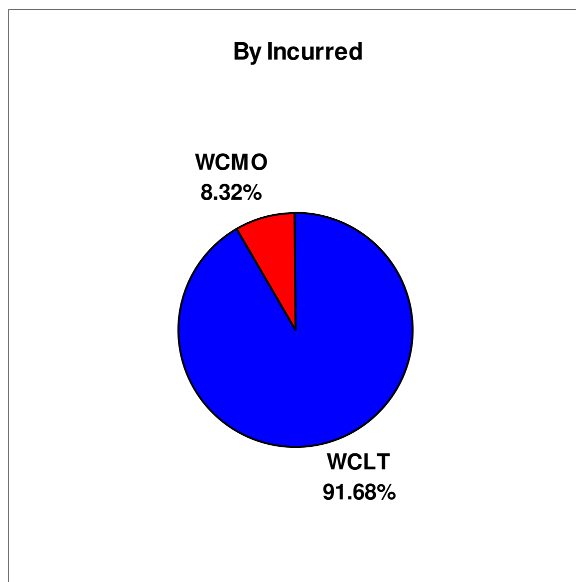
CLIENT STATUS REPORT

SECTION #1: TOTAL CLAIMS

Total Frequency & Severity by Line, by Analysis Period

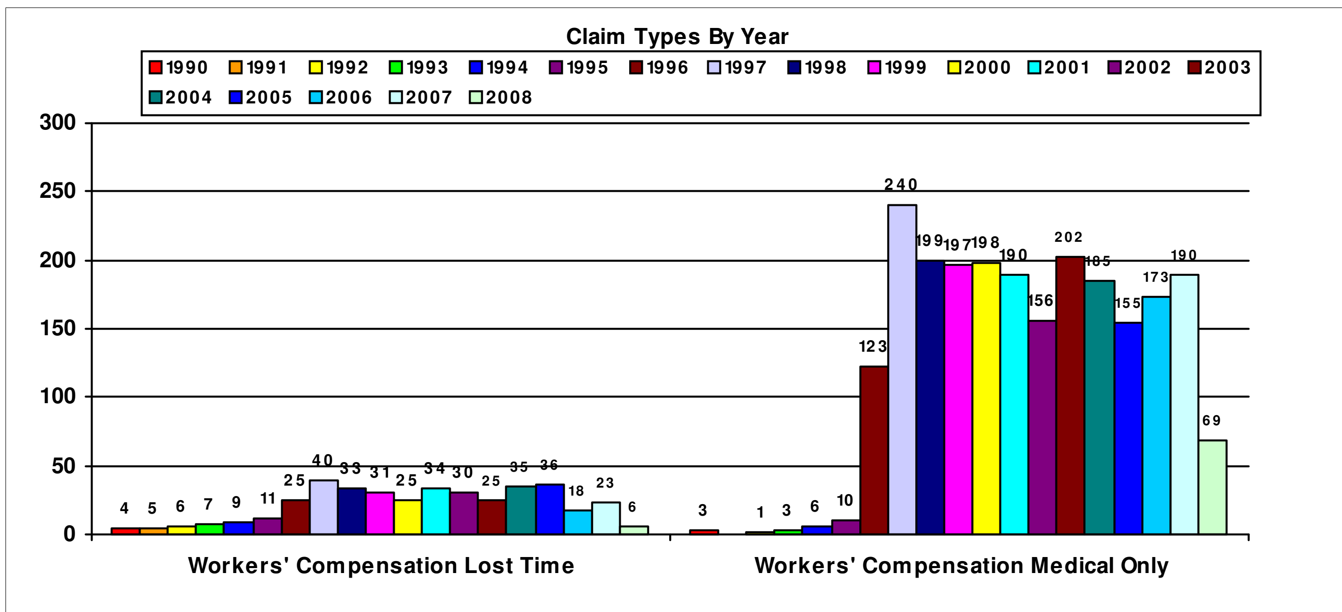
This chart shows both open and closed claims handled by PGCS for CLIENT from 07/01/1990 to 12/31/2008. The pie chart on the left of the exhibit shows the number of claims broken down by line of coverage along with the percentage that those claims represent of the total handled. The pie chart on the right shows you the total incurred by line of coverage along with that line's respective percentage of the total for the period.





Claim Development by Line, by Claim Period

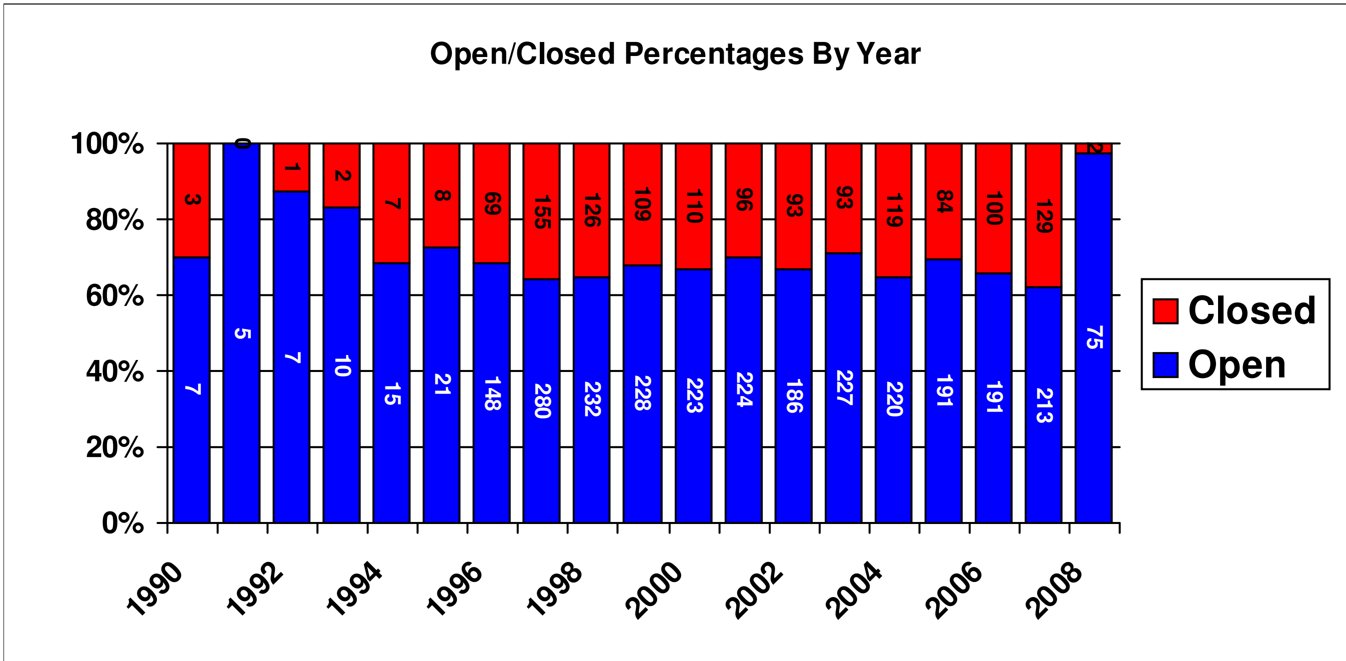
This exhibit provides a benchmarking tool to assist CLIENT in analyzing claim volume by line of coverage. The bar graph below compares the number of claims for each claim type, valued as of the end of the analysis period. This allows CLIENT to track the claim activity from one year to the next.



CLIENT STATUS REPORT

Closure Reports

The graphs contained in this section identify the total number of claims opened in a specific fund year, regardless of accident date, for all coverages combined and by line of coverage. The graph then identifies the percentage of those claims that closed during each fund year.

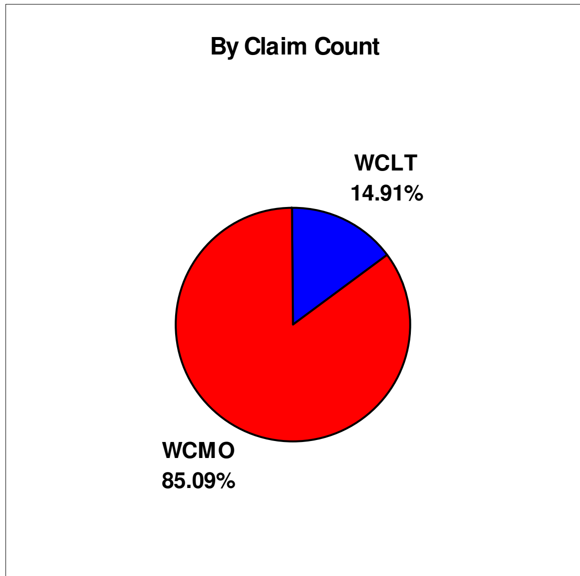


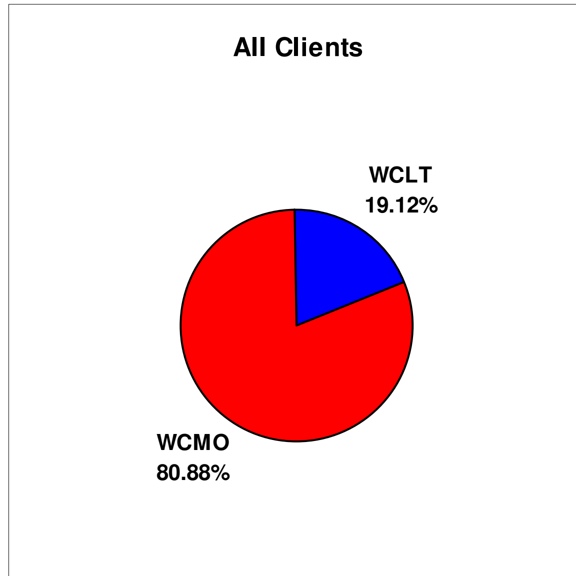
CLIENT STATUS REPORT

SECTION #2: CLIENT/ALL CLIENTS COMPARISONS

Total Workers' Compensation Claims by Type

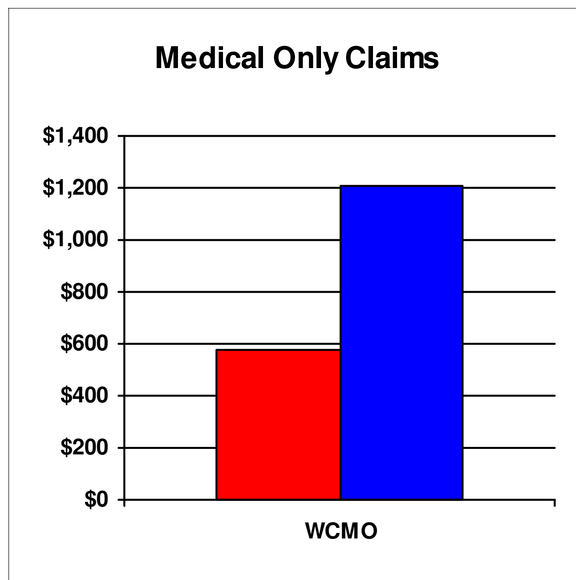
This exhibit compares CLIENT's workers' compensation claims count (left) with that of all PGCS clients (right). It further breaks down the claim counts into percentages of both medical and indemnity claims. This illustrates your medical/indemnity split compared to the PGCS client base for the same period.





Average Incurred per Claim by Line

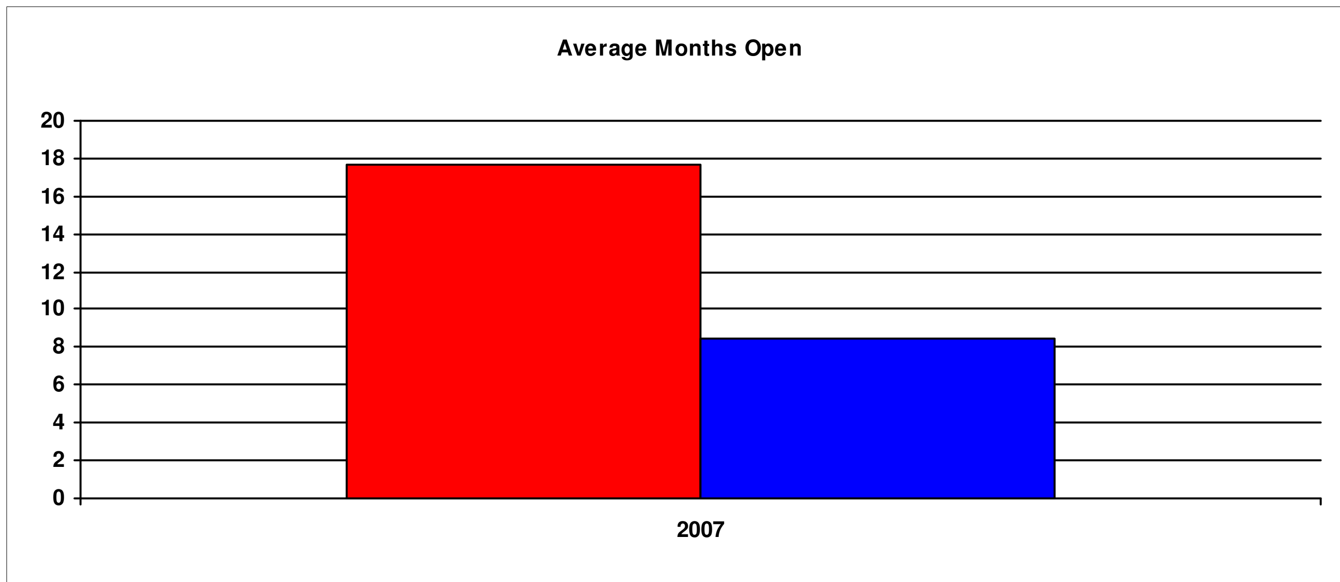
In order to demonstrate an 'apples to apples' comparision, we have run this report on a fund year basis. This exhibit shows CLIENT's actual average cost per claim for claims which occurred during the time period reported compared to the corresponding averages for all PGCS clients.



CLIENT STATUS REPORT

Average Months Open

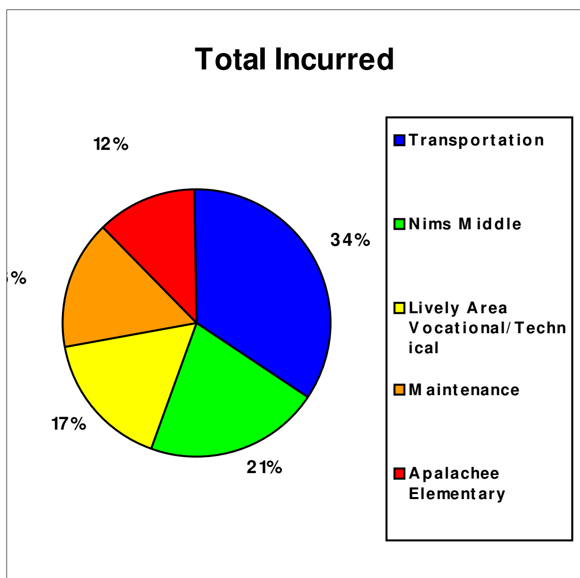
This exhibit shows, by line of coverage, the average number of months that a claim remained open during the noted reporting period as compared to averages for all PGCS clients.

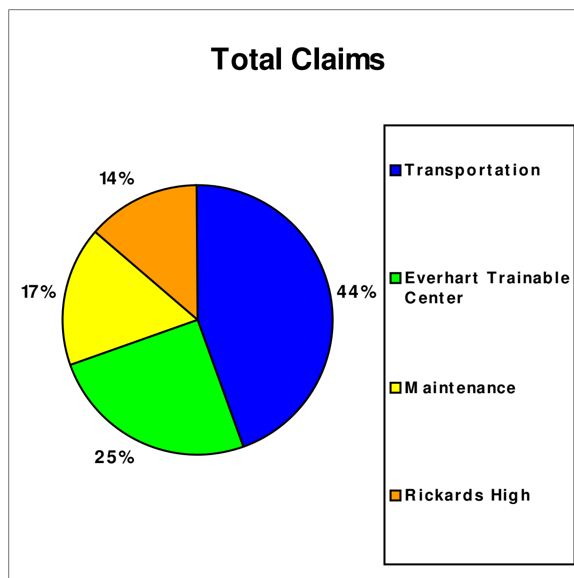


SECTION #3: TOP FIVE LOCATIONS

Totals By Incurred & Claim Counts

These exhibits illustrate the geographic distribution of CLIENT's claims by severity and frequency.



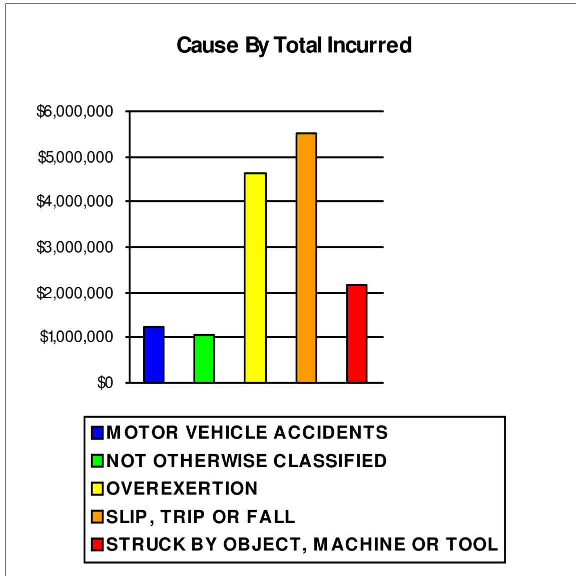


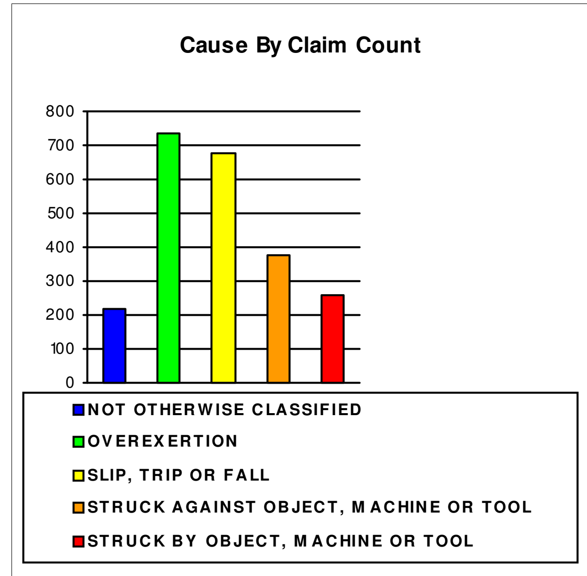
CLIENT STATUS REPORT

SECTION #4: WORKERS' COMPENSATION LOSSES TOP FIVE

By Cause Of Loss

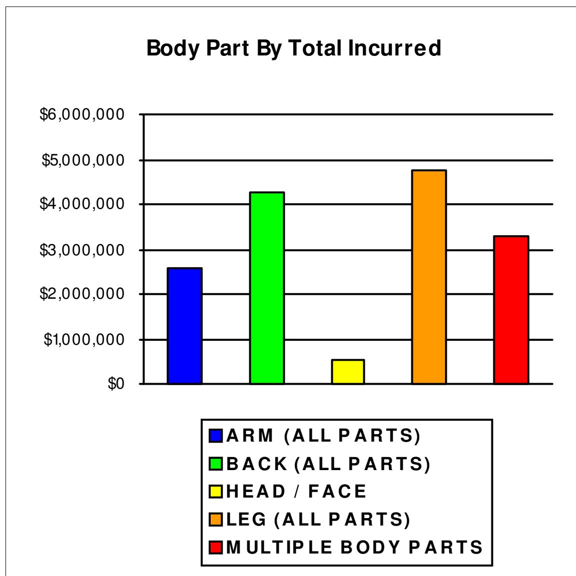
This exhibit illustrates CLIENT's top 5 workers' compensation causes of loss.

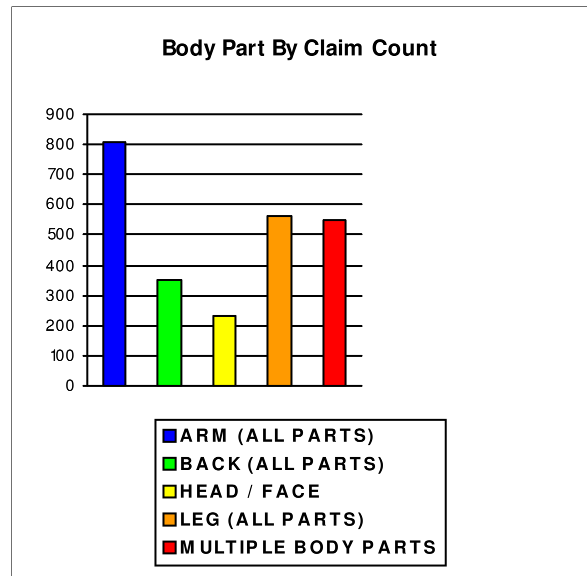




By Body Part

This exhibit illustrates CLIENT's top 5 workers' compensation body parts.



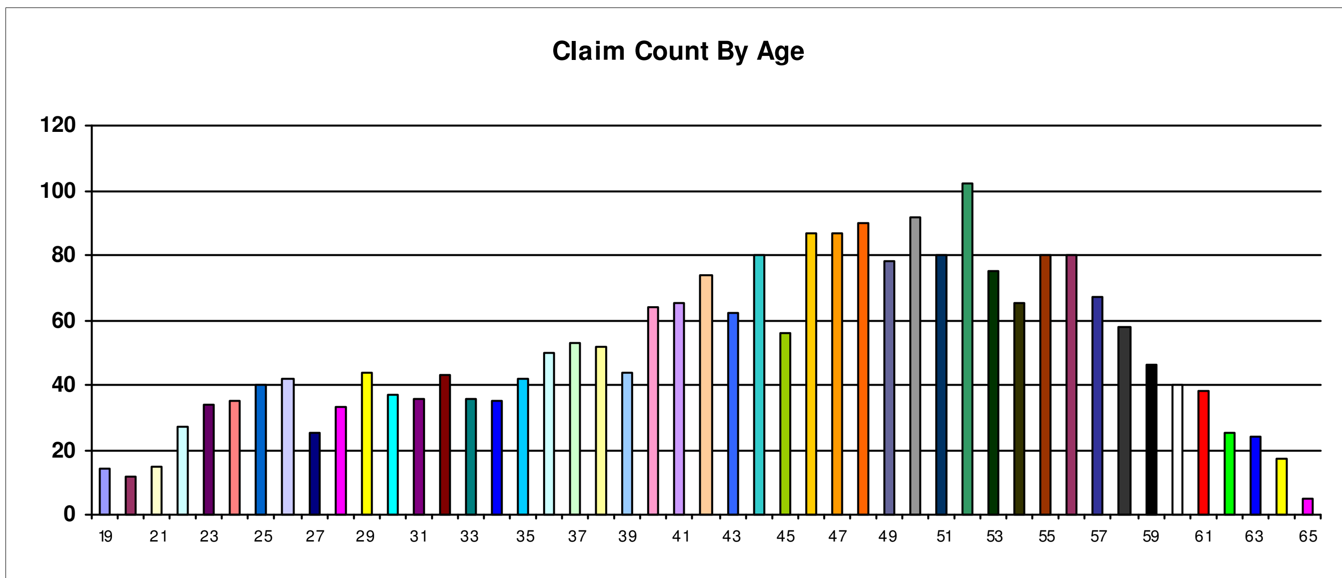


CLIENT STATUS REPORT

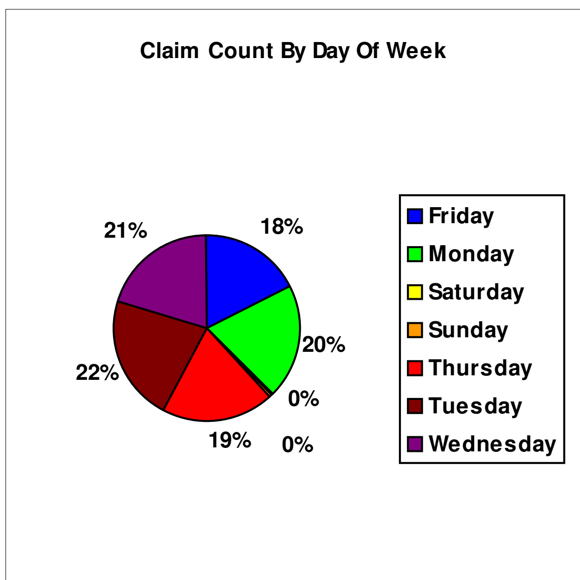
SECTION #5: CLAIMANT PROFILE

This section graphically depicts the percentage of claims based upon criteria below:

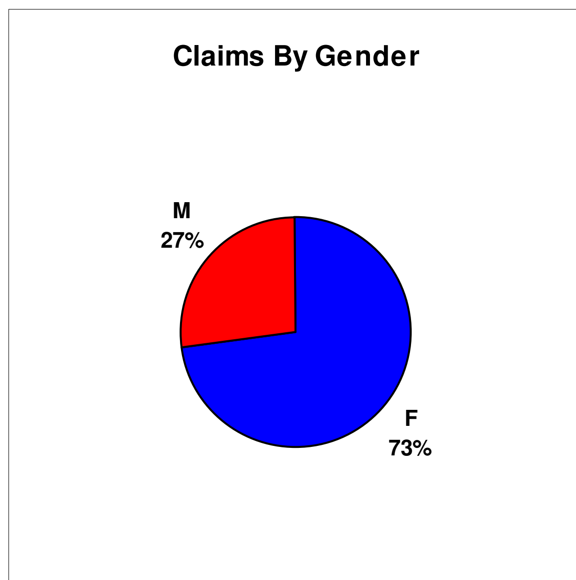
By Age Of Employee



By Day Of Week:



By Gender:



Preferred Governmental Claim Solutions
Member Experience Report

Sorting on report is as follows:

Fund Year (with subtotal)
Policy # (with subtotal)
Coverage Type
Claim Type
Employee/Claimant Name

COVERAGE CODES	CLAIM TYPE CODES	COVERAGE CODES	CLAIM TYPE CODES
AL - Auto Liability	ALBI - Bodily Injury	GL - General Liability	GLIC - Inverse Condemnation
	ALMP - Medical Payments		GLMP - Medical Payments
	ALPD - Property Damage		GLNFSB - No-Fault Sewer Backup
	ALPIP - PIP		GLPD - Property Damage
	ALUM - Uninsured/Underinsured Motorist		GLPI - Personal Injury
AP - Auto Physical Damage	APCL - Collision	IM - Inland Marine	IM - Inland Marine
	APCM - Comprehensive	LE - Law Enforcement Liability	LEBI - Bodily Injury
BM - Boiler & Machinery	BM - Boiler & Machinery		LEPD - Property Damage
CR - Crime	COMPF - Computer Fraud		LEPI - Personal Injury
	EMPDIS - Employee Dishonesty		LEWA - Wrongful Arrest
	FORG - Forgery/Alteration	PC - Catastrophic Property	APCAT - Catastrophic Automobile Loss
	THEFT - Theft		PRCAT - Catastrophic Property Loss
ELL - Educator's Legal Liability	ELLAO - All Other	POL - Public Officials Liability	PUBAO - Public Officials All Others
	ELLSH - Sexual Misconduct (School)		PUBCO - Contractual Liability
EO - Errors & Omissions	EOPI - Errors & Omissions		PUBLU - Land Use/Zoning
EP - Employment Practices Liability	EPAO - All Other		PUBNM - Non-Monetary
	EPDISC - Discrimination	PR - Property	BUSINT - Business Interruption
	EPPT - Pre-Termination		EXT - Property Extensions
	EPSH - Sexual Harassment		PROP - Building & Contents
	EPWD - Wrongful Discharge		PRTP - Property Of Others (Rented/Borrowed)
GL - General Liability	GLBI - Bodily Injury	WC - Workers' Compensation	WCEL - Employers Liability
	GLCO - Breach Of Contract		WCLT - Lost Time
	GLEB - Employment Benefits		WCMO - Medical Only
	GLED - Eminent Domain		WCRO - Report Only

Preferred Governmental Claim Solutions
Member Experience Report

CLIENT NAME

2008 - 07/01/2008 TO 06/30/2009

SIR Pkg 2008

Claim #	Employee / Claimant	Claim Type	Occur Date		Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2008151389 - Claimant alleges bodily injury as a result of a Coach grabbing him.												
156096	**Employee** / **Claimant**	GLBI	10/24/2008		OP	0.00	0.00	0.00	6.85	25,000.00	0.00	25,006.85
EV2008151389 Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**0.00**	**0.00**	**0.00**	**6.85**	**25,000.00**	**0.00**	**25,006.85**
EV2009154264 - drivers ed student wrecked car												
159174	**Employee** / **Claimant**	APCL	03/25/2009		OP	6,613.00	-6,613.00	0.00	6,718.00	0.00	0.00	6,718.00
EV2009154264 Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**6,613.00**	**-6,613.00**	**0.00**	**6,718.00**	**0.00**	**0.00**	**6,718.00**
Department Totals	**Claim Count: Open + Closed = Total**		**2**	**0**	**2**	**6,613.00**	**-6,613.00**	**0.00**	**6,724.85**	**25,000.00**	**0.00**	**31,724.85**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2009152580 - Child was struck by teacher driving in to work. Sustained fatal injuries.												
157374	**Employee** / **Claimant**	GLBI	01/09/2009		OP	6.85	0.00	0.00	6.85	10,000.00	0.00	10,006.85
EV2009152580 Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**6.85**	**0.00**	**0.00**	**6.85**	**10,000.00**	**0.00**	**10,006.85**
Department Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**6.85**	**0.00**	**0.00**	**6.85**	**10,000.00**	**0.00**	**10,006.85**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2008149374 - Gutter along parent pick up area damaged by unknown vehicle.												
PROP153860	**Employee** / **Claimant**	PROP	07/21/2008		CL	0.00	0.00	0.00	1,465.17	0.00	0.00	1,465.17
EV2008149374 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,465.17**	**0.00**	**0.00**	**1,465.17**
Department Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,465.17**	**0.00**	**0.00**	**1,465.17**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2009154217 -												
159123	**Employee** / **Claimant**	GLBI	03/07/2009		OP	6.85	0.00	0.00	6.85	10,000.00	0.00	10,006.85
EV2009154217 Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**6.85**	**0.00**	**0.00**	**6.85**	**10,000.00**	**0.00**	**10,006.85**
Department Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**6.85**	**0.00**	**0.00**	**6.85**	**10,000.00**	**0.00**	**10,006.85**

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DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008149370 - Rain gutter damaged by truck or bus entering parking lot.											
PROP153856	**Employee / Claimant**	PROP	07/23/2008	CL	0.00	0.00	0.00	1,431.50	0.00	0.00	1,431.50
EV2008149370 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,431.50**	**0.00**	**0.00**	**1,431.50**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,431.50**	**0.00**	**0.00**	**1,431.50**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2009153014 - Student was attacked by two other students in the school restroom.											
157841	**Employee / Claimant**	GLBI	01/06/2009	OP	0.00	0.00	0.00	0.00	10,000.00	0.00	10,000.00
EV2009153014 Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**10,000.00**	**0.00**	**10,000.00**
EV2008153366 - Claimant alleges negligence from the school administrators.											
158214	**Employee / Claimant**	GLBI	01/30/2009	OP	0.00	0.00	0.00	0.00	5,000.00	0.00	5,000.00
EV2008153366 Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**5,000.00**	**0.00**	**5,000.00**
Department Totals	**Claim Count: Open + Closed = Total**	**2**	**0**	**2**	**0.00**	**0.00**	**0.00**	**0.00**	**15,000.00**	**0.00**	**15,000.00**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2009155323 - insured hit parked vehicle.											
160314	**Employee / Claimant**	ALPD	05/08/2009	OP	1,007.78	577.22	0.00	1,007.78	577.22	0.00	1,585.00
EV2009155323 Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**1,007.78**	**577.22**	**0.00**	**1,007.78**	**577.22**	**0.00**	**1,585.00**
Department Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**1,007.78**	**577.22**	**0.00**	**1,007.78**	**577.22**	**0.00**	**1,585.00**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008151910 - Staff member struck fence while backing up insured vehicle.											
156666	**Employee / Claimant**	APCL	11/21/2008	CL	0.00	0.00	0.00	1,126.00	0.00	0.00	1,126.00
EV2008151910 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,126.00**	**0.00**	**0.00**	**1,126.00**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,126.00**	**0.00**	**0.00**	**1,126.00**

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Claim #	Employee / Claimant	Claim Type	Occur Date		Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2009153882 - tree fell on guy anchor.												
158771	**Employee / Claimant**	PROP	01/16/2009		CL	0.00	0.00	0.00	20,000.00	0.00	0.00	20,000.00
EV2009153882 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**20,000.00**	**0.00**	**0.00**	**20,000.00**
Department Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**20,000.00**	**0.00**	**0.00**	**20,000.00**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2008150122 - pump switch failed on chill water line causing to much pressure causing da												
154727	**Employee / Claimant**	PROP	07/09/2008		CL	0.00	0.00	0.00	7,121.15	0.00	0.00	7,121.15
EV2008150122 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**7,121.15**	**0.00**	**0.00**	**7,121.15**
Department Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**7,121.15**	**0.00**	**0.00**	**7,121.15**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2008149844 - While turning left bus struck fence pole and mail box causing damage to bus												
154367	**Employee / Claimant**	APCL	08/21/2008		CL	0.00	0.00	0.00	1,522.82	0.00	0.00	1,522.82
EV2008149844 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,522.82**	**0.00**	**0.00**	**1,522.82**
EV2008150123 - Bus 3015 hit parked bus 1029 causing damage												
154728	**Employee / Claimant**	APCL	09/08/2008		CL	0.00	0.00	0.00	1,101.50	0.00	0.00	1,101.50
EV2008150123 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,101.50**	**0.00**	**0.00**	**1,101.50**
EV2008153475 - windsheild												
158331	**Employee / Claimant**	APCM	10/08/2008		CL	0.00	0.00	0.00	304.00	0.00	0.00	304.00
EV2008153475 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**304.00**	**0.00**	**0.00**	**304.00**
EV2008153476 - windsheild												
158332	**Employee / Claimant**	APCM	10/09/2008		CL	0.00	0.00	0.00	300.68	0.00	0.00	300.68
EV2008153476 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**300.68**	**0.00**	**0.00**	**300.68**

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Claim #	Employee / Claimant	Claim Type	Occur Date	Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008153471 - Damage to bus not sure exactly how it happened.											
158327	**Employee / Claimant**	APCL	10/14/2008	CL	0.00	0.00	0.00	1,970.00	0.00	0.00	1,970.00
EV2008153471 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,970.00**	**0.00**	**0.00**	**1,970.00**
EV2007153467 - Insured was coming out of park when they hit a hole damaging bus.											
158325	**Employee / Claimant**	APCL	10/22/2008	CL	0.00	0.00	0.00	2,339.60	0.00	0.00	2,339.60
EV2007153467 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**2,339.60**	**0.00**	**0.00**	**2,339.60**
EV2008153472 - Windshield.											
158328	**Employee / Claimant**	APCM	10/24/2008	CL	0.00	0.00	0.00	161.00	0.00	0.00	161.00
EV2008153472 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**161.00**	**0.00**	**0.00**	**161.00**
EV2008153474 - windshield.											
158330	**Employee / Claimant**	APCM	11/04/2008	CL	0.00	0.00	0.00	345.00	0.00	0.00	345.00
EV2008153474 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**345.00**	**0.00**	**0.00**	**345.00**
EV2008153478 - windshield.											
158334	**Employee / Claimant**	APCM	11/04/2008	CL	0.00	0.00	0.00	298.00	0.00	0.00	298.00
EV2008153478 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**298.00**	**0.00**	**0.00**	**298.00**
EV2008152055 -											
156821	**Employee / Claimant**	ALBI	11/17/2008	OP	0.00	0.00	0.00	0.00	10,000.00	0.00	10,000.00
156820	**Employee / Claimant**	ALPD	11/17/2008	CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EV2008152055 Totals	**Claim Count: Open + Closed = Total**		**1 1**	**2**	**0.00**	**0.00**	**0.00**	**0.00**	**10,000.00**	**0.00**	**10,000.00**
EV2009154030 - bus struck object.											
158931	**Employee / Claimant**	APCL	02/09/2009	CL	0.00	0.00	0.00	1,200.08	0.00	0.00	1,200.08
EV2009154030 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,200.08**	**0.00**	**0.00**	**1,200.08**
EV2009154024 - insured struck tree while turning											
158925	**Employee / Claimant**	APCL	02/19/2009	CL	0.00	0.00	0.00	1,786.90	0.00	0.00	1,786.90
EV2009154024 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,786.90**	**0.00**	**0.00**	**1,786.90**

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DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2009154027 - windshield											
158927	**Employee / Claimant**	APCM	02/26/2009	CL	0.00	0.00	0.00	286.00	0.00	0.00	286.00
EV2009154027 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**286.00**	**0.00**	**0.00**	**286.00**
EV2009155249 - windshield											
160240	**Employee / Claimant**	APCM	03/27/2009	CL	478.71	0.00	0.00	478.71	0.00	0.00	478.71
EV2009155249 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**478.71**	**0.00**	**0.00**	**478.71**	**0.00**	**0.00**	**478.71**
EV2009155233 - insured struck other vehicle while turning.											
160221	**Employee / Claimant**	ALPD	04/29/2009	CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EV2009155233 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Department Totals	**Claim Count: Open + Closed = Total**	**1**	**15**	**16**	**478.71**	**0.00**	**0.00**	**12,094.29**	**10,000.00**	**0.00**	**22,094.29**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008148774 - cracked windshield Bus # 1022											
APCM153209	**Employee / Claimant**	APCM	07/08/2008	CL	0.00	0.00	0.00	496.25	0.00	0.00	496.25
EV2008148774 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**496.25**	**0.00**	**0.00**	**496.25**
EV2008148786 - Bus ran into some low hanging wires and pulled drop from house.											
ALPD 153223	**Employee / Claimant**	ALPD	07/08/2008	CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ALPD153222	**Employee / Claimant**	ALPD	07/08/2008	CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EV2008148786 Totals	**Claim Count: Open + Closed = Total**	**0**	**2**	**2**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
EV2008148950 - Bust struck other vehicle.											
ALPD153397	**Employee / Claimant**	ALPD	07/14/2008	CL	0.00	0.00	0.00	1,681.01	0.00	0.00	1,681.01
EV2008148950 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,681.01**	**0.00**	**0.00**	**1,681.01**
EV2008150083 - Other vehicle struck school bus.											
154683	**Employee / Claimant**	APCL	08/18/2008	CL	-40.00	0.00	-960.00	2,349.00	0.00	1,389.00	2,349.00
EV2008150083 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**-40.00**	**0.00**	**-960.00**	**2,349.00**	**0.00**	**1,389.00**	**2,349.00**

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DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008150486 - Vehicles struck each others side mirrors.											
155130	**Employee / Claimant**	ALPD	08/25/2008	CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EV2008150486 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
EV2008150088 - Bus struck a metal pole while backing up.											
154688	**Employee / Claimant**	APCL	08/28/2008	CL	0.00	0.00	0.00	1,915.90	0.00	0.00	1,915.90
EV2008150088 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,915.90**	**0.00**	**0.00**	**1,915.90**
EV2008150485 - Bus struck rear left side of claimants vehicle.											
155129	**Employee / Claimant**	ALPD	09/16/2008	CL	0.00	0.00	0.00	4,124.98	0.00	0.00	4,124.98
EV2008150485 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**4,124.98**	**0.00**	**0.00**	**4,124.98**
EV2008151469 - Insured vehicle struck other vehicle while making a right turn.											
156187	**Employee / Claimant**	ALPD	10/02/2008	CL	0.00	0.00	0.00	2,047.46	0.00	0.00	2,047.46
EV2008151469 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**2,047.46**	**0.00**	**0.00**	**2,047.46**
EV2008151570 - Hanging vine struck windshield and cracked it.											
156297	**Employee / Claimant**	APCM	10/22/2008	CL	0.00	0.00	0.00	298.00	0.00	0.00	298.00
EV2008151570 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**298.00**	**0.00**	**0.00**	**298.00**
EV2008151571 - Winshield had small crack that kept getting larger. Winshield replacement on											
156298	**Employee / Claimant**	APCM	11/04/2008	CL	0.00	0.00	0.00	298.00	0.00	0.00	298.00
EV2008151571 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**298.00**	**0.00**	**0.00**	**298.00**
EV2008151912 - School bus struck claimant's vehicle while turning out of RAA Middle School											
156668	**Employee / Claimant**	ALPD	11/07/2008	CL	0.00	0.00	0.00	1,765.15	0.00	0.00	1,765.15
EV2008151912 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,765.15**	**0.00**	**0.00**	**1,765.15**
EV2008151868 - Iv hit OV causing damage to Nissian Altma 2006											
156621	**Employee / Claimant**	ALBI	11/13/2008	OP	0.00	0.00	0.00	0.00	10,000.00	0.00	10,000.00
156626	**Employee / Claimant**	ALPD	11/13/2008	CL	0.00	0.00	0.00	2,230.64	0.00	0.00	2,230.64
EV2008151868 Totals	**Claim Count: Open + Closed = Total**		**1 1**	**2**	**0.00**	**0.00**	**0.00**	**2,230.64**	**10,000.00**	**0.00**	**12,230.64**

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DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008151843 - Bus struck a pole while making a turn.											
156596	**Employee / Claimant**	APCL	11/21/2008	CL	0.00	0.00	0.00	3,502.00	0.00	0.00	3,502.00
EV2008151843 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**3,502.00**	**0.00**	**0.00**	**3,502.00**
EV2008152068 - School bus struck patrol car.											
156840	**Employee / Claimant**	APCL	12/11/2008	CL	0.00	0.00	0.00	8,389.33	0.00	0.00	8,389.33
156838	**Employee / Claimant**	ALPD	12/11/2008	CL	0.00	-307.25	0.00	8,297.75	0.00	570.25	8,297.75
EV2008152068 Totals	**Claim Count: Open + Closed = Total**		**0 2**	**2**	**0.00**	**-307.25**	**0.00**	**16,687.08**	**0.00**	**570.25**	**16,687.08**
EV2008153287 - School bus struck a tree while making left turn.											
158131	**Employee / Claimant**	APCL	12/12/2008	CL	0.00	0.00	0.00	4,328.81	0.00	0.00	4,328.81
EV2008153287 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**4,328.81**	**0.00**	**0.00**	**4,328.81**
EV2009153281 - School bus struck another school bus in parking lot.											
158126	**Employee / Claimant**	APCL	01/26/2009	CL	0.00	0.00	0.00	1,106.00	0.00	0.00	1,106.00
EV2009153281 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,106.00**	**0.00**	**0.00**	**1,106.00**
EV2009155261 - insured vehicle was parked when chain link gate was blown into it.											
160253	**Employee / Claimant**	APCL	03/24/2009	CL	1,240.82	0.00	0.00	1,240.82	0.00	0.00	1,240.82
EV2009155261 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**1,240.82**	**0.00**	**0.00**	**1,240.82**	**0.00**	**0.00**	**1,240.82**
EV2009155262 - windshield											
160254	**Employee / Claimant**	APCM	04/07/2009	CL	268.00	0.00	0.00	268.00	0.00	0.00	268.00
EV2009155262 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**268.00**	**0.00**	**0.00**	**268.00**	**0.00**	**0.00**	**268.00**
EV2009155257 - insured was turning when other driver hit insured and did not stop.											
160249	**Employee / Claimant**	APCL	04/09/2009	CL	1,458.00	0.00	0.00	1,458.00	0.00	0.00	1,458.00
EV2009155257 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**1,458.00**	**0.00**	**0.00**	**1,458.00**	**0.00**	**0.00**	**1,458.00**
EV2009155255 - insured was backing up to park and hitt somthing											
160247	**Employee / Claimant**	APCL	04/10/2009	CL	1,185.00	0.00	0.00	1,185.00	0.00	0.00	1,185.00
EV2009155255 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**1,185.00**	**0.00**	**0.00**	**1,185.00**	**0.00**	**0.00**	**1,185.00**

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SIR Pkg 2008

Claim #	Employee / Claimant	Claim Type	Occur Date		Status	This Period* Paid	Reserve Chgs	Collected	To Date Paid	Reserved	Collected	Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2009155250 - insured was stop when other vehicle hit it												
160241	**Employee / Claimant**	APCL	04/14/2009		CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EV2009155250 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
EV2009155258 - insured hit hole damaging door and door rod.												
160250	**Employee / Claimant**	APCL	04/14/2009		CL	1,331.70	0.00	0.00	1,331.70	0.00	0.00	1,331.70
EV2009155258 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**1,331.70**	**0.00**	**0.00**	**1,331.70**	**0.00**	**0.00**	**1,331.70**
EV2009155260 - when exiting through gate, gate swung closed htting bus mirror.												
160252	**Employee / Claimant**	APCL	04/14/2009		CL	1,629.21	0.00	0.00	1,629.21	0.00	0.00	1,629.21
EV2009155260 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**1,629.21**	**0.00**	**0.00**	**1,629.21**	**0.00**	**0.00**	**1,629.21**
EV2009155256 - While Making a left turn door came in contact with ground												
160248	**Employee / Claimant**	APCL	04/21/2009		CL	1,043.70	0.00	0.00	1,043.70	0.00	0.00	1,043.70
EV2009155256 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**1,043.70**	**0.00**	**0.00**	**1,043.70**	**0.00**	**0.00**	**1,043.70**
EV2009155252 - insured struck parked vehicle while trying to exit parking lot.												
160244	**Employee / Claimant**	ALPD	04/22/2009		OP	0.00	1,000.00	0.00	0.00	1,000.00	0.00	1,000.00
160243	**Employee / Claimant**	APCL	04/22/2009		OP	0.00	1,500.00	0.00	0.00	1,500.00	0.00	1,500.00
EV2009155252 Totals	**Claim Count: Open + Closed = Total**		**2**	**0**	**2**	**0.00**	**2,500.00**	**0.00**	**0.00**	**2,500.00**	**0.00**	**2,500.00**
EV2009155253 - insured was turning and struck sign												
160245	**Employee / Claimant**	APCL	04/29/2009		CL	1,664.00	0.00	0.00	1,664.00	0.00	0.00	1,664.00
EV2009155253 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**1,664.00**	**0.00**	**0.00**	**1,664.00**	**0.00**	**0.00**	**1,664.00**
Department Totals	**Claim Count: Open + Closed = Total**		**3**	**27**	**30**	**9,780.43**	**2,192.75**	**-960.00**	**52,650.71**	**12,500.00**	**1,959.25**	**65,150.71**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2008149449 - Some debris shot up from a weed eater and broke a back window of parked												
153937	**Employee / Claimant**	GLPD	07/21/2008		CL	0.00	0.00	0.00	559.54	0.00	0.00	559.54
EV2008149449 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**559.54**	**0.00**	**0.00**	**559.54**
Department Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**559.54**	**0.00**	**0.00**	**559.54**

Preferred Governmental Claim Solutions
Member Experience Report

CLIENT NAME

2008 - 07/01/2008 TO 06/30/2009

SIR Pkg 2008

Claim #	Employee / Claimant	Claim Type	Occur Date	Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008150167 - IV hit OV											
154773	**Employee / Claimant**	ALPD	09/09/2008	CL	0.00	0.00	0.00	1,183.02	0.00	0.00	1,183.02
EV2008150167 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,183.02**	**0.00**	**0.00**	**1,183.02**
Department Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,183.02**	**0.00**	**0.00**	**1,183.02**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008151827 - Student tripped over a chair and fell.											
156579	**Employee / Claimant**	GLBI	10/10/2008	OP	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EV2008151827 Totals	**Claim Count: Open + Closed = Total**		**1 0**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
EV2008152574 - Discrimination complaint on a student.											
157370	**Employee / Claimant**	GLBI	12/17/2008	OP	0.00	0.00	0.00	0.00	25,000.00	0.00	25,000.00
EV2008152574 Totals	**Claim Count: Open + Closed = Total**		**1 0**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**25,000.00**	**0.00**	**25,000.00**
EV2008153396 - Ov backed into IV											
158248	**Employee / Claimant**	APCL	12/19/2008	CL	0.00	0.00	0.00	1,056.08	0.00	1,056.08	1,056.08
EV2008153396 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**1,056.08**	**0.00**	**1,056.08**	**1,056.08**
EV2009152922 - Claimant alleges sexual assault by other student on school grounds.											
157750	**Employee / Claimant**	GLBI	01/14/2009	OP	0.00	0.00	0.00	0.00	25,000.00	0.00	25,000.00
EV2009152922 Totals	**Claim Count: Open + Closed = Total**		**1 0**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**25,000.00**	**0.00**	**25,000.00**
EV2009153179 - IV struck OV.											
158108	**Employee / Claimant**	ALBI	02/05/2009	CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
158016	**Employee / Claimant**	ALPD	02/05/2009	OP	0.00	0.00	0.00	5,045.78	66.07	0.00	5,111.85
EV2009153179 Totals	**Claim Count: Open + Closed = Total**		**1 1**	**2**	**0.00**	**0.00**	**0.00**	**5,045.78**	**66.07**	**0.00**	**5,111.85**
EV2009153580 - FIRE MAIN BUSTED AT SCHOOL.											
158441	**Employee / Claimant**	PROP	02/17/2009	CL	0.00	0.00	0.00	9,931.75	0.00	0.00	9,931.75
EV2009153580 Totals	**Claim Count: Open + Closed = Total**		**0 1**	**1**	**0.00**	**0.00**	**0.00**	**9,931.75**	**0.00**	**0.00**	**9,931.75**
Department Totals	**Claim Count: Open + Closed = Total**		**4 3**	**7**	**0.00**	**0.00**	**0.00**	**16,033.61**	**50,066.07**	**1,056.08**	**66,099.68**

Preferred Governmental Claim Solutions
Member Experience Report

CLIENT NAME

2008 - 07/01/2008 TO 06/30/2009

SIR Pkg 2008

Claim #	Employee / Claimant	Claim Type	Occur Date		Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
SIR Pkg 2008 Totals	**Claim Count: Open + Closed = Total**		**15**	**52**	**67**	**17,893.62**	**-3,843.03**	**-960.00**	**121,411.32**	**133,143.29**	**3,015.33**	**254,554.61**

Preferred Governmental Claim Solutions
Member Experience Report

CLIENT NAME

2008 - 07/01/2008 TO 06/30/2009

				This Period*			To Date			
	Open	Closed	Total	Paid	Reserve Chgs	Collected	Paid	Reserved	Collected	Incurred
Fund Year Totals	15	52	67	17,893.62	-3,843.03	-960.00	121,411.32	133,143.29	3,015.33	254,554.61

Preferred Governmental Claim Solutions
Member Experience Report

CLIENT NAME

2007 - 07/01/2007 TO 06/30/2008

SIR Pkg 2007

Claim #	Employee / Claimant	Claim Type	Occur Date	Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008145787 - Attorney rep letter alleging claimant was severely and permanently injured w											
GLBI150013	**Employee** / **Claimant**	GLBI	03/16/2008	OP	0.00	10,000.00	0.00	0.00	10,000.00	0.00	10,000.00
EV2008145787 Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**0.00**	**10,000.00**	**0.00**	**0.00**	**10,000.00**	**0.00**	**10,000.00**
Department Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**0.00**	**10,000.00**	**0.00**	**0.00**	**10,000.00**	**0.00**	**10,000.00**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008149373 - lightning strike damaged equipment.											
PROP153859	**Employee** / **Claimant**	PROP	06/25/2008	CL	0.00	0.00	0.00	2,797.18	0.00	0.00	2,797.18
EV2008149373 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**2,797.18**	**0.00**	**0.00**	**2,797.18**
EV2008148788 - lightning strike											
PROP53225	**Employee** / **Claimant**	PROP	06/30/2008	CL	0.00	0.00	0.00	1,500.00	0.00	0.00	1,500.00
EV2008148788 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,500.00**	**0.00**	**0.00**	**1,500.00**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**2**	**2**	**0.00**	**0.00**	**0.00**	**4,297.18**	**0.00**	**0.00**	**4,297.18**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008147779 - Claim states a student was struck by a foul ball in the eye/ face.											
GLBI152147	**Employee** / **Claimant**	GLBI	03/13/2008	CL	0.00	0.00	0.00	666.15	0.00	0.00	666.15
EV2008147779 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**666.15**	**0.00**	**0.00**	**666.15**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**666.15**	**0.00**	**0.00**	**666.15**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2007145267 - Claim states a student at cheerleading camp was dropped on her head.											
GLBI149452	**Employee** / **Claimant**	GLBI	08/01/2007	OP	0.00	0.00	0.00	6.50	32,493.50	0.00	32,500.00
EV2007145267 Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**0.00**	**0.00**	**0.00**	**6.50**	**32,493.50**	**0.00**	**32,500.00**
EV2007143745 - A multimedia projector was stolen from the GED classroom at Rickards High											
PROP147885	**Employee** / **Claimant**	PROP	11/26/2007	CL	0.00	0.00	0.00	1,550.00	0.00	0.00	1,550.00
EV2007143745 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,550.00**	**0.00**	**0.00**	**1,550.00**

CLIENT NAME

2007 - 07/01/2007 TO 06/30/2008

SIR Pkg 2007

Claim #	Employee / Claimant	Claim Type	Occur Date		Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2007143809 - A projector 2200 Lumens was stolen from the Drafting classroom at Rickards												
PROP147951	**Employee / Claimant**	PROP	12/03/2007		CL	0.00	0.00	0.00	1,619.00	0.00	0.00	1,619.00
EV2007143809 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,619.00**	**0.00**	**0.00**	**1,619.00**
Department Totals	**Claim Count: Open + Closed = Total**		**1**	**2**	**3**	**0.00**	**0.00**	**0.00**	**3,175.50**	**32,493.50**	**0.00**	**35,669.00**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2007144408 - Claim states claiamnt sustained injuries after colliding with a school staff me												
GLBI148542	**Employee / Claimant**	GLBI	12/20/2007		OP	0.00	0.00	0.00	5,513.40	26,486.60	0.00	32,000.00
EV2007144408 Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**0.00**	**0.00**	**0.00**	**5,513.40**	**26,486.60**	**0.00**	**32,000.00**
Department Totals	**Claim Count: Open + Closed = Total**		**1**	**0**	**1**	**0.00**	**0.00**	**0.00**	**5,513.40**	**26,486.60**	**0.00**	**32,000.00**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2007143099 - Theft of trailer, bicycle and bicycle helmets.												
PROP147204	**Employee / Claimant**	PROP	10/20/2007		CL	0.00	0.00	0.00	6,412.00	0.00	0.00	6,412.00
EV2007143099 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**6,412.00**	**0.00**	**0.00**	**6,412.00**
Department Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**6,412.00**	**0.00**	**0.00**	**6,412.00**
DEPARTMENT NUMBER - DEPARTMENT NAME												
EV2008145359 - Notice states pipe bursted at Ft. Braden.												
PROP149561	**Employee / Claimant**	PROP	03/17/2008		CL	0.00	0.00	0.00	3,243.13	0.00	0.00	3,243.13
EV2008145359 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**3,243.13**	**0.00**	**0.00**	**3,243.13**
EV2008147210 - Claim states the school sign was vandalized.												
PROP151554	**Employee / Claimant**	PROP	04/13/2008		CL	0.00	0.00	0.00	5,418.49	0.00	0.00	5,418.49
EV2008147210 Totals	**Claim Count: Open + Closed = Total**		**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**5,418.49**	**0.00**	**0.00**	**5,418.49**
Department Totals	**Claim Count: Open + Closed = Total**		**0**	**2**	**2**	**0.00**	**0.00**	**0.00**	**8,661.62**	**0.00**	**0.00**	**8,661.62**

Preferred Governmental Claim Solutions
Member Experience Report

CLIENT NAME

2007 - 07/01/2007 TO 06/30/2008

SIR Pkg 2007

Claim #	Employee / Claimant	Claim Type	Occur Date	Status	This Period* Paid	This Period* Reserve Chgs	This Period* Collected	To Date Paid	To Date Reserved	To Date Collected	To Date Incurred
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2007145643 - Claim states the claimant's son was released to his natural father. The schoo											
GLBI149856	**Employee / Claimant**	GLBI	10/06/2007	CL	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EV2007145643 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008149372 - Lightning strike damaged alarm system.											
PROP153858	**Employee / Claimant**	PROP	06/30/2008	CL	0.00	0.00	0.00	2,429.64	0.00	0.00	2,429.64
EV2008149372 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**2,429.64**	**0.00**	**0.00**	**2,429.64**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**2,429.64**	**0.00**	**0.00**	**2,429.64**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2007138220 - Fire alarm system was damaged as a result of lightning at the Gilchrist Elem											
142136	**Employee / Claimant**	PROP	07/01/2007	CL	0.00	0.00	0.00	8,991.28	0.00	0.00	8,991.28
EV2007138220 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**8,991.28**	**0.00**	**0.00**	**8,991.28**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**8,991.28**	**0.00**	**0.00**	**8,991.28**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008148775 - lightning struck a tree and water line at Astoria Park Elementary.											
PROP153210	**Employee / Claimant**	PROP	06/16/2008	CL	0.00	0.00	0.00	1,389.90	0.00	0.00	1,389.90
EV2008148775 Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,389.90**	**0.00**	**0.00**	**1,389.90**
Department Totals	**Claim Count: Open + Closed = Total**	**0**	**1**	**1**	**0.00**	**0.00**	**0.00**	**1,389.90**	**0.00**	**0.00**	**1,389.90**
DEPARTMENT NUMBER - DEPARTMENT NAME											
EV2008147255 - Claim states a student slipped on water.											
GLBI151600	**Employee / Claimant**	GLBI	03/12/2008	OP	0.00	0.00	0.00	0.00	20,000.00	0.00	20,000.00
EV2008147255 Totals	**Claim Count: Open + Closed = Total**	**1**	**0**	**1**	**0.00**	**0.00**	**0.00**	**0.00**	**20,000.00**	**0.00**	**20,000.00**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 1993 10/01/1993 - 09/30/1994 Policy Age: 228 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
WC	0.00	0	1	1	3,923.00	4.20	1,077.00	495.80	5,500.00
	Totals:	**0**	**1**	**1**	**3,923.00**	**4.20**	**1,077.00**	**495.80**	**5,500.00**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 1998 10/01/1998 - 09/30/1999 Policy Age: 167 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
WC	0.00	0	1	1	93,785.44	2,368.38	11,495.56	3,631.62	111,281.00
	Totals:	**0**	**1**	**1**	**93,785.44**	**2,368.38**	**11,495.56**	**3,631.62**	**111,281.00**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 1999 10/01/1999 - 09/30/2000 Policy Age: 155 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date		Reserves		Total Incurred
					Loss	Expense	Loss	Expense	
WC	0.00	1	0	1	75.65	31,088.40	0.00	0.00	31,164.05
	Totals:	**1**	**0**	**1**	**75.65**	**31,088.40**	**0.00**	**0.00**	**31,164.05**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2000 10/01/2000 - 09/30/2001 Policy Age: 143 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
WC	0.00	0	2	2	130,108.16	11,795.94	38,979.86	9,920.66	190,804.62
	Totals:	**0**	**2**	**2**	**130,108.16**	**11,795.94**	**38,979.86**	**9,920.66**	**190,804.62**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2001   10/01/2001 - 09/30/2002   Policy Age: 131 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
WC	0.00	3	2	5	339,792.37	56,714.71	85,490.86	10,263.71	492,261.65
	Totals:	**3**	**2**	**5**	**339,792.37**	**56,714.71**	**85,490.86**	**10,263.71**	**492,261.65**

Aggregate Report

CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2002 10/01/2002 - 09/30/2003 Policy Age: 119 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date		Reserves		Total Incurred
					Loss	Expense	Loss	Expense	
LE	0.00	1	0	1	0.00	0.00	0.00	0.00	0.00
WC	0.00	2	1	3	65,955.08	34,364.94	29,518.14	4,943.62	134,781.78
	Totals:	**3**	**1**	**4**	**65,955.08**	**34,364.94**	**29,518.14**	**4,943.62**	**134,781.78**

Aggregate Report

CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2003   10/01/2003 - 09/30/2004   Policy Age: 106 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date		Reserves		Total Incurred
					Loss	Expense	Loss	Expense	
AL	100,000.00	18	0	18	35,067.42	428.00	0.00	0.00	35,495.42
AP	100,000.00	20	0	20	17,466.15	257.00	0.00	0.00	17,723.15
GL	100,000.00	27	0	27	16,197.92	2,380.00	0.00	0.00	18,577.92
IM	100,000.00	2	0	2	0.00	0.00	0.00	0.00	0.00
LE	100,000.00	1	0	1	0.00	0.00	0.00	0.00	0.00
PR	100,000.00	3	0	3	6,100.00	0.00	0.00	0.00	6,100.00
WC	350,000.00	59	0	59	89,490.52	21,032.47	0.00	0.00	110,522.99
	Totals:	**130**	**0**	**130**	**164,322.01**	**24,097.47**	**0.00**	**0.00**	**188,419.48**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2004 10/01/2004 - 09/30/2005 Policy Age: 94 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
AL	100,000.00	59	0	59	154,041.42	39,531.53	0.00	0.00	193,572.95
AP	100,000.00	22	0	22	11,800.05	3,805.40	0.00	0.00	15,605.45
GL	100,000.00	30	1	31	99,520.59	64,615.97	0.00	0.00	164,136.56
LE	100,000.00	7	0	7	64,750.00	212,343.48	0.00	0.00	277,093.48
POL	100,000.00	6	0	6	0.00	0.00	0.00	0.00	0.00
PR	100,000.00	2	0	2	1,093.00	0.00	0.00	0.00	1,093.00
WC	350,000.00	75	3	78	200,316.81	221,593.53	7,304.46	911.43	430,126.23
	Totals:	**201**	**4**	**205**	**531,521.87**	**541,889.91**	**7,304.46**	**911.43**	**1,081,627.67**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2005 **10/01/2005 - 09/30/2006** **Policy Age: 82 Months**

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
AL	100,000.00	54	0	54	230,827.85	97,439.58	0.00	0.00	328,267.43
AP	100,000.00	10	0	10	3,033.63	0.00	0.00	0.00	3,033.63
EP	100,000.00	3	0	3	75,000.00	304,709.35	0.00	0.00	379,709.35
GL	100,000.00	43	0	43	37,654.13	86,537.84	0.00	0.00	124,191.97
LE	100,000.00	3	1	4	0.00	56,930.31	25,000.00	11,741.67	93,671.98
WC	350,000.00	82	1	83	628,493.47	106,493.60	96,023.79	4,120.87	835,131.73
	Totals:	**195**	**2**	**197**	**975,009.08**	**652,110.68**	**121,023.79**	**15,862.54**	**1,764,006.09**

Aggregate Report

CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2006 10/01/2006 - 09/30/2007 Policy Age: 70 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date		Reserves		Total Incurred
					Loss	Expense	Loss	Expense	
AL	100,000.00	47	0	47	119,271.62	3,129.50	0.00	0.00	122,401.12
AP	0.00	8	0	8	18,785.13	213.00	0.00	0.00	18,998.13
EP	100,000.00	2	0	2	0.00	0.00	0.00	0.00	0.00
GL		1	0	1	0.00	0.00	0.00	0.00	0.00
GL	100,000.00	58	0	58	93,221.55	21,994.90	0.00	0.00	115,216.45
LE	100,000.00	4	0	4	0.00	136,269.50	0.00	0.00	136,269.50
PR	99,484,784.00	4	0	4	22,645.40	0.00	0.00	0.00	22,645.40
WC	350,000.00	96	1	97	255,720.56	77,893.45	337.11	2,167.16	336,118.28
	Totals:	**220**	**1**	**221**	**509,644.26**	**239,500.35**	**337.11**	**2,167.16**	**751,648.88**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2007   10/01/2007 - 09/30/2008   Policy Age: 58 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
AL	200,000.00	34	1	35	53,423.24	24,088.82	5,000.00	12,076.99	94,589.05
EP	100,000.00	1	0	1	0.00	75.00	0.00	0.00	75.00
GL	200,000.00	54	2	56	162,937.31	59,030.96	200,000.00	35,969.04	457,937.31
LE	100,000.00	3	0	3	2,500.00	25,608.49	0.00	0.00	28,108.49
POL	100,000.00	2	0	2	0.00	0.00	0.00	0.00	0.00
PR	84,777,657.00	3	0	3	13,090.77	0.00	0.00	0.00	13,090.77
WC	350,000.00	66	4	70	571,736.84	87,996.63	202,073.21	22,482.97	884,289.65
	Totals:	**163**	**7**	**170**	**803,688.16**	**196,799.90**	**407,073.21**	**70,529.00**	**1,478,090.27**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2008 10/01/2008 - 09/30/2009 Policy Age: 46 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
AL	200,000.00	44	3	47	140,597.42	59,921.61	45,000.00	48,967.09	294,486.12
AP	0.00	3	0	3	0.00	0.00	0.00	0.00	0.00
EP	100,000.00	2	2	4	0.00	13,342.54	12,500.00	24,212.46	50,055.00
GL	200,000.00	80	0	80	239,346.96	437.99	0.00	0.00	239,784.95
LE	100,000.00	3	1	4	0.00	22,312.01	5,000.00	12,389.94	39,701.95
POL	100,000.00	1	0	1	0.00	0.00	0.00	0.00	0.00
WC	350,000.00	78	7	85	598,587.05	97,341.82	166,834.76	34,238.27	897,001.90
	Totals:	**211**	**13**	**224**	**978,531.43**	**193,355.97**	**229,334.76**	**119,807.76**	**1,521,029.92**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2009 10/01/2009 - 09/30/2010 Policy Age: 33 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
AL	200,000.00	27	0	27	107,808.30	791.35	0.00	0.00	108,599.65
AP	0.00	1	0	1	0.00	0.00	0.00	0.00	0.00
EP	100,000.00	11	6	17	0.00	107,786.97	47,500.00	58,396.47	213,683.44
GL	200,000.00	66	0	66	147,106.90	163.90	0.00	0.00	147,270.80
LE	100,000.00	1	0	1	0.00	0.00	0.00	0.00	0.00
PR	87,506,969.00	1	0	1	22,301.00	0.00	0.00	0.00	22,301.00
WC	350,000.00	73	2	75	354,958.70	15,381.73	159.61	265.74	370,765.78
	Totals:	**180**	**8**	**188**	**632,174.90**	**124,123.95**	**47,659.61**	**58,662.21**	**862,620.67**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2010 10/01/2010 - 09/30/2011 Policy Age: 21 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date Loss	Paid To Date Expense	Reserves Loss	Reserves Expense	Total Incurred
AL	200,000.00	38	1	39	102,062.05	1,080.15	25,000.00	92.45	128,234.65
AP	0.00	1	0	1	0.00	0.00	0.00	0.00	0.00
EP	100,000.00	1	3	4	0.00	34,964.02	12,500.00	21,503.06	68,967.08
GL	200,000.00	79	3	82	341,233.36	4,112.66	33,000.00	277.00	378,623.02
LE	100,000.00	0	1	1	0.00	0.00	50,000.00	25,000.00	75,000.00
WC	350,000.00	63	7	70	202,381.88	23,229.45	85,187.87	17,109.93	327,909.13
	Totals:	**182**	**15**	**197**	**645,677.29**	**63,386.28**	**205,687.87**	**63,982.44**	**978,733.88**

Aggregate Report
CLIENT NAME

Valuation: 06/30/2012
Run Date: 07/02/2012

Fund Year: 2011 10/01/2011 - 09/30/2012 Policy Age: 9 Months

Coverage	Retention Level	Closed Claims	Open Claims	Total Claims	Paid To Date		Reserves		Total Incurred
					Loss	Expense	Loss	Expense	
AL	200,000.00	18	10	28	19,464.11	1,245.45	98,300.00	934.55	119,944.11
EP	100,000.00	0	2	2	0.00	0.00	25,000.00	25,000.00	50,000.00
GL	200,000.00	76	9	85	317,598.29	7.90	27,500.00	192.10	345,298.29
LE	100,000.00	2	1	3	100.00	0.00	15,000.00	15,000.00	30,100.00
PR		1	0	1	0.00	0.00	0.00	0.00	0.00
WC	350,000.00	20	28	48	139,279.64	10,555.38	171,634.62	15,065.17	336,534.81
	Totals:	**117**	**50**	**167**	**476,442.04**	**11,808.73**	**337,434.62**	**56,191.82**	**881,877.21**

EQUAL OPPORTUNITY

POLICY & PRACTICES

Preferred Governmental Claim Solutions (PGCS) is committed to providing equal employment opportunity without regard to race, color, religion, sex, sexual orientation, disability, or any other protected status with respect to recruitment, hiring, upgrades, training, promotion, and other terms and conditions of employment. This policy complies with applicable state and local laws governing non-discrimination in employment.

PGCS values people from diverse backgrounds, working to create an open atmosphere of trust, honesty and respect. Harassment or discrimination of any kind – including that involving race, color, religion, gender, age, national origin, citizenship, disabilities, sexual orientation, veteran status, or any other similarly protected status – is unacceptable. This principle applies to all aspects of employment, including recruitment, hiring, placement, transfer, promotion, layoff, recall, termination and other terms and conditions of employment.

Preferred Governmental Claim Solutions complies with state regulations and federal laws relating to equal employment opportunities and affirmative action. The company shall continue to work cooperatively with government and community organizations to take affirmative action to ensure equal employment and advancement opportunities.

DRUG-FREE WORKPLACE FORM

The undersigned vendor in accordance with Florida Statute 287.087 hereby certifies that

Preferred Governmental Claim Solutions (PGCS) does:
(Name of Business)

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for the drug abuse violations.

3. Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

4. In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of Chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community, by any employee who is so convicted.

6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

Bidder's Signature

6/30/16

Date

160029F

CHIEF FINANCIAL OFFICER
JEFF ATWATER
STATE OF FLORIDA

February 23, 2016

Mr. Sam R. Boone, Jr.
President
Preferred Governmental Claim Solutions, Inc.
615 Crescent Executive Court
Lake Mary, Florida 32746

Re: Qualified Servicing Entity Annual Report

Dear Mr. Boone:

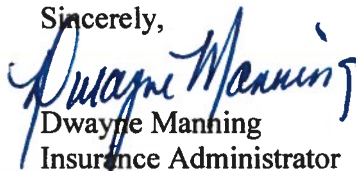
The Qualified Servicing Entity Annual Report Form for your company has been received. I have reviewed this report and your company is in compliance with Rule 69L-5.230(11) F.A.C. (Retaining Authorization as a Qualified Servicing Entity). This letter will confirm that your company has been recertified for the period **March 1, 2016 through February 28, 2017.**

Attached is a copy of Form DFS-F2-SI-23 (Qualified Servicing Entity Annual Report Form), to be used for future filing as we no longer mail the form prior to the due date. Also attached is a copy of Form DFS-F2-SI-19 (Certification of Servicing for Self-Insurers), this form is to be completed thirty (30) days of entering into a contract for servicing.

Your next annual report is due in our office no later than **March 1, 2017.**

Should you have any questions or need further assistance, please contact me at (850) 413-1784.

Sincerely,



Dwayne Manning
Insurance Administrator

Attachments

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
Dwayne Manning • Insurance Administrator
Division of Workers' Compensation • Bureau of Financial Accountability
200 East Gaines Street • Tallahassee, Florida 32399-4221 • Tel. 850-413-1784 • Fax 850-414-2244
Email • Dwayne.Manning@Myfloridacfo.com
AFFIRMATIVE ACTION • EQUAL OPPORTUNITY EMPLOYER

BROWN-3 160029 OP ID: JW

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/10/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	
Brown & Brown of Florida, Inc. Daytona Beach Office P.O. Box 2412 Daytona Beach, FL 32115-2412 M. Decker Youngman	CONTACT NAME: LAURIE KOHLER #16095 PHONE (A/C, No, Ext): 386-239-7242 FAX (A/C, No): 386-323-9159 E-MAIL ADDRESS: lkohler@bbdaytona.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Travelers Prop & Cas of Amer	25674
INSURER B : Continental Casualty Co	20443
INSURER C : Travelers Indemnity	25658
INSURER D : XL Specialty Ins Inc.	37885
INSURER E :	
INSURER F :	

INSURED: BROWN & BROWN INC ETAL
P O BOX 2412
DAYTONA BEACH, FL 32115

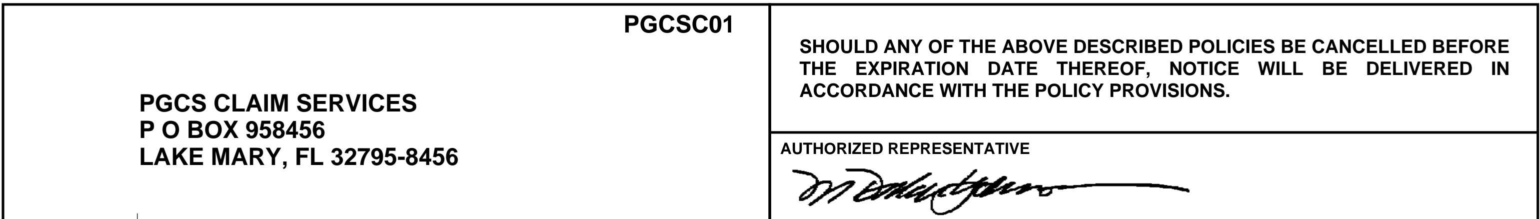
COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC OTHER:			TC2JGLSA9527B87416	01/01/2016	01/01/2017	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
A	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS			TC2JCAP9527B86216	01/01/2016	01/01/2017	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
B	[X] UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED RETENTION $			6011849429	01/01/2016	01/01/2017	EACH OCCURRENCE	$ 5,000,000
							AGGREGATE	$ 5,000,000
								$
A C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		TC2JUB9517B58016 TRKUB9518B76116	01/01/2016 01/01/2016	01/01/2017 01/01/2017	[X] PER STATUTE [ ] OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
D	INS AGENTS E&O			ELU142465-16	01/01/2016	01/01/2017	LIMIT	5,000,000
							AGGREGATE	25,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

FOR INFORMATION
NAMED INSURED: PREFERRED GOVERNMENTAL CLAIM SOLUTIONS, INC. dba PGCS



CERTIFICATE HOLDER	CANCELLATION
PGCSC01 PGCS CLAIM SERVICES P O BOX 958456 LAKE MARY, FL 32795-8456	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE

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CITY OF GAINESVILLE

Implementation Plan

The long term and overall success of any program relies heavily, if not foremost, on the leadership. For that reason, PGCS key leadership team members will be heavily involved in the conversion process.

The Account Coordinator, Cheryl Riley, will oversee all conversion and triage activities along with Sheila Kraft, W/C Unit Manager.

From the Vice President down, leadership is emphasized, expected and rewarded. It is woven into the culture of our organization. Unlike tangible product, our product is service. Service is delivered by people; therefore to offer the best service requires the best leadership. Ongoing leadership training is a part of our organization.

This leadership will be responsible for overseeing the human resources required to meet the obligations outlined and required by the RFP. Recruitment and selection of qualified staff is a critical component to a successful transition. In anticipation of the limited period of time from the award of the contract to the actual start date, PGCS will take a proactive approach to the need for additional qualified adjusters and nurses.

Initial Planning Meeting

An initial planning meeting will be scheduled with Risk Management immediately after the City approves the Contract. Representatives of PGCS Claims, I/T and Accounting divisions will attend. Information will be obtained in order to draft the City's special handling instructions and program the City's reporting structure. A tour of PGCS facilities may be conducted. We will also require a loss run and data feed for claims "as of" August 31, 2016 for test loading into Risk Master.

Staffing

The City of Gainesville claims team will consist of current PGCS employees whose resumes were submitted during the RFP process. The team will be in place one week prior to inception of the program.

Training & Orientation

The orientation program for the City of Gainesville will begin on September 26, 2016, and will continue for one week. Each individual will be provided an orientation manual which includes PGCS policies and procedures, instructions for use of Risk Master, and The City's Special Claim Handling Instructions, along with the time frames in which to complete the orientation program. The staff will be responsible for familiarizing themselves with all parts of the orientation manual, most of which will be covered in detail during the training period. The focus of all training is to employ the policies & procedures of PGCS through the use of available resources to effectively and rapidly assist the claimant, employer and others.

Intake & Triage of Open Files

PGCS anticipates reviewing open existing files beginning one week prior to inception of the program. PGCS management team members will review each open file and provide instructions for further handling. This task will also include a review to determine adequacy of reserves, reconciliation of loss payments, and completion of an action plan and strategy to bring the file to conclusion.

Claim Payments & Accounting

In the usual process in preparation for payment of claims after October 1, 2016, the decision must be made by August 26, 2016 as to which bank and type of funding to be utilized. Bank account set-up, signature cards for PGCS signatures, ACH agreements, etc., should be completed and on file with the bank by September 23, 2016. The MICR sheet and bank account information should be given to PGCS by September 2, 2016 for set up in the check writing system. The initial funding should be in the account prior to October 1, 2016. This will allow for any immediate payment of medical bills identified as nearing the 45 days payment deadline. Receipt of the medical bill history file will determine when regular check runs will begin. PGCS utilizes client-owned banking. The bank account is set up in the City's name utilizing the City of Gainesville FEIN.

Regulatory Reporting

Upon award of the contract, the necessary EDI information will be requested and the Client Update List will be filed with DWC.

Upon receipt of the bill history all bills processed by the previous company will be coded in our system to show that EDI has been filed and are not the responsibility of PGCS.

In order to ensure that all payment and filing rules are met and no penalties incurred, the backlog of bills (if one exists) will be sorted by received date and the oldest bills processed first. If necessary, additional staff will be utilized to process all bills within the State guidelines.

It is PGCS policy to EDI medical bills weekly and, as shown in our State "Report Cards", our turnaround times are excellent. Our average time from payment to filing is 5.9 days for the last 6 months. Our Acceptance Performance is 98.7% and our average time for corrections is 1.4 days.

MMSEA reporting will require obtaining Gainesville's RRE I/D information and updating of the City's profile. This should be completed prior to October 1, 2016.

Information Systems & Technology

In order for this to be a seamless transition an integral and critical portion of the work flow will be accomplished by the IS/IT departments of both parties. All computer systems should be operational for new employee training. This includes Risk Master User enrollments, security levels & account settings. The IS department will be concentrating on the data conversions and additional programming. Data sample files will be requested at the initial meeting and should contain the following:

- Employer/location/Payroll Class codes
- Vendor Files
- Eligibility
- Claimant/claim
- EOB history

An interim data test conversion will occur the first week of June utilizing information from the City's August 31, 2016 loss run. The final data conversion should take place September 29th & 30th, 2016. An EDI Submitter Client List update form will be sent to the DWC to register the change in submitter number on September 23, 2016. The first EDI run should take place on October 7, 2016.

All implementation tasks will be completed prior to the October 1, 2016 inception date of the program.

QUALITY ASSURANCE PROGRAM

WORKERS' COMPENSATION

At **PGCS**, our goals are superior claim handling and the very best in customer satisfaction.

Table of Contents:

Section One:	Investigation
Section Two:	Reserving
Section Three:	Indemnity Management
Section Four:	State Filings
Section Five:	Follow-Up
Section Six:	Litigation
Section Seven:	Excess
Section Eight:	Customer Service

Investigation:

Same Day Three Point Contact:

The employer is contacted to verify the facts of the loss. File notes are then documented with the following data:

- Prior medical history, wages, work history, and disability status
- Did the accident arise out of and in the course and scope of employment?
- Where and when the accident occurred. List all witnesses
- Whether all injuries claimed are causally related to the accident
- If all safety and supervisory rules and regulations were followed

The injured worker is contacted to gather pertinent facts surrounding the incident. File notes are then documented with the following data:

- Details of how the incident occurred
- The extent of the injury
- Wages / Concurrent earnings
- Prior medical and work history
- Current medical treatment and treating physician
- Disability status, witness information and any other information
- Recorded statement of the employee and witnesses

The medical provider is contacted to obtain information relative to the injury. File notes are then documented with the following data:

- Diagnosis & Prognosis
- History provided by the employee
- Treatment Plan
- Extent of disability and any additional information regarding return to work
- Exposure (sick building syndrome, chemicals, etc.)

Compensability:

The adjuster must document reasons for accepting compensability or outline continuing investigation/determination in file notes.

Subrogation:

The adjuster must identify and investigate the potential for subrogation and refer the file to the subrogation department.

Examples of Subrogation Claims:

- Dog bites
- MVA
- Defective equipment/machinery
- Slip & Fall
- Any injury in which a third party is involved

Under no circumstances should a lien be waived or reduced without authorization from PGCS management after consulations with the client.

120 Day Letter/Denial:

Procedures for 120 Day Letter & Denial:

- Document fully the rationale for the 120 day investigation
- 120 Day Letter/Denial must be sent within fourteen (14) days of receipt of the claim
- 120 Day Letter/Denial must be sent certified mail, return receipt
  The adjuster must continue to document investigation until the final compensability determination is made

Presumption Claims:

Additional investigation for Presumption Claims:

- Obtain all pre-employment applications and physicals.
- Obtain names of all treating physicians past and present.
- Obtain current life vitals (height, weight, etc.)
- Determine risk factors (HBP, diabetes, family history, smoking)
- Document events that lead up to the occurrence.
- Determine if any pre-existing conditions.
- Conduct index bureau check, background check, hospital check.

Reserving:

Initial Reserves:

All Claims must be given an initial reserve based on the known information within seven (7) days of receipt of the claim by the adjuster.

Factors to consider in reserve evaluation:

- Age of the injured worker
- Injury diagnosis
- Estimated length of disability
- Employment availabilty
- Input all details into the file notes

Revisions:

Reserve revisions should be completed at initial thirty (30) days based on additional investigation. Reserves must then be reviewed at each diary interval thereafter.

Factors to consider in reserve revision:

- Treatment Plan (surgical candidate)
- Job Loss
- Changes in medical status
- Litigation

Reserve Procedures:

- Each reserve change must be documented in the Corrus notes with rationale.
- A reserve worksheet must be completed for every reserve change.
- A reserve worksheet must be completed with Present Day Value calculations attached.
- The file and reserve worksheet are forwarded to the supervisor / manager for review, approval and input into the system.

Indemnity Management:

Temporary Total Disability:

- Temporary Total Disability payments are due no later than the last day of the bi-weekly pay period once the injured worker has been placed on a no work status. They are paid at 66 2/3 % of the average weekly wage subject to the maximum compensation rate for the year. 104 weeks is the maximum amount payable for all temporary benefits. All subsequent payments continue bi-weekly until the injured worker is no longer entitled to the benefit.

Temporary Partial Disability:

- Temporary Partial Benefits are due seven days after the end of the first week back to work, if the injured worker is making less then 80% of his earnings. If TPD is being paid with zero earnings then the payment is due no later that the last day of the bi-weekly period. These benefits are paid using the 80/80 formula on the DWC-3. Note that the maximum is 104 weeks for all temporary benefits.

Permanent Impairment Benefits:

- Impairment Benefits begin the day after overall Maximum Medical Improvement has been reached. The adjuster must start the benefit within 14 days of knowledge. For accidents from 1994 – Sept 30, 2003 the benefits are paid at 50% of the compensation rate. The injured worker is entitled to 3 weeks for each percentage of impairment. For accidents after 10/01/03 the benefit is paid at 75% of the compensation rate and the number of weeks is based on the sliding scale. A 50% reduction of the IB amount is taken if the injured worker is back working making at least 80% of his pre-injury earnings. IB is paid weekly and must always be paid a week in advance.

- IB Determination is as follows:

1 – 10 % = 2 weeks for each percentage.
11 – 15% = 3 weeks for each percentage.
16 – 20% = 4 weeks for each percentage.
21% and up = 6 weeks for each percentage.

Permanent Total Benefits:

Are payable at 66 2/3% of the average weekly wage. For accidents before 10/01/03 the benefits continues for the life of the injured worker. For accidents after 10/01/03 the PTD Benefits stop at age seventy-five (75) unless the injured worker is seventy (70) years old or older at the time of acceptance, then the benefit would continue for five (5) years. Payments are due by the last day of the bi-weekly period. Remember to take the SSDI Offset and GRICE Offset when applicable. **It is mandatory to use Workers Computation. Com to calculate all offsets (GRICE, SSDI), back benefits, permanent total and permanent total supplemental benefits, penalties & interest. A copy of the printout goes on the left hand side of the file.**

Permanent Total Supplemental Benefits:

PTs are paid at 5% of the compensation rate for dates of accident prior to 10/01/03 and are paid at 3% of the compensation rate times the number of calendar years since the injury as of 10-01-03. The new law has also provides for

termination of all supplemental benefits at age sixty-two (62). Payments are due by the last day of the bi-weekly period. Each calendar year PTD is recalculated with the 3% increase so that on January 1st the payment increases. Offsets must be included in all calculations (SSDI/GRICE).

Note: The PTD and PTS payments combined cannot exceed the statewide maximum compensation rate for that current year.

State Filings:

DWC-1 - 1st Report/Notice of Injury

- Form must be filed within fourteen (14) days of employer knowledge of lost time. The NOI is filed to the DWC no later than the 14th day after the injured worker is off work and indemnity benefits have been started. The adjuster must also file the DWC-1 within fourteen (14) days of employer knowledge if denying the entire claim or denying indemnity benefits. The day of injury counts as one of the days. The adjuster must include holidays and weekends in the count.

  Note: Even if the employer keeps the injured worker on salary while out of work ***THE ADJUSTER MUST*** file the DWC-1.

DWC-1a – Wage Statement

- The employer must send the wage statement within fourteen (14) days after knowledge of the accident. Once the adjuster has received the wage statement, the average weekly wage and compensation rate must be amended if applicable and the additional paid within fourteen (14) days.

  Note: If the employee has concurrent employment send the employee a blank wage statement for the concurrent employer to complete and return. This is the employee's responsibility.

DWC- 4 – Notice of Action /Change

- Form must be filed within fourteen (14) days after knowledge of a change in status. (Example: The injured worker has been returned to work so a DWC-4 would be due once adjuster is notified of this change in status).

DWC-12 – Notice of Denial

- Form due within fourteen (14) days from receipt of the Notice of Injury if the adjuster is denying the entire claim. The adjuster has fourteen (14) days to accept or deny any indemnity or medical benefits from date of receipt of request. A denial is issued on any files that the adjuster is asserting the 120 day rule.

DWC-13 – Claims Cost Report

- The initial DWC-13 is due within six (6) months of the date of injury if indemnity has been paid on the file or if an indemnity claim has been denied. DWC-13 due if file has been reopened for medical bill or additional indemnity payments.

DWC-19 – Earnings Report

- Once the employee is released to return to work on light duty status, the Temporary Partial Letter & Earnings Report must be sent certified mail, return receipt requested within five (5) calendar days. The adjuster needs to follow up for return of the DWC-19. Temporary Partial Disability benefits can be denied if the employee does not sign and return the DWC-19.

Follow-Up:

Diary:

- Set 30-day diary to confirm Wage Statement, DWC-19 (if applicable), signed Fraud Statement. Check every 30 days until received.

- Set 30 day diary and 90-day diary for Action Plan – Update file with Action Plan 30 days from date of accident then every 90 days thereafter or a significant change in the file.

Initial Action plans should include a brief history of the employee information and accident description. Document compensability and reasons why, subrogation, 120-day investigation, presumption and reserves.

90-Day Action Plans should include updated medical and claim status, compensability, reserves and resolution.

- Set 60 diary to follow up regarding 120-day investigation.
- Set 90 diary to follow up on Subrogation document 3rd party information and Lien letters. Update every 90 days until completed.

Medical Diary:

- Set 30-day diary to follow up on medical activity.
- Set MMI /PPI diary after initial MMI request and follow up every thirty (30) days until received.
- Respond to medical providers within 3 days regarding authorizations.
- **Be sure to document all medical authorizations or denials in Corrus notes.**
- **Please Note it is ENCOURAGED to combine diaries if possible. (reserve review, Action Plan, and subro every 90 days) ***

Litigation:

Referring A Claim To Defense Counsel:

At times it will be necessary to refer a claim to a defense attorney. Defense counsel will include only those firms/attorneys approved by PGCS management or the employer.

At the time a claim is referred to defense counsel, the adjuster shall prepare and forward a cover letter to the attorney with a copy of the file. This cover letter shall be a brief synopsis of the facts of the case along with a description of the issues being placed in dispute as well as instructions on how the adjuster wishes

to proceed in litigating the matter. The letter should solicit an advice/opinion from the attorney as to any items they feel need further work up by the adjuster. A litigation budget shall be requested by the adjuster at this time.

Whenever possible, an adjuster will resolve all issues and/or claims without retaining defense counsel.

Settlement Evaluations:

Settlement evaluations from defense for mediation should be received 45 days before the mediation on Large Loss reportable files.

The claims handler should complete their settlement evaluation 30 days prior to mediation and document it accordingly in the file notes, with pertinent settlement authority provided by supervisor and clients, prior to commencing settlement negotiations.
Management must be made aware of all cases that will go to trial or appeal and kept informed of significant changes in testimony and of the trial and/or appellate outcome.

File Outcome:

PGCS policy is to return the injured employees back to the workforce whenever possible. However, it is recognized that certain cases may lend themselves to settlement because of disputes between the employer and employee.

If a claim must be settled, it is to be done in the most cost-effective manner possible and in the best interest of all parties involved. The adjuster will take a cost/benefit analysis approach to the resolution of all disputed claims. PGCS will only settle a claim when it is in the employer and/or the client company's best interest to do so.

The employer will be kept advised by the adjuster of all settlement issues and developments as the claim progresses. The adjuster will comply with any and all state law requirements governing the approval of settlements.

Structured Settlements and Medicare Set Aside vendor referral must be approved by the specific reinsurance carrier on the claim.

The adjuster will document their cost/benefit analysis in the file notes. This analysis will be an ongoing process as the case proceeds through litigation and the facts and evidence change and/or develop. Claims involving dollar amounts in excess of the adjuster's authority will be referred to the claims supervisor or the claims manager.

Excess Reporting:

The majority of our clients have established protection for themselves from catastrophic losses or aggregate excess losses by means of an excess insurance policy. As a result of this, it becomes necessary at times to report losses to the individual excess carrier.

Any claim which falls into the criteria below, must be reported to the appropriate excess carrier within forty-eight (48) hours of receipt of the loss report.

Monetary Threshold:

Any claim that will result in an "Incurred Loss" that is over fifty-percent (50%) of the self-insured retention (SIR). "Incurred Loss" means the probable ultimate paid loss plus allocated loss expenses that can be attributed towards meeting the self-insured retention.

Injury Threshold:

Any claim involving a:

- Disability of 52 weeks or more
- Fatality
- Spinal cord injury
- Head injury, including skull fracture and brain damage
- Third or second degree burns over 10% of the body
- Amputation
- Impairment of vision, loss of an eye, or hearing loss of 50% or greater
- Nerve damage causing paralysis or loss of sensation in a limb
- Massive internal injuries affecting body organs
- Significant shattering or non-union of a limb or multiple fractures

- Permanent loss of use of an arm or leg
- Heart and/or hypertension claim
- Exposure to diseases, chemicals or adverse environmental conditions
- Multiple employee injuries from a single accident
- Claims involving permanent total disability
-

These are the usual, but minimum requirements for reporting to a reinsurance carrier. The adjusters should become familiar with any reinsurance carrier policies, which relate to their clients and comply with any specific reporting requirements contained therein.

Customer Service:

- All phone calls and emails are to be returned within twenty-four (24) hours of receipt.
- Voice mail and automated email response must indicate if an employee is not available for a business day or longer.
- Each employee must have a "buddy" that can handle any urgent calls in their absence. The "buddy" must be identified on the voice mail and in the automated email response.

SECTION VII – PRICE PROPOSAL

CLAIM AND RISK MANAGEMENT SERVICES

PROPOSAL FORM

CITY OF GAINESVILLE

Proposer

Name: **Preferred Governmental Claim Solutions (PGCS)**

Service Address: **615 Crescent Executive Court, Suite 600**
Lake Mary, Florida 32746

Claims Manager: **Kenneth Picton**

Telephone: **(321) 832-1435)**

If your company has a policy of converting any claims to time and expense please complete the following:

1) Period of time after which a claim becomes time and expense:
Not Applicable

2) Any classification of claims that are considered time and expense from their onset:
Not Applicable

3) Cost components of time and expense claims:
$ **Not Applicable**

In the event that claims/files convert to time and expense after a specified period of time then the company will be required to provide the client a report three (3) months prior to the end of such period of any claims.

A) Workers' Compensation

1) Claims Service:

Estimated Annual Cost Per Entity: **$104,640 Flat Rate**

Medical Only

Rate per **250** (exposure unit)

Indemnity

Rate ____________ per **55** (exposure unit)

2) Loss Reporting - Risk Management Information System (RMIS) Cost:

Estimated Annual Cost per Entity: **Included**

Rate ____________ per ____________ (exposure unit)

3) Option to take over Open Claims at inception

Medical Only

Rate **0** per **Included** (exposure unit)

Indemnity

Rate **0** per **Included** (exposure unit)

B) General Liability:

1) Claims Service: $**44,000 Flat Rate**

Estimated Annual Cost per Entity:

Rate ____________ per **61** (exposure unit)

2) Loss Reporting - Risk Management Information System (RMIS) Cost:

Estimated Annual Cost **Included**

Rate ____________ per (exposure unit)

3) Option to take over Open Claims at inception

Rate ____________ per **Included** (exposure unit)

C) Automobile Liability

1) Claims Service: **$41,000 Flat Rate**

Estimated Annual Cost per Entity

Rate ____________ per **61** (exposure unit)

2) Loss Reporting - Risk Management Information System (RMIS) Cost:

Estimated Annual Cost per Entity:

Rate ____________ per **Included** (exposure unit)

3) Option to take over Open Claims at inception

Rate **0** per **Included** (exposure unit)

D) Additional Pricing

Please indicate pricing for the two optional successive one-year renewals.

Workers Compensation $110,160

Liability Auto & General Liability $ 87,000

Hourly rate for any consulting services by job title;
Included

Pricing for any "Other Services" Medical Bill Review:
$5.50 Per Bill
Network Access: 28% of savings below Fee Schedule

Deviations from Model Program

Please indicate whether your proposal will or will not comply with the Request for Proposals with respect to the term, endorsement, or condition listed below. The absence of any notation will be presumed to indicate full compliance:

Will All Will Not

Obligations Not Terminated by Contract
Access to Claim Files
Ownership of Claim Files
Liaison with Agency
Workers' Compensation/Employer's Liability
General Liability/Automobile Liability
Compliance with Division Rules
Administration Services
Claims Services
Loss Prevention Services
Loss Statistics Services
Individual Claim Details
Report Format
Frequency of Reports
Subrogation Report
Report of Inactive Claims
Severity Report
Loss Fund Reconciliation

Local Preference is requested: _ yes **XX** no
If Local preference is requested this exhibit must be submitted with the proposal.

A copy of your Occupational License and Zoning Compliance Permit must be submitted with the proposal if a local preference is requested. **N/A**

Signature of Authorized Representative

Kenneth Picton, Vice President

Name and Title, Typewritten

COST OF SERVICES
THE CITY OF GAINESVILLE
THIRD PARTY CLAIMS ADMINISTRATION

WORKERS' COMPENSATION

TOTAL ANNUAL FIRM FIXED FEES FOR THE FIRST TWO YEARS:

Claims Administration	$ 104,640
Medical Bill Review Services	$ 5.50 per bill
Network Access	28% of Savings below Florida Fee Schedule

ANNUAL FIRM FIXED RENEWAL FEES FOR SUBSEQUENT THREE YEARS:

Claims Administration	$ 110,160
Medical Bill Review Services	$ 5.50 per bill
Network Access	28% of Savings below Florida Fee Schedule

SERVICES INCLUDED

- Administrative Services
- First Notice of Injury Services
- Loss Statistic Services
- Loss Fund Reconciliation
- Claim System/Website Access
- MMSEA, State of Florida, and Excess Reporting
- Subrogation
- 1099 Processing
- OSHA 300
- Data Conversion
- Run In Claims

COST OF SERVICES
THE CITY OF GAINESVILLE
THIRD PARTY CLAIMS ADMINISTRATION

AUTO & GENERAL LIABILITY

TOTAL ANNUAL FIRM FIXED FEES FOR THE FIRST TWO YEARS:

Claims Administration $ 85,000

ANNUAL FIRM FIXED RENEWAL FEES FOR SUBSEQUENT THREE YEARS:

Claims Administration $ 87,000

SERVICES INCLUDED

- Administrative Services
- Claim Reporting Services
- Loss Statistic Services
- Loss Fund Reconciliation
- Claim System/Website Access
- MMSEA, and Excess Reporting
- Subrogation
- 1099 Processing
- Data Conversion
- Run In Claims

Attachment A

Reference Form

THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR PROPOSAL.

Number of year's your company has been doing this type of work. 60 Years

List at least four references of similar services performed over the past two years.

1) Job Location: **615 Crescent Executive Court, Suite 600 Lake Mary, Florida 32746**

Date(s) work performed: **10/01/2013 to the Present**

Project Name: **City of Delray Beach**

Project Address: **100 NW 1st Avenue, Delray Beach, FL 33444**

Contact Name: **Eddie DeMicco**

Contact Title: **Risk Manager**

Contact Phone Number: **561-243-7150** Fax Number: **561-243-7156**

Proposal Team Member who worked for the organization or the type of work performed:
Workers' Compensation and Liability

2) Job Location: **615 Crescent Executive Court, Suite 600 Lake Mary, Florida 32746**

Date(s) work performed: **10/01/1993 to the Present**

Project Name: **City of Hallandale Beach**

Project Address: **400 South Federal Highway, Hallandale Beach, FL 33009**

Contact Name: **Jim Bushman**

Contact Title: **Risk Manager**

Contact Phone Number: **954-457-1310** Fax Number: **954-457-1457**

Proposal Team Member who worked for the organization or the type of work performed:
Workers' Compensation

Attachement A

3) Job Location: 615 Crescent Executive Court, Suite 600, Lake Mary, Florida 32746

Date(s) work performed: 10/01/1994 to the Present

Project Name: City of Plantation

Project Address: 400 NW 73rd Avenue, Plantation Florida 33317

Contact Name: John McCarthy

Contact Title: Risk Manager

Contact Phone Number: 954-797-2226 Fax Number: 954-797-2727

Proposal Team Member who worked for the organization or the type of work performed:

Workers' Compensation

4) Job Location: 615 Crescent Executive Court, Suite 600, Lake Mary, Florida 32746

Date(s) work performed: 10/01/2009 to the Present

Project Name: Palm Beach County BOCC

Project Address: 100 Australian Avenue, Suite 200, West Palm Beach, FL 33406

Contact Name: Harry George

Contact Title: Manager, Workers' Compensation

Contact Phone Number: 561-233-5441 Fax Number: 561-233-5420

Proposal Team Member who worked for the organization or the type of work performed:

Workers' Compensation

CITY OF GAINESVILLE
ASSIGNED STAFF

Cheryl Riley, Account Manager – Responsible for servicing the City's program.

Workers' Compensation

Sheila Braga, Assistant Claim Manager – Responsible for oversight of the City's workers' compensation unit.

Lynn Owens, Claim Specialist II – Responsible for handling of the City's lost time workers' compensation claims.

Maria Beahm, Claim Specialist II – Responsible for handling of the City's medical only workers' compensation claims.

Carmen Garcia-Swint, Lead Telephonic Nurse Case Manager - Responsible for the management and independent decision making on medical claims.

Liability

Natalie Bowen, Liability Supervisor – Responsible for oversight of the City's Liability Unit

David Smyth, Sr. Claim Specialist – Responsible for handling of the City's Liability claims.

Administrative

Gail Couchman, Director of IT Services – responsible for data maintenance and production of reports.

Heather Payne, Accounting Manager – responsible for banking, check registers, and accounts receivable.

Rachael Mountford, Accounting Assistant – Responsible for issuing claim payment checks on behalf of the City.

Preferred Governmental Claim Solutions (PGCS)

Cheryl J. Riley, CWC, RMPE
Workers' Compensation Claims Manager
P.O. Box 958456
Lake Mary, Florida 32795
407-677-7478

Summary of Skills and Strengths:

- Over 27 years experience as a workers' compensation claim representative.
- Ability to work under pressure and interface well with all levels of management and office personnel.
- Strong customer relations and service capabilities.
- Excellent communication skills.
- Strengths include multi-tasking, professional, team player, extensive litigation experience, self managing, analytical and excellent planning and scheduling skills

Employment:

PGCS – Workers' Compensation Claims Manager
July 2009 to Present

Responsibilities include:

- Maintain positive client, inter-departmental, intra-company and governmental relations
- Plan, directs, monitors, staff assignments. Responsible for quantity and quality of product
- Develops activity and financial plans
- Monitors and controls Claims Operations resources
- Develops and recommends work and product improvement

PGCS – Quality Assurance Manager
July 2008 to 2009

Responsibilities include:

- Review claim files to ensure appropriate actions are being taken
- Complete Quarterly Quality Reviews for Corporate Compliance
- Identify areas where additional training may be required
- Assist with Claim Department Special projects

USIS – Account Executive
August 2007 – June 2008

Responsibilities include:

- Acting as the liaison between our client and the workers' compensation department
- Resolving claims issues for client in a timely manner
- Coordinating with all parties to provide accurate data reporting for purposes of underwriting
- Tracking Excess requests and recoveries
- Coordinating and attending claims review meetings in each client diocese within the State of Florida

- Reviewing claims files to ensure appropriate actions are being taken
- All other client related duties as deemed necessary

FHM – Workers' Compensation Adjuster
September 2002 – July 2007

Responsibilities include:

- Managing all aspects of incoming and existing workers' compensation claims from initial set-up to closure, as well as all aspects of litigation
- Handling all communications with injured workers, employers and professionals associated with each case
- Knowledge of Florida Workers' Compensation statutes and compliance regulation

INSURANCE OVERLOAD SYSTEMS – Workers' Compensation Claim Specialist
July 2002 – August 2002

Responsibilities include:

- Managing all aspects of incoming and existing workers' compensation claims for RSKCo/CAN Insurance Companies from initial set up to closure
- Handled all aspects of litigation for incoming and existing workers' compensation claims

Education:

- Board Certified in November 2002 (CWC)
- Numerous Training Courses
- Seminars directed by legal and medical professionals
- State of Florida sponsored seminars

References:

Available upon request

160029F

Sheila Kraft
Assistant Claims Manager
P.O. Box 958456
Lake Mary, Florida 32795

Objective:

To obtain a position with an organization that will utilize my experience in Workers' Compensation Claims, while offering opportunities for advancement and growth.

Qualification:

Workers' Compensation License. Over ten years experience in the field of Workers' Compensation.

Employment History:

PGCS Claims Services,
Lake Mary, Florida
1990- Present

Responsibilities:

- Supervise Workers Compensation municipality claims for the State of Florida.
- Member of PGCS Leadership Team.
- Contribute new ideas and troubleshooting client issues or concerns.
- Travel to client reviews
- Evaluate files for reserve accuracy as well as timely filing of forms to the Division of Workers' Compensation
- Perform Quality Assurance audits.
- Review Excess reporting according to excess carrier requirements.
- Conduct personnel reviews as well as reprimands as needed.
- Demonstrate excellent ability to use good time management.
- Express oral and written communication skills as well as interpersonal. Strong customer service skills.
- Excellent work ethic.

Language:

- Speak and write fluently in Spanish

Education:

- 1988 High School Diploma, Seminole High School
- College – General Courses
- Workers' Compensation continued education classes to maintain license.

References: Available upon request

Lynn Owens
Claim Specialist II
P.O. Box 958456
Lake Mary, Florida 32795
Home#: 407-532-5287
Mobile#: 407-463-6932
Email: LOWENS7@BELLSOUTH.NET

OBJECTIVE

To obtain a challenging ***full-time*** position with an industry leader that utilizes my experience in Claims Management, Customer Relations, Leadership, Training & Development, Quality Assurance, Regulatory Compliance and Project Management.

PROFESSIONAL SUMMARY

Experience with successfully managing all aspects of Training & Development in a large center including New Hire Orientation and Transitional Training. Frequent presentations to senior management conveying results and suggestions to not only meet, but exceed goals. Possess stellar Interpersonal Skills as well as the ability to think and work effectively in a fast past and progressive environment. Excellent ability to coach/mentor, motivate, lead courageously and advocate as a Change Agent when warranted. Ability to inspire, build trust, cultivate strong long lasting relationships and leverage Individual and Cultural Diversity. A quick learner with sound Business Acumen.

EXPERIENCE

2/29/16 – Present

PGCS, Claim Specialist II
Adjudicates all levels of Workers Compensation Claims to determine proper outcomes, develops litigation/defense strategies, and closely interacts with all parties involved.

9/29/14 – 2/26/16

York Risk Services, Contract Specialist (Full-time Regular)
To build and maintain a comprehensive network of providers for the purpose of servicing client needs, to foster and maintain relationships with participating and nonparticipating providers for the purpose of maintaining and increasing network penetration. Successfully negotiate provider agreements to provide meaningful value for our clients/customers, which in turn, offer greater coverage and savings to the network. Physician credentialing and grievance processes included.

7/1/13 – 9/19/14

Champions, Program Coordinator (*Full-time seasonal*)
Assists in operating and managing all aspects of 9 Champions programs. Effectively maintains the relationship between Site Director/ Instructor and Area Manager to include training, human resources, marketing, customer/client relations, financial systems, quality control and physical facility. Provides age appropriate programs to all children enrolled. Develops and maintains positive customer and community relations. Establishes strong working relationships among all site staff in the area.

09/07/10 – 6/8/13

Champions, a division of Knowledge Learning Corporation (*Part-time*)

Site Director - Frontline management role. Effectively operates and manages all aspects of KLC programs. Directly accountable for operational aspects of the child care center, ensuring quality care and education for children; achievement of financial targets, applying rigorous, proactive cost controls; incorporating active continuous improvement in quality of operations; delivering exemplary customer service; and ensuring legal compliance. Meets expectations for delivering customer acquisition and retention, quality program, financial management, operational compliance, and demonstrates expected behaviors.
Recipient of the 2011 - 2012 Excellence in Education Award
Nominee 2012 – 2013 Excellence in Education Award
Presented in the Champions Brand Book 2013

Hartford Insurance Company

7/04 – 6/30/10 Training & Development Consultant, Southeast Workers' Compensation Center, Lake Mary, FL

- Directed and coordinated all training and educational efforts in the center
- Reported monthly on the correlation between Training & Quality
- Participated in weekly Quality Audits (CPI & QBR)
- Facilitated Strategy Conferences around the audit results, identified areas of opportunity and presented remedies
- Coordinated all licensing and certifications in the center for the states of FL, NC, SC, *AL, & GA
- Maintained and updated all education and licensing records

Hartford Insurance Company
Central Recovery Operations/Department of Subrogation

7/02 – 7/04 Team Leader, CMS & SRS, Maitland, FL

- Led a cross functional team of 8 – 10 adjusters
- Data Mining of the subrogation results and adjusted our handling needs accordingly

2001 – 7/02 Quality Assurance and Education Team Leader, Maitland, FL

- Verified proper handling of all claims per the center's standards
- Implemented and facilitated all training needs

99 – 2001 Workers' Compensation Consultant, Maitland, FL

- Adjudicated a myriad of High Exposure claims with a minimum threshold of $100K for multiple jurisdictions

97 – 99 Subrogation Coordinator, Syracuse, NY

- Liaison between the center and Subrogation Department
- Communicated with centers around their results, successes, shortcomings and identified training needs

Hartford Insurance Company

96 – 97 Workers' Compensation Specialist, Syracuse, NY

- Adjudicated multi-jurisdictional claims involving all levels of litigation
- Acted in a TPA capacity which allowed for consistent communication with customers

95 - 96 **Team Leader, Medical Mgmt. Call Center. Syracuse, NY**

- **Supervised and managed Med bill Call Center with a team of 15 – 20 agents**
- **Spearheaded the Telephonic Call Monitoring and Review Program**
- **Analyzed daily stats to meet the needs of the center as well as the customers**
- **Orchestrated weekly Team Building exercises to strengthen the**

relationship between the center and agents

94 - 95 Workers' Compensation Claim Rep., Syracuse, NY

- Handled WC claims at all levels
- Held weekly roundtables with Home Office Consultants around Reserving and Settlement Authority

93 – 94 Outside Claim Representative, All-Lines, Albany/Syracuse, NY

- Adjusted All-Lines claims in multiple jurisdictions to include Homeowners

2/90 – 93 Inside Claim Representative, Buffalo, NY

- Managed Auto, Property, Bond and Liability claims

7/89 – 2/90 Hartford Temporary Workers, Claim Rep. Trainee, All-Lines Buffalo, NY

- Introduction to All-Lines claim handling with the exception of Workers' Compensation

EDUCATION

Canisius College, Buffalo, NY
Bachelor of Arts, Sociology, minor Math Education - Graduated

University of Buffalo, Amherst, NY
Master of Science, Public Administration/Affairs - Graduated

PROFESSIONAL DESIGNATIONS

Child Development Associate

Recipient of the Excellence in Education Award from Knowledge Universe

American Educational Institute
Senior Claim Law Associate (SCLA)

FL All-Lines Adjuster License, 06-20

160029F

Maria Beahm
Claim Specialist I
P.O. Box 958456
Lake Mary, Florida 32795
386-456-0316
386-837-2453

<u>Objective:</u>

To further fulfill my obligations as a claims specialist for worker's compensation.

Strengths:

- Ability to learn new procedures and make ethical decisions
- Excellent communication skills and experience with multiple municipalities and clients
- Excellent organizational skills
- Ability to maintain good relationships with clients
- Ability to adjudicate both medical and litigated claims to completion
- Completed courses for CEU credits beyond state requirements

Education:

High School Diploma 1985 – Seminole High School, Sanford, FL.

License:

- Worker's Compensation Adjuster License, 1993

Employment History:

Preferred Governmental Claims Solutions (previously ISAC)
April 1991 – present

Responsibilities:
- Mailroom filing
- Clerical filings
- Lost time adjuster handling worker's compensation claims for municipalities and school boards
- Handle all litigation and settlement aspects of claims to include depositions
- Attending mediations and testifying at final hearings.
- Filing DWC- reports with the State in a timely manner.
- Currently handling NLT claims for City of Naples, City of Marco Island, City of Cape Coral, Cape Coral Charter School & Brevard County BCC.

Insurance Servicing and Adjusting Company (purchased by Brown & Brown Co.; renamed PGCS). April 1991

Fetco Electronics

1990 – 1991

Responsibilities:

- Continued making transformers and electronic boards.

Lenco Electronics
1989 – 1990

Responsibilities:

- Made transformers for submarines, space shuttles, and military aircraft.

Natalie S. Bowen
P.O. Box 958456
Lake Mary, Florida 32746
407-568-2107
pnwhit@yahoo.com

OBJECTIVE

Seeking a position offering continued career growth within the insurance industry with a progressive company that offers upward mobility.

EDUCATION

- Bachelor of Arts in Legal Studies from University of Central Florida

EXPERIENCE

10/2007 – Present **Preferred Governmental Claims Solutions**
Liability Claims Supervisor

- Confirm coverage, investigate claims, including commercial general, auto, law enforcement and public official's liability, establish reserves and negotiate settlements on claims involving governmental entities.
- Manage litigation and monitor legal costs and expenses.
- Evaluate claims for and pursue subrogation recovery.
- Maintain close relationship with the client and report to the carrier as required.

10/1998 – 10/2007 **Gallagher Bassett Services**
Multi-State General Liability and Auto Liability Senior Claims Representative

- Maintain full spectrum of claims, including commercial general liability, auto liability, and first party commercial property claims for various local and national accounts.
- Responsible for reporting on media sensitive and large dollar exposure claims for a national fast food chain.
- Confirm coverage, investigate claims, establish reserves, manage costs and negotiate settlements.
- Manage litigation, monitor and audit legal cost and expenses.
- Evaluate claims for and pursue subrogation recovery.
- Maintain close relationship with the client and report to the carrier as required.
- Conduct training with new adjusters on policy and procedures with regard to claims handling and reporting.
- Acting supervisor in the supervisors' absence.

4/94 – 10/98 **Claims Capabilities, Inc**., Orlando, FL
Workers Compensation Adjuster

- Review and process workers compensation claims.
- Gather information regarding lost time and wages.
- Determine compensability of claims.
- Calculate and issue indemnity payments.

- Monitor medical status and treatment.
- Knowledge of laws and regulations governing workers compensation insurance.

4/93 - 3/94 **G.A.B. Business Services**, Maitland, FL

Mail and File Room Supervisor/Medical Payments

- Supervised crew of three through the processing and delivery of incoming and outgoing mail.
- Issued payment of medical bills.
- Pulled and delivered claim files to adjusters.
- Maintained inventory of office supplies.

6/92 - 4/93 **Crims, Inc**., Orlando, FL

File Clerk

- Processed and delivered incoming and outgoing mail.
- Pulled and delivered claims files to adjusters.

SKILLS

- Excellent oral and written communication, including presentation skills.
- Analytical and interpretive skills.
- Strong organizational skills organizational and interpersonal skills.

LICENSES

- General Lines Agent and Adjuster, Florida

David Michael Smyth
Sr. Claim Specialist
P.O. Box 958456
Lake Mary, Florida 32795
(407) 822-3863

SUMMARY OF QUALIFICATIONS:

- Proven experience in litigation, mediation and negotiation skills
- Excellent communication skills, including public speaking
- Team goal, customer satisfaction and best practices oriented

PROFESSIONAL CERTIFICATIONS: Adjusters License – All lines, State of Florida

EDUCATION: Bachelor of Science in Criminal Justice 1987
University of South Carolina, Columbia, South Carolina

EXPERIENCE: Preferred Governmental Claim Services: November 2010 - Present

Senior Claim Specialist

- Handles property and casualty governmental municipality claims
- Submits coverage, reserve and settlement recommendations
- Negotiates claims to conclusion
- Represents Company at mediations and trials
- Represents Company at account claim reviews

Zurich North America: June 2006 – August 2010

Liability Specialist III

- Handled third tier level property and casualty litigation claims
- Submitted coverage, reserve and settlement recommendations
- Represented Company at mediations and trials
- Represented Company at account claim reviews

Walt Disney World: April 2004 – May 2006

Guest Service Specialist

- Third party property and casualty claims handler

The Hartford: December 1988 – January 2003

Claims Service Specialist

- Territory: United States
- Handled general liability claims for Lowe's Home Improvement

Resident Claims Representative

- Handled property, casualty and workers' compensation claims
- South Carolina Arbitration Forum Panelist

Claims Supervisor

- Coordinated training program for incoming claim representatives
- Supervised five claim representatives

- Handled large exposure litigation claims
- Performed employee evaluations

Field Claims Representative

- Handled property, casualty and workers' compensation claims

AWARDS AND HONORS:

1987 University of South Carolina Baseball Most Valuable Player

Carmen Garcia-Swint

PROFESSIONAL EXPERIENCE:

10/31/2013– Present ***AmeriSys***
Lead TCM for PGCS/ PGIT files
Telephonic Nurse Case Manager
Triage files for acuteness of injury and coordination of care.

- Responsible for the management and independent decision making on medical claims. Monitor, analyze, evaluate and coordinate the delivery of high quality, timely, cost effective medical treatment as needed by an injured employee to promote and appropriate, prompt return to work when medically indicated.

6/25/2007 – Present ***AmeriSys*** Oviedo, FL
Telephonic Nurse Case Manager

- Responsible for the management and independent decision making on medical claims. Monitor, analyze, evaluate and coordinate the delivery of high quality, timely, cost effective medical treatment as needed by an injured employee to promote and appropriate, prompt return to work when medically indicated.

01/24/2005 – 6/24/2007 ***Crawford and Company*** Orlando, FL
Telephonic Case Management

- Evaluation of appropriateness of medical care, coordination and facilitation of safe return for Workers' Compensation

2003 – 01/21/2005 ***Broadspire / Cunningham Lindsey*** Orlando, FL
Nurse Case Manager

- Evaluation of appropriateness of medical care, coordination and facilitation of safe return for Workers' Compensation

1999 – 2003 ***CNA Orlando, FL*** Orlando, FL
Nurse Case Manager

- Evaluation of appropriateness of medical care, coordination and facilitation of safe return for Workers' Compensation

1996 – 1999 ***CNA Dallas, TX*** Dallas, TX
Nurse Case Manager

- Evaluation of appropriateness of medical care, coordination and facilitation of safe return for Workers' Compensation

1995 – 1996 ***CRA / Concentra*** Dallas, TX
Nurse Case Manager

- Pre-authorization Workers' Comp.
- Medical review of procedures, surgeries and admission for Workers' Compensation

1994 – 1995 ***North Texas Healthcare*** Dallas, TX
Nurse Case Manager

- Pre-authorization Private Insurance
- Medical review of procedures, surgeries and admission for Workers' Compensation

1976 – 1994 ***Jackson Memorial Hospital*** Miami, FL
Utilization Management

- Neonatal – Premature special care unit

EDUCATION:

1976 Nursing Diploma – Jackson Memorial School of Nursing
1976 Associates Degree in Nursing and in Arts - Miami Dade Community Hospital

LICENSES & CERTIFICATES

- Florida Register Nurse (License # RN 856042)
- Texas Register Nurse (in active) (609375)
- Certified Disability Management Specialist (009577)

Gail Couchman

P.O. Box 958456, Lake Mary, Florida 32795
cell (407)492-3637
gcouchman@live.com

An accomplished Business Analyst and Software Developer with extensive experience

in business analysis, software development, and life cycle management.

Summary of Qualifications

- 20+ years experience with business consulting, facilitation, process improvement, work value analysis, and office automation.
- 18+ years experience in software development and life cycle management with expertise in multi-tiered architecture, system integration, components, and web services.
- 18+ years experience in training, user documentation, and presentations.
- 18+ years experience in project management, testing, quality assurance, problem tracking, and version management.
- 5+ years experience in the medical industry with expertise in HL7, system integration, and multi-modality, multi-facility scheduling in hospitals, diagnostic imaging centers, call centers, practices, and surgical centers. Working knowledge of medical necessity, ICD9, CPT, HIPAA, HCFA, PACS, HIS, MPI and EDI.
- 5+ years experience in Affirmative Action with expertise in availability analysis, work group analysis, job group analysis, and EEO compliance reporting.
- 3+ years experience in intellectual property and the patent application process.
- 3+ years experience in library management, cataloging, and MARC.
- 20+ years experience in small business and corporate accounting with working knowledge of general ledger, AP, AR, payroll, asset accounting, material management, inventory control, timekeeping, billing, and financial reporting.
- 3+ years experience in commercial automated payroll processing.
- Excellent conceptual, analytical, organizational, verbal/written communication and presentation skills.
- Able to work both independently and as a team member.
- Dedicated, hard-working individual with the intercommunication skills to work at all levels of the organization.
- Familiar with the constraints of data-sensitive environments, such as human resources, financial, educational, and medical.
- Successfully manages competing priorities.
- Ability to quickly focus on changing priorities.
- Proactive and strong problem solving skills.
- Flexible and adaptable

CAREER HIGHLIGHTS

Preferred Governmental Claim Services, Lake Mary, FL
DIRECTOR, I/T SERVICES 2016 - Present

- Claims data administration, claims payment processing, client reporting
- Application development, implementation, system integration, data conversion, maintenance, and support.

Unique Business Solutions, Inc., Houston, TX, Orlando, FL
BUSINESS SYSTEMS ANALYST 1988 – 1999, 2001 - Present

Conceptualized, designed, and developed business and information technology solutions for a wide range of clients.

- Business consulting, process improvement, work value analysis, and office automation.
- Application development, implementation, system integration, data conversion, maintenance, and support.
- Project management, testing, quality assurance, problem tracking, and version management.
- Worked with clients to improve process and organizational effectiveness and efficiency by implementing better controls, refining organizational structures, improving the use of technology, and consolidating redundant operations
- Identified and documented functional and technical requirements through research, observation, and interviews with system users and domain experts.
- Designed and developed monolithic and multi-tiered applications, interfaces for system integration, components, web services.
- Developed user documentation and training materials, and conducted training sessions.

General Service Division, Fortune 100 Company –Member of a 5-person team that performed a Work Value Analysis of the General Services Division of a Fortune 100 company as the organization strived to reinvent many of its key business processes after consolidating several regional service centers. Departments included Accounts Payable, Payroll, Asset Accounting, Fleet, Grounds Maintenance, Facilities Maintenance, Photography, Food Services, Parking Garage, Records Storage, Revenue Accounting, and the Credit Card Processing Center.

Fundraising, Non-Profit Organization – Designed and developed an appeals management system to track appeals, monetary donations, and in-kind donations.

Circulation Library, Educational Facility – Designed and developed a library management system for a school library, including check-in, check-out, cataloging, catalog searches., and a MARC import interface.

Civil Engineering Firm – performed an assessment of client's field operations, project management, billing, and collections and recommended operational and technology changes to management.

Designed and developed a project management and billing system to automate timesheet data entry, allocate billable labor to the appropriate project, streamline the monthly billing process, and facilitate collections.

Human Resources, Fortune 100 Company – Designed and developed a reporting system to track, audit, and report personnel transactions for 100,000+ employees at three North American locations to produce Affirmative Action performance reports and to meet requirements for EEOC reporting.

Member of a 2-person team responsible for setting departmental performance goals for the corporate Affirmative Action program. Tasks included acquiring census data and conducting workforce analysis, availability (8-Factor) analysis, job force analysis, and utilization analysis for 100,000+ employees at three North American locations.

Designed and developed a case management system to track information for sexual harassment and discrimination investigations.

Designed and developed an interface to analyze workforce statistics and approve termination recommendations from departmental management during a workforce reduction initiative.

Regulatory Compliance Division, Fortune 100 Company – Defined key functional and technical requirements on a key IT initiative involving the scheduling and management of certification training to meet regulatory compliance requirements.

Transportation Division, Fortune 100 Company – Defined key functional and technical requirements on a key IT initiative involving the testing and licensing of commercial drivers.

Warehouse Operations, Moving & Storage Firm – Defined key functional and technical requirements on a key IT initiative involving warehouse operations. Upgraded and enhanced an application that is used in multiple corporate locations.

Horticulture Division, Resort Complex – performed an assessment of client's greenhouse operations, arboricultural operations, pest control operations, and event rental services and recommended operational and technology changes to management.

Designed and developed a system to plan the resort's planting beds years in advance in order to forecast plant material requirements.

Designed and developed a project management and task scheduling system to promote interdepartmental collaboration.

Designed and developed a timekeeping interface for the task scheduling system to automate timesheet data entry and allocate billable labor to the appropriate project.

Designed and developed a billing interface for the task scheduling system to automate the billing process and post billing transactions to the corporate general ledger system.

Asset Accounting, Fortune 100 Company – Defined key functional and technical requirements for a system to track material movements and facilitate auditing of serialized assets at 4000+ field locations.

Designed and developed an application to track the location of asset ledgers and asset files within the department.

Automated Payroll Processing, Software Development Firm – Enhanced and supported a commercial automated payroll processing product.

Medical Scheduling, Software Development Firm – Conceptualized, designed, and developed a multi-facility, multi-modality, rules-based scheduling solution for a software development firm specializing in automated patient access and scheduling technologies.

Presenter, Data Modeling– Presented a one-hour session at Computer Associates' CA-World, a technical conference, on the basics of data modeling.

Presenter, Effective User Interviews– Presented a one-hour session at Computer Associates' CA-World, a technical conference, on tips and techniques for conducting effective user interviews.

Central Florida Preparatory School, Gotha, FL

TECHNOLOGY INSTRUCTOR 2003 - 2004

Fulfilled a challenging role to implement a technology program for an accredited private K-12 school.

- Developed technology curriculum to meet accreditation standards.
- Established instructional lab and implemented technology program with minimal budget.
- Classroom instruction for 150 elementary, middle, and high school students. Supported virtual school students.
- Network administration, security, and support for instructional lab.

Medical Specialty Software, Inc., Kissimmee, FL

DIRECTOR, SOFTWARE DESIGN 1997 - 2001

Conceptualized, designed, and developed the ScheduleQuest® product line, a multi-facility, multi-modality, rules-based scheduling solution for the medical industry

- Member of 5-person team consisting of domain experts, analysts, and developers.
- Project management for development and integration projects; collaborate with business partners, consultants, and client development teams.
- Multi-tiered software product included Windows user interface, web user interface, data access component, scheduling component, interface component, and IP messaging system. Integrated with third-party medical necessity component.
- Integrated commercial product with client's PACS, HIS, MPI, or HL7 interface.
- Technical Representative at training, sales presentations, and trade shows, such as HIMSS, RSNA, and Windows on Healthcare.
- Identify and document functional requirements through research, observation, and interviews with system users and domain experts

CO-INVENTOR

U.S. Patent No. 6,389,454 – Multi Facility Appointment Scheduling System

Collaborated with patent attorney during the patent application process, including documenting invention, development of claims, and discussing application with patent examiner.

160029F

Heather D. Payne
Accounting Leader
P.O. Box 958456
Lake Mary, Florida 32795
HeatherDPayne@gmail.com
386.366.2116

EDUCATION:

Bachelor of Science in Business Administration, August 2007

Major: Finance
University of Central Florida, Orlando, FL

PROFESSIONAL EXPERIENCE:

Preferred Governmental Claims Solutions, Inc — Lake Mary, FL — 4/2012 – Present
Accounting Operations Leader

- Responsible for handling PGCS operations as it pertains to accounting, payroll, benefits, financial audits, catastrophe plan preparation and human resources (new hires, termination filings, etc.)
- Prepares and analyzes monthly/quarterly/annual financial reports, responsible for closing each month
- Creates and analyzes budgets in collaboration with department leaders and profit center leader
- Provides financial analysis and cost control information to senior leadership

FL Hospital Memorial — Ormond Beach, FL — 8/2011 – 4/2012
Financial Analyst

- Analyzed and provided detailed performance improvement data and financial reports
- Determined validity and reliability of daily and monthly operational statistical data
- Provided budget reports, reconciliations and ensured budget data accuracy
- Maintained and set up new users and departments in various financial & budgeting systems

HNTB Corporation — Lake Mary, FL — 9/2009 – 6/2011
Project Administrator

- Responsible for budgeting, scheduling, month-end processing, project accounting, reporting and cash management; performed all administrative and financial functions for assigned projects
- Attended monthly project review meetings to report on financial issues and performance
- Provided financial analysis and cost control information to project team and management

Harris Corporation — Melbourne, FL — 3/2009 – 9/2009
Lead Program Financial Analyst

- Analyzed budgets/costs for financial stability and risk, prepared findings, and made recommendations
- Forecasted revenue, operating profit, accounts receivable, and cash flow
- Prepared monthly internal and customer financial reports

Brown & Brown, Inc. — Lake Mary, FL — 7/2007 – 2/2009
Compliance/Staff Internal Auditor

- Conducted financial, operational, and information technology audits nationwide
- Reviewed profit center operations for possible errors and omissions, inefficiency, and ineffectiveness
- Assessed & evaluated internal controls, adherence to corporate policies, and compliance with state and federal laws and regulations

DESIGNATIONS/CERTIFICATIONS:

- Accredited Adviser in Insurance, AAI — January 2008
- Associate in Risk Management, ARM — April 2008
- Associate in Information Technology, AIT — April 2008
- Certified Employee Benefits Specialist, CEBS — June 2008

RACHAEL MOUNTFORD
Accounting Assistant
P.O. Box 958456
Lake Mary, Florida 32795
407-687-1974 Cell
E-mail Ntatton516@gmail.com

Summary:

Precise, detail-oriented Accounts Payable/Check Processing with sound judgment and decision-making skills. Enjoys building positive client and vendor relationships. Encourages process and procedures to be maintained and followed.

Highlights:

- Knowledge of Sage, RiskMaster CSC, Courrs, Concur, Platinum, and Various online Banking
- Microsoft Office, Excel, Word, Access, Adobe Acrobat
- File keeping
- Strong communication skills
- Solution-oriented
- Independent worker
- Strive for exultant attendance
- 50 WPM
- Establishes a hour to hour weekly calendar

Sept. 2007- Present Brown & Brown/PGCS Lake Mary, Florida

Accounting Assistant 2016-present

- General accounting functions to assist Accounting Leader
- Accurately enter invoices into accounting system for approximately 30 customers.
- Accurately account for cash receipts, preparing deposits and entering deposit into accounting system.
- Handle client bank reconciliations, abandoned property, stop pays, deposits, etc.
- Other miscellaneous duties, including filing, maintain subcontractor documentation, special projects, fixed asset submission/inventory, and etc., as assigned by management.

Accounts Payable Skills 2012-2015

- Code invoices onto payment vouchers, enter into accounting system, and prepare for mailing
- Filing, maintaining, complete yearly pre- audit, and rotate past vender invoices
- Resolve any invoice issues or discrepancy
- Verify all venders W-9 with IRS websites
- Timely posting of cash receipts into accounting system

Check Processing Skills 2012-2015

- Print Work Comp, Liability, and medical checks on 31 unique clients bank accounts
- Print Explanation of Benefits for medical checks, match with check, and prepare for mailing
- Verifying accounts have appropriate funds
- Running weekly check registers and sending them to clients on expected days/times
- Handle outstanding checks, abandoned property, voids and stop pays
- Submit Positive Pay files, review for exceptions, and approve online ACH payments

Claims Assistant: 2009-2011

- Worked alongside and assisted 5 work comp claims adjusters.
- Creating and filing various state forms for state/EDI/claimant/attorney.
- Handled bill call- questions, payments, denials, reconsiderations, and requesting proper forms/notes of bills.
- Reviewed & processed bills that are paid %100
- Prepared files for closing closed and place in designated file room in alpha order.
- Set up Dr appointments/transportation for claimants with close contact with medical providers and claimant.
- Copied files for attorneys, doctors, and state audits.

Intake Coordinator: 2008-2009

- Receiving and creating new injury reports for setting up claims in the system.
- Handled all request for ISO reports.
- Processing all transfers of files from LT- lost time to MO-medical only or vice versa.

Technical Asst: 2007-2008

- File locating, alphabetizing & sorting file copies,
- Construction of new volume files
- Indexing daily mail and sorting/indexing/delivering faxes.

Receptionist Backup: 2007-2012

- Being sole contact for all visitors coming in
- Data entry and setting up schedules for conference rooms
- Multi phone line skills for 4 combined intercompany departments.

Mail Room backup: 2009-2011

- Open, sort, date stamp all incoming mail, and deliver in a timely manner.
- Meter all outgoing mail and have ready for drop off.

Accomplishments at PGCS

Volunteered for the company focus group to gather ideas of improvement in process, procedures, and cost reduction. Appointed by the group I presented these ideas to our leadership team. Some of my ideas had been approved by the team and implemented. Leading to my first of second exciting accomplishment of earning Employee of the Month! I had also become the Employee Birthday coordinator. The most important thing I look back on is being noticed for my hard work, attendance, mastering any task given, and that lead to moving up in the company. I appreciate everything I've learned over the years.

Dec. 2006-2007 Curves for Women Sanford, Florida

Sales Agent/ Circuit Trainer

Sales Agent: 2006-2007

- Greeted incoming members, appointments and walk-ins.
- Creating and exceeding a sales funnel with a monthly quota of 10 memberships or more.
- Initial consultations with client with review of membership, policies, and goals.
- Opened/closed the establishment and handled all cash flow for day to day business.
- Created new incentives, games while circuit training, achievement boards, recipe of the week, ect.

Trainer: 2006-2007

- Responsible for facilitating training sessions with members as to proper nutrition, and safety.
- Set up personal file for each client of restrictions, needs, goals, weight, and measurements.
- Monitoring progress of each client with recording monthly weight, measurements and BMI.
- Entering monthly progress in a unique data system and giving clients progress reports.
- Positive goal accountability adviser.

Further years of work history can be supplied upon request.

Subcontractors

PGCS subcontracts with USIS, Inc. *dba* AmeriSys for managed care / medical management services. Please reference the pricing grid above for managed care / medical management fees.

USIS, Inc. (corporation) is a wholly owned subsidiary of Brown & Brown Inc., one of the nation's largest insurance agency/brokerage organizations. The financial and management depth and resources afforded by our affiliation with Brown & Brown assures our customers that we will be there for them even during the most troubling times.

AmeriSys has been providing successful medical management and medical bill review/cost containment services to our clients for over 25 years. Many of our clients have been with us for 20+ years. We have an excellent reputation in the Workers' Compensation arena and new business is often through referrals. Honesty and integrity are cornerstones of our culture; from the leadership down, ethical and professional behavior is expected and demonstrated. Our team is professional, experienced, customer service and quality driven, committed to the company's philosophy ***"Service Beyond the Contract"***. Our IT department and our systems are kept current and innovative; our IT team is all in-house so we are able to tailor our programs to our clients' needs, and ensure our staff has the current equipment to succeed in their jobs. Our staff members are mainly long term employees; training is thorough; continuing education is encouraged. We have adequate staff to accomplish the job in a quality manner to ensure successful outcomes for our clients and our employees.

AmeriSys currently provides cost containment services which include medical bill review for an insurance company, two Florida self-insurance funds, 20 self-insured entities including Broward County Government and Palm Beach County Sheriff's Office, and, on behalf of FWCIGA, 8 insolvent insurance carriers. AmeriSys also provides these services to PGCS which includes a Florida Governmental Insurance Trust with over 200 governmental entities.

AmeriSys Medical Bill Review staff consists of a Quality Controller, 1 Supervisor and 11 personnel who currently process over 250,000 bills annually for these clients. This team consistently meets and exceeds all benchmarks established or required of them. Our experienced team has the personnel and ability to meet and exceed the requirements set forth by the City of Gainesville

AmeriSys has a proprietary Medical Management system, Corrus, which includes our Medical Bill Review component. With proprietary software and our in-house staff of 8 staff programmers, we have the ability to tailor Corrus to meet the needs of the City of Gainesville

ADDENDUM NO. 1

Date: June 9, 2016

RFP Due Date: July 7, 2016
at 3:00 P.M. (Local Time)

RFP Name: Third Party Claims Adjusting Services

RFP No.: RMDX-160031-DD

NOTE: This Addendum has been issued to those holders on record of Request for Proposal No. RMDX160031-DD, distributed May 21, 2016.

The original Specifications remain in full force and effect except as revised by the following changes which shall take precedence over anything to the contrary:

1. Interested parties are reminded that all inquiries must be submitted **in writing** to the City of Gainesville Purchasing Division no later than 12:00 p.m. (local time), June 22, 2016. Inquiries may be submitted as follows:

   Email: drymonjd@cityofgainesville.org
   or
   Faxed (352) 334-3163
   Attention: Doug Drymon, Senior Buyer

2. Please find attached:
   a) Copy of the black out period definitions (Financial Procedures Manual Section 41-424 Prohibition of lobbying in procurement matters).
   b) Spreadsheet showing 5-year loss runs for the fiscal years 2010 through 2015.

Following are responses to inquiries which have been received as of this date from prospective proposers:

3. Question: May companies from outside the USA (example: Canada or India) submit a proposal?
   Answer: No. Companies must be licensed in the state of Florida and have a liability Adjuster located in Gainesville. (Note: The City can provide a work station for the Adjuster to use in the Risk Management Office.)

4. Question: Will the vendor selected to provide TPA services be required to any attend meetings in Gainesville?
   Answer: Yes. This would include (but is not limited to) attending hearings, depositions and other proceedings where appropriate or desirable from the City's standpoint.

5. Question: Can the tasks stipulated in the RFP be performed from outside the USA (such as from Canada or India)?
   Answer: No. Many of the requested services are expected to be performed on-site by a company representative. Please refer to Items I (F) and III (B) (1) of Exhibit F in the RFP document by way of example.

6. Question: May proposals be submitted by email?
   Answer: No. Proposals must be submitted in paper form to the address indicated in the RFP document by the stated deadline. Please refer to Section I (C) – "Proposal Submission" - of the RFP document for specific details regarding proposal submission.

7. Question: Is it possible to request a copy of current TPA's contract?
   Answer: There is no reason to review the current expiring contract, as the evaluation of proposals and final award will be undertaken using the requirements and specifications outlined within the advertised RFP.

8. Question: What is the current annual fee paid by the City for TPA services?
   Answer: The current fee that the City pays for TPA services is of no importance insofar as this RFP is concerned. Proposers are encouraged to submit their most competitive fee based on providing the level and quality of services that the City is seeking to obtain through this RFP.

9. Question: Why has the city issued this RFP at this time?
   Answer: The current contract for TPA services is expiring on October 1, 2016. Past practice has been to issue an RFP at the end of the contract term and any extensions which the City has exercised.

10. Question: Does the current TPA's contract with the city expire in 2016?
    Answer: Yes. Please refer to the answer given to Question 9.

11. Question: Are there any service issues with the current TPA?
    Answer: There are no issues with the current TPA.

12. Question: Please provide loss runs for the past 5 years.
    Answer: Loss runs for Fiscal Years 2010 through 2015 are provided as a separate document to this Addendum.

13. Question: How many open claims (by type) are there before the 2010-2011 periods which are not on the loss history exhibit? Answer: Please refer to the RFP.

14. Question: Please provide a breakdown of the total number of currently open workers' compensation claims (by claims type – indemnity and medical only). Answer: Please refer to the RFP.

15. Question: Is the city through this RFP requesting that the TPA provide medical managed services, such as medical bill review, PPO network access and savings, and case management services (telephonic or field)? Who provides these services to the city currently?
    Answer: Please refer to the RFP (especially Exhibit F) to see the services the City is requesting.

16. Question: What fees are paid by the city for these various medical management services?
    Answer: Please refer to the response provided to Question 8.

7. Question: How many medical bills have been processed and paid each year for the past 3 full years?
   Answer: The City does not compile and store this information in a manner that makes it readily accessible to comply with this request.

18. Question: Please clarify the city's preferred type of TPA fee- per claim or annual?
    Answer: Please review Section VII ("Price Proposal") of the RFP document to understand the format in which fees are to be presented.

19. Question: For staffing, the RFP requires one local liability adjuster. Would a liability adjuster based in the Orlando area, who can respond to the claims as needed, be acceptable to the city to meet the local requirement, or does the adjuster need to be based in Gainesville?
    Answer: The City desires the adjuster to be based in Gainesville, and has previously provided a work station within the Risk Management Office for the adjuster's use.

ACKNOWLEDGMENT: Each Proposer shall acknowledge receipt of this Addendum No. 1 by his or her signature below, **and a copy of this Addendum signature page is to be returned with your proposal.**

CERTIFICATION BY PROPOSER

The undersigned acknowledges receipt of this Addendum No. 1 and the Proposal submitted is in accordance with information, instructions, and stipulations set forth herein.

PROPOSER: PGCS Claim Services

BY: Kenneth Fisher

DATE: 6-13-2016

41-424 **Prohibition of lobbying in procurement matters**

Except as expressly set forth in Resolution 060732, Section 10, during the black out period as defined herein no person may lobby, on behalf of a competing party in a particular procurement process, City Officials or employees except the purchasing division, the purchasing designated staff contact. Violation of this provision shall result in disqualification of the party on whose behalf the lobbying occurred.

Black out period means the period between the issue date which allows for immediate submittals to the City of Gainesville Purchasing Department for an invitation for bid or the request for proposal, or qualifications, or information, or the invitation to negotiate, as applicable, and the time the City Officials and Employee awards the contract.

Lobbying means when any natural person for compensation, seeks to influence the governmental decision making, to encourage the passage, defeat, or modification of any proposal, recommendation or decision by City Officials and Employees, except as authorized by procurement documents.

ADDENDUM NO. 2

Date: June 20, 2016

RFP Due Date: July 7, 2016
at 3:00 P.M. (Local Time)

RFP Name: Third Party Claims Adjusting Services

RFP No.: RMDX-160031-DD

NOTE: This Addendum has been issued only to the holders of record of the specifications and to the attendees of the non-mandatory pre-proposal conference held on June 16, 2016.

The original Specifications remain in full force and effect except as revised by the following changes which shall take precedence over anything to the contrary:

1. All questions must be submitted **in writing** to the City of Gainesville Purchasing Division by 12:00 p.m. (local time), June 22, 2016. Questions may be submitted as follows:
   Email: drymonjd@cityofgainesville.org
   or
   Faxed (352) 334-3163
   Attention: Doug Drymon, Senior Buyer

2. Please find attached:
   a) Copy of the black out period definitions (Financial Procedures Manual Section 41-424 Prohibition of lobbying in procurement matters) distributed during the non-mandatory pre-proposal conference.
   b) Copy of the June 16, 2016 Pre-Proposal Conference sign-in sheet showing attendees.

3. Doug Drymon, Senior Buyer with the City of Gainesville Purchasing Division, discussed the RFP requirements with the attendees. Mr. Drymon began the discussion by introducing David Jarvis, Workers' Compensation and Loss Control Manager with the City of Gainesville Risk Management Department, and Doug Prentiss, Safety Specialist, to those who were in attendance.
   a. Sign-in Sheet was circulated on which all attendees were asked to indicate their attendance.
      i. Name on submitted Proposal to match business name as signed in at pre-proposal conference.
   b. Proposals are to be received by the Purchasing office no later than 3:00 p.m. on July 7, 2016. Any proposals received after 3:00 p.m. on that date will not be accepted.
   c. Send questions in writing to Doug Drymon, Senior Buyer, via email or fax.
      i. All communication through Doug Drymon only. Do not communicate with other City staff.
      ii. Deadline for receiving questions or requests for additional information or clarification is June 22, 2016 @ 12:00 P.M. (Noon). All inquiries must be submitted in writing.
   d. Discussed Proposal due date, time and delivery location.
      i. Deliver (or have delivered) to Purchasing by 3:00 p.m. on July 7, 2016.
      ii. Clearly mark outside of delivery package containing proposal with RFP number & name, Proposer's name, and proposal due date.

e. Various forms (i.e. Drug Free Workplace, Living Wage, etc.) are to be completed and returned with your proposal.
    i. Any form in the Request for Proposal document which does not apply should be marked "N/A" or with a similar notation, then signed, dated and returned with your proposal.
    ii. Sign, date and return all Addenda signature pages. Also acknowledge Addenda where indicated on page 32 of RFP Document.

Following are answers/clarifications to questions received at the non-mandatory pre-proposal conference or which have been submitted to the Purchasing Office since Addendum No. 1 was issued:

4. Question: Who is the current broker for the City's insurance business?
   Answer: Marsh USA, Inc.

5. Question: Regarding the on-site Adjuster – is this person expected to perform any out-of-the-office investigations?
   Answer: Yes, although not always for vehicle-related accidents. Sewer back-ups are one of the most common types of occurrences which the Adjuster is called upon to respond to with a personal visit.

6. Question: Have there been any issues from the City's standpoint with the current TPA services provider?
   Answer: No.

7. Question: How does the City handle the assignment of medical providers (Physicians), medical facilities (such as MRI's), legal counsel (Attorneys) and the like?
   Answer: The City determines which outside parties (such as physicians, attorneys, medical facilities and investigation services) may be selected to handle claims cases. For example, the City is currently using Alliance for private investigative services, and is very satisfied with their service.

8. Question: How long has the City been with its current TPA services provider?
   Answer: About 10 years continuously.

9. Question: How does the City handle managed care?
   Answer: The City has opted out of managed care.

10. Question: How many employees does the City presently have?
    Answer: Approximately 2,400 and growing.

11. Question: What is the length of the current expiring TPA term?
    Answer: The present term covers three (3) years plus two additional extensions.

12. Question: Will the City be using the services of an outside consultant to undertake the evaluation of the proposals that are received in response to the RFP for Third Party Claims Adjusting Services?
    Answer: No.

ACKNOWLEDGMENT: Each Proposer shall acknowledge receipt of this Addendum No. 2 by his or her signature below, **and a copy of this Addendum signature page is to be returned with your proposal.**

CERTIFICATION BY PROPOSER

The undersigned acknowledges receipt of this Addendum No. 2 and the Proposal submitted is in accordance with information, instructions, and stipulations set forth herein.

PROPOSER: **Preferred Governmental Claim Solutions (PGCS)**

BY: ____________________

DATE: June 30, 2016

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