Request for Proposal

Third Party Workers' Compensation Claims Administration and Managed Care Services

East Bay Regional Park District

www.ebparks.org

Issue Date: January 16, 2018

Due Date: 5:00pm, February 9, 2018

East Bay Regional Park District
Request for Proposal
Workers' Compensation TPA Services
Contract period: July 1, 2018 – June 30, 2023

ISSUE DATE: January 16, 2018

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PROPOSAL DUE DATE: 5:00pm on February 9, 2018

SUBMITTAL LOCATION: email proposal to:
afong@ebparks.org
East Bay Regional Park District

TENTATIVE INTERVIEW: Monday, March 12, 2018

PROPOSAL CONTENT:

I. Introduction

The "East Bay Regional Park District" is interested in obtaining competitive proposals from qualified third-party administrators (TPA) for administration of the District's self-insured workers' compensation claims including bill review, utilization review, and nurse case management (collectively called "managed care services"). The District seeks a service provider with experience in public entity workers' compensation self-insurance that promotes a proactive approach to manage and administer benefits in accordance with California State Laws and statutes with a focus on quality care.

It is the District's intent to contract with an experienced firm to provide claims administration and managed care services for all new and existing self-funded workers' compensation claims. **The contract period is for 5 years beginning July 1, 2018 and terminating on June 30, 2023, with an option to negotiate a two-year extension. The contract will be subject to annual review, satisfactory performance of TPA services, and satisfactory negotiation of contract terms. The District desires to obtain bids for a "bundled" program so completion of Attachments A-1 through A-4, B and C in its entirety is imperative in order to be considered in this RFP process. It is anticipated that oral interviews will take place on March 12, 2018.**

This RFP requires that interested firms submit specific information in accordance with Section VI (proposal requirements) and Section VII (cost proposal). Bidders may expand on the information requested and/or provide other related information.

The contract will require the selected TPA operate under the general direction of the District and consult District personnel in developing effective procedures and practices to successfully administer the District's self-insurance program for worker's compensation. It will also require the claims administrator meet all legal requirements of the State of California Department of Industrial Relations, Division of Workers' Compensation including the California Labor Code, rules and regulations of self-insurance, and the California Administrative Code. In addition, the claims administrator must comply with conditions of the District's excess insurance contracts, performance standards, and labor contract provisions. Kaiser Permanente is the District's current designated medical provider.

A copy of the most recent East Bay Regional Park District Public Self-Insurer's Annual Report is attached for informational purposes.

The final decision and award of the contract will be made to the proposing firm evaluated as offering the best combination of services and cost. The District reserves the right to reject any or all proposals received.

II. Background

About the District

Established in 1934, the East Bay Regional Park District is a multi-county special district that operates 73 parks covering more than 121,030 acres of land including 1,250 miles of trails for hiking, biking, horseback riding and nature study. The District offers lakes, shorelines, campgrounds, visitor centers, interpretive and recreational programs, picnic areas, indoor/outdoor rental facilities, golf courses and much more. The District employs over 700 permanent regular employees, to include police/fire personnel, 250 temporary seasonal employees, and some volunteers that are also covered for workers' compensation benefits. The District has a seven-member elected Board of Directors and the adopted budget for 2017 is $210 million. The Risk Management department operates under the auspices of the Legal Division and works closely with its workers' compensation TPA to ensure benefits are properly and timely administered to injured workers. For additional background information on the District, please visit www.ebparks.org.

Employee Benefits

All employees have a defined benefit pension plan under CalPERS or TransAmerica.

The District's Public Safety Division has about 70 sworn police and fire officers covered under Labor Code Section 4850. Non-sworn Public Safety personnel with at least six months of service are covered by the District's Police Association contract that allows for up to one year of job injury leave. All other permanent employees are eligible for up to six months of full salary continuation under the Job Injury Leave benefit.

Claim Information

The current claim count as of December 31, 2017: Indemnity (54), Medical (14), and Future Medical (76), totaling 144 open claims. The number of claims filed in the past five calendar years is as follows: 122 claims (2017), 115 claims (2016), 119 claims (2015), 117 claims (2014), and 96 claims (2013). Outstanding reserves for open claims as of December 31, 2017 is $6,365,733.

Excess Coverage

Currently, the District is a member of the California State Association of Counties – Excess Insurance Authority (CSAC-EIA) for excess workers' compensation coverage. The current self-insured retention is $350,000. Prior to July 1, 2009, the District was a member of Local Agency Workers' Compensation Excess Joint Powers Authority (LAWCX) and other excess carriers with varying self-insured retention thresholds.

Current TPA & Staffing Structure

The District has been self-insured for workers' compensation since 1980. Its workers' compensation program is currently administered by Athens Administrators. Current staffing is a

dedicated senior claims examiner (110 claim files – can have up to 150 maximum files), claims assistant (10 medical only files – can have up to 25 maximum files) and future medical examiner (24 future medical files – has 170 other client files). They are under the supervision of a claims supervisor and division manager. Future medical files are counted as a 1:1 ratio. **It is the desire of the District to maintain this staffing model.**

Managed Care (Bill Review, Utilization Review, and Nurse Case Management)

Ancillary services for medical bill review, utilization review, and nurse case management are presently bundled with the current TPA. Nurse case management is assigned with the approval of the District on a case by case basis; nurse case management are reserved for complex or one-time task assignments.

Third Party Subrogation

The District handles its own third party recovery.

III. General Expectations

The District knows it is in good hands with a company that understands the extraneous issues that surround public entity workers' compensation accounts. But just like people, each public entity has its personality. The District has a strong culture of respect and values its employees.

As in all public entities, the District likes to keep a hands-on approach to the various issues. It is expected that the following protocols are followed in every claim:

Three point contact:

We believe this contact must continue after the initial case set up. We expect to see communication between the examiner, the injured worker, and the District on any claim where there is long-term disability or other complex issues. It is also expected that phone calls be returned within 24 hours of receipt and emails responded to within 48 hours.

Risk Department notification:

The Risk Manager is the key contact person for questions in relation to District policies to include Job Injury Leave, work statuses, wage information, temporary disability entitlements, and return to work issues. The Risk Manager works in much the same manner as other entity contacts though there may be more involvement in our Job Injury Leave program. When there is knowledge of a possible long-term disability it is important that the District be advised, as it triggers the process for potential backfilling of the position. Constant communication between the District and TPA is crucial as the District can be used as an internal resource for resolving claims. Permanent & stationary reports with permanent work restrictions should be reported to the District as soon as they are received. This may have a crucial impact on the determination of the injured employee's ability to return to work.

Whenever there is a dramatic increase in reserves, a reserve increase that will involve the excess program (CSAC-EIA or LAWCX), an issue that may involve the Union, or assistance needed with complex or stalled issues, the Risk Manager should be contacted.

The settlement authority levels are not delegated because of the way the District operates. However, you should expect a prompt reply on all settlement requests.

Return to Work Program

The District's successful Return to Work Program has been instrumental in getting injured employees back to work expeditiously. A release to modified work is acted upon almost immediately to bring the injured worker back to work. Often, the Risk Manager is the frontline contact for supervisors who receive this information before the TPA. However, it is protocol for the TPA to solicit this information from the doctor for employees that remain off work for extended periods of time.

Utilization Review (UR):

Utilization review is a helpful resource in controlling costs. However, when there are multiple issues that may require the overriding of the UR analysis or procedure, the District is available to discuss the issue. The expectation is that the UR process and review of the determination happens in a timely manner.

Other Resources:

The District has an informal list of defense attorneys.

IV. Minimum Qualifications

Each proposal received by the District will be evaluated to determine if the proposing firm meets the following minimum qualifications. Proposals that do not meet these minimum qualifications will not advance in the RFP process.

A. The firm, its principals, and its lead claims examiners servicing the District shall have at least five (5) years of experience in California as a third party workers' compensation administrator and provider of ancillary services such as bill or utilization review for public entities.
B. Proposed claims service office is located in close proximity to the SF Bay Area and provides assurance of reasonable staffing at that location for the term of the contract.
C. If awarded contract, the TPA shall procure and keep in force during the terms of the contract, at the TPA's own cost, the following policies of insurance with companies licensed to do business in the State of California which are rated at least "A" or better by A.M. Best Company and which are acceptable to the District: 1) General liability of $1 million per occurrence and at least $2 million in aggregate for bodily injury, personal injury, and property damage 2) Automobile liability of $1 million per accident for bodily injury and property damage 3) Workers' compensation as required by the Labor Code of the State of California

and Employer's liability limits of $500,000 per accident 4) Professional errors and omissions of $1 million per occurrence and $2 million in the aggregate. The specific requirements of each of these policies will be stipulated on the Contract for Services to the awarded firm.

V. Scope of Work

Claims Administration

A. Provide one "dedicated" public agency experienced senior claims examiner who possesses a self-insurance certificate to administer the District's claims. Caseload not to exceed 150 files. Provide a claims examiner assistant (caseload not to exceed 25 medical only files) as well as future medical claims examiner if necessary. See "Current TPA & Staffing Structure" under the background section of this RFP for current staffing structure. Future medical claims are counted as a 1:1 ratio.
B. Determine liability for claimed injuries and illnesses on a timely basis and in accordance with the California Labor Code;
C. Determine eligibility for and authorize payment of medical and indemnity benefits on a timely basis;
D. Maintain a current diary that supports review of each file every 30 days, but in no event to exceed 45 days; Supervisory review at 90 days;
E. Three point contact shall be concluded within 24 hours after receipt or knowledge of a claim; calls will continue to the injured worker every 2 weeks if off work, once a month if modified until released to full duty;
F. Provide access to claims examiner diaries to the District at no charge;
G. Review, compute, and after approval by the District, pay all informal ratings, findings and awards, and settlements; arrange for informal disability ratings whenever possible to avoid unnecessary litigation;
H. Pay any and all penalties due in accordance with the California Labor Code. Such penalties shall be paid by the claims administrator with liability for the action determined by record unless penalties were incurred as a result of the District's action or inaction;
I. Establish files containing medical and factual information on each reported claim, together with complete accounting records and maintain in accordance with statutory time requirements;
J. Prepare, file, and maintain all information and reports as required by the State of California, Department of Self-Insurance;
K. Provide the District with information and recommendations for implementation strategies for changes or proposed changes in statutes, rules and regulations affecting the District under the California Labor Code for workers' compensation;

L. Review with the District the program's progress, including identification of problem areas and recommended solutions and attend quarterly and monthly meetings required by the District;
M. Establish procedures to support the payment of all benefits and allocated expenses together with appropriate documentation necessary to reconcile a trust fund checking account provided by the District;
N. Perform regular indexing thru the District's relationship with CSAC-EIA that provides this service at no cost to the District;
O. Provide, at no cost to the District, informational pamphlets as required by the State of California relative to their workers' compensation benefits;
P. Refer litigated cases to defense attorneys approved by the District for the purposes of defending the District's interest before the Workers' Compensation Appeals Board and courts of law;
Q. Track data to include total off work and modified days for Cal OSHA reporting;
R. File the District's Federal and State Form 1099 for Workers' Compensation vendors;
S. Produce computer generated reports as specified by the District;
T. Coordinate Medicare and Medicaid set aside agreements in compliance with Section 111 of the MMSEA including required reporting;
U. Comply with CSAC-EA claims administration guidelines (October 4, 2013 amended copy attached) and LAWCX protocols for claims prior to 7/1/09.

Bill Review

A. Review all bills in a timely manner for compliance with applicable fee schedules and reduce accordingly, including those that fall outside of a fee schedule or PPO network;
B. Identify and reduce all duplicate billings;
C. Deny charges for all items not required for injury described;
D. Identify all unauthorized charges to insure billing does not exceed parameters of injured workers' treatment plan;
E. Maintain contracts with effective PPO organizations (including pharmacies), that include providers in the Alameda and Contra Costa counties;
F. Provide reports on a monthly and annual basis outlining bill review activity, savings and costs. Provide ad hoc reports as requested;
G. Provide a computer system that interfaces with both the District's workers' compensation TPA and utilization review provider;
H. Handle all provider inquiries regarding bill reductions.

Utilization Review

A. Certify, modify, or deny service requests within the applicable time standards and provide medical advice as warranted;
B. Provide timely reports to the District outlining utilization review requests, approvals, denials, and cost/savings;
C. Provide a computer system that interfaces with the selected TPA and bill review service provider.

Nurse Case Management

A. Provide telephonic and field case management nurses as requested by the District on a case by case basis;
B. Maintain close liaison with selected doctors and ensure maximum efficiency in the management of claims by practicing proactive case management and return-to-work when clinically feasible;
C. Coordinate all medical management services with the selected TPA and ancillary service providers as necessary.

VI. Proposal Requirements

General Submittal Requirements

Bidders submitting proposals must include (1) a written response to proposed services AND (2) cost proposals for all services. **Cost proposals must be submitted in accordance with Section VII - Cost Proposal**.

The following elements are required for ALL proposals:

A. Cover Letter – To include the title of the RFP, name and mailing address of the firm, contact person, telephone number and email address. Acknowledgement that your proposal is public information and may be released to any person who requests it. If any information is considered proprietary and not to be released to the public, you must specifically designate such information. The cover letter must be signed by an officer authorized to sign on behalf of the firm and enter into contracts.

B. Cost Proposal – Each bidder must include a cost proposal for the proposed services in accordance with Section VII - Cost Proposal. The District is seeking a bundled program so please complete all cost proposal worksheets located in the Attachment section of this RFP. Do not make any reference to cost, fees, rates, estimated savings, or other financial

details in your written proposal response. The cost proposal attachments shall be included in a separate section of your proposal and clearly identified.

C. Proposal Exceptions – Each bidder must complete and submit **Attachment B - Proposal Exceptions** when submitting proposals, regardless if an exception is taken to the proposed scope of work, performance expectations, insurance requirements or any other information contained in this RFP.

D. Client References – Each bidder must complete and submit **Attachment C – Client References**.

Specific Submittal Requirements

Bidders shall submit a proposal for all components outlined in this section. Some of the written requirements are common to the four components, however, each section must have its own response for each component.

Claims Administration

A. Service Team Qualifications: Provide an organizational chart outlining your proposed service team including names, titles, and length of service in your organization. For each proposed team member, provide a summary of qualifications including claims handling experience, indemnity case load, experience working with public entity self-insured entities, education, and any professional designations and awards. Include full resumes for each member of your proposed service team. If you have not designated staff to service the District's account, provide the selection criteria/qualifications for any staff necessary to service the District's account.

B. Claims Administrative Services: Section V - Scope of Work- Claims Administration Services lists a majority of what is expected of the TPA if awarded the contract. Please answer the following specific questions as it relates to claims administrating handling:

1. How will you specifically staff the District's account? In the event that the District's files exceed 175 files, how will you handle the overflow? What is your contingency plan for claims handlers in the event of absences?
2. Describe the performance standards for your claims examiners? What happens if a claims examiner is not able to keep up with his/her diaries?
3. How do you monitor for excess recovery?
4. Please outline your usual and customary procedure for processing a new claim, how reserves are established/monitored and your firm's philosophy on claims handling.

Please explain your approach to handling questionable and delayed claims. Before issuing a denial or acceptance of such a claim, please explain whether your actions will be discussed with District staff and their input considered.

5. Please explain your role in administering a Return to Work Program. How do you monitor claims for referral to the District's program, particularly if the employee's work status is "off work?" How often do you check with the physician in returning an employee back to modified work following surgery? How timely would you refer a claimant to a Return to Work Program once notified by a physician?
6. Elaborate on what kind of communication we can expect surrounding the District's claims? What is your philosophy regarding client involvement in handling claims?
7. Explain how professional vendors (attorneys, doctors, and investigators) are monitored for quality and cost control.
8. Do you have a Pharmacy Benefits Management (PBM) program? What kind of savings can the District expect from the involvement of such a program? Is there a cost to the District for involvement in the PBM?

C. Ancillary Services: Identify any company-owned and affiliated ancillary services to include, but not limited to, bill review, utilization review, and nurse case management. Provide a description of each ancillary service including an organizational chart, physical location, description of where the work is being conducted, management structure, and number of employees.

D. Claims Management System: Describe in detail how your computer system is utilized to provide workers' compensation services. Discuss the capabilities of the system including whether the system tracks lost time, temporary modified duty and temporary partial disability. Provide samples of standard and customized computer-generated reports you prepare for your clients (note: limit 1-2 pages per sample). Indicate which reports are included in the proposed fee for service and which will involve a supplemental cost. Explain your in-house computer support system and training to clients.

E. SSAE 16/SOC 1 (formerly SAS 70) Audit Compliance: Indicate your firm's compliance with SSAE 16/SOC 1 annual audit compliance reporting and indicate the date and results of the most recent completed audit report.

Bill Review

A. Firm's Qualifications: Describe the firm and provide a brief statement of qualifications in providing bill review services. Describe your experience doing business with self-insured public entities in California. Discuss what distinguishes your company from other bill

review providers. Provide a company-wide organizational chart with reference to the proposed service office and proposed service team.

B. Service Team Qualifications: Provide a brief summary of the qualifications and experience of each proposed team member, including their length of service with your firm and their resume. Provide an organization chart representing your staff and identify any sub-consultants you plan to utilize to supplement your proposed staff.

C. Services: Describe your bill review services, features of your system, unique capabilities, and ability to customize the delivery of your services. Provide an organizational chart, physical location, description of where the work is being conducted, management structure, and number of employees.

Utilization Review

A. Firm's Qualifications: Describe the firm and provide a brief statement of qualifications in providing utilization review services. Describe your experience doing business with self-insured public entities in California. Discuss what distinguishes your company from other utilization review providers. Provide a company-wide organizational chart with reference to the proposed service office and proposed service team.

B. Service Team Qualifications: Provide a brief summary of the qualifications and experience of each proposed team member, including their length of service with your firm and their resume. Provide an organization chart representing your staff and identify any sub-consultants you plan to utilize to supplement your proposed staff.

C. Services: Describe your utilization review services including standards and guidelines you use to review treatment requests. Please indicate when a review would require a nurse review versus a doctor review. Describe any unique capabilities or approaches your firm has for reviewing medical treatment requests. Discuss any methods you employ to help clients reduce utilization review costs. Provide an organizational chart, physical location, description of where the work is being conducted, management structure, and number of employees.

Nurse Case Management

A. Firm's Qualifications: Describe the firm and provide a brief statement of qualifications in providing nurse case management services. Describe your experience providing telephonic and field case management in California. Indicate the office location nurses

would be working from. Discuss what distinguishes your company from other nurse case management providers. Provide a company-wide organizational chart with reference to the proposed service office and proposed service team.

B. Service Team Qualifications: Provide a brief summary of the qualifications and experience of each proposed team member, including their length of service with your firm, whether they are licensed registered nurses.

C. Services: Describe your nurse case management services including guidelines and expectations regarding your nurse case management program. Describe any unique capabilities or approaches your firm has in providing nurse case management services. Provide an organizational chart, physical location, description of where the work is being conducted, management structure, and number of employees.

VII. Cost Proposal

The District is requesting cost proposals for a bundled program so please complete all cost proposal worksheets in Attachment Sections A-1 through A-4 of this RFP.

VIII. General Guidelines

A. Costs for developing proposals are entirely the responsibility of the party.
B. Responding to the RFP shall not be chargeable in any way to the District. This RFP is not in any way to be construed as an agreement, obligation, or other contract between the District and any person or firm submitting a proposal.
C. Proposal shall be reviewed by the District and those deemed to be most qualified in the sole discretion of the District shall be scheduled for an interview.
D. The District shall not discriminate on the basis of race, color, ancestry, religion, creed, national origin, gender, sexual orientation, physical handicap, age and marital status in the award or performance of any contract or subcontract resulting from or relating to this contract.
E. The proposal will not constitute an agreement, but rather, will supply provisions which will be incorporated by reference into an agreement between the parties for claims administration and ancillary services.
F. The District reserves the right to withdraw this RFP at any time without prior notice. The District also makes no representation that any agreement will be awarded to any bidder responding to this RFP. The District expressly reserves the right to reject any and all proposals and to be the sole judge of the responsibility of any bidder and of the

suitability of the materials and/or services to be rendered. The District reserves the right to waive any minor irregularities, informalities, or oversights at its sole discretion. The term "minor" as used herein means any bidder or District irregularities or oversights that does not materially affect or alter the intent and purpose of this RFP, and does not provide an unfair advantage to a bidder.

G. If necessary, the District reserves the right to contract directly with any ancillary service (i.e., bill review, utilization review) that it deems would better serve the District for cost efficiency and service delivery. It is expected that claims adjusting firm shall cooperate with any such ancillary service.

H. Any party submitting a proposal shall not contact or lobby any District Board member, District employee (except those specified for contact) or agent regarding the RFP. Any party attempting to influence or circumvent the RFP, bid submittal, and review process may have their bid rejected for violating this provision of the RFP.

I. With regard to any proposal sent by mail to the District, the proposer shall be solely responsible for its delivery to the District prior to the date and hour set forth herein. Any proposals received subsequent to the date and hour set forth herein, because of delayed mail delivery or any other reason, will not be considered by the District.

J. The District reserves the right to reject any or all of the proposals received, to negotiate with qualified proposers, or to cancel the request for proposals in part or in its entirety without explanation to the proposers.

IX. Attachments (A-1 through A-4, B, C)

See attachments A-1 through A-4, B, C

Attachment A-1 Claims Administration Cost Proposal

Complete and include this cost proposal worksheet for workers' compensation claim administration services.

1. **Claims Administration Services**

Proposed **FIXED SUM** for Workers' Compensation Claims Administration Services to include assumption of all open claims, new indemnity, new medical only, new first aid, and all future medical claims for the proposed **FIVE** (5) year contract period:

YEAR 1 (July 1, 2018 - June 30, 2019) *(if applicable, include data conversion/transfer charge)*	**$**_____
YEAR 2 (July 1, 2019 - June 30, 2020)	**$**_____
YEAR 3 (July 1, 2020 - June 30, 2021)	**$**_____
YEAR 4 (July 1, 2021 - June 30, 2022)	**$**_____
YEAR 5 (July 1, 2022 - June 30, 2023)	**$**_____
TOTAL 5 YEARS (July 1, 2018 - June 30, 2023)	**$**_____

The cost related to claims administration for the proposed FIVE (5) year contract period should include standard and customized reports and computer access fees (2 users). If there is a data transfer/conversion charge, please include in the cost for Year 1. If there are any other associated costs not mentioned, please indicate in the comments section below.

Comments:

_____

_____

_____

Submitted by:

_____

(Firm Name)

_____

(Signature of Individual Authorized to Bind on Behalf of Firm) (date)

Attachment A-2 Bill Review Services Cost Proposal

Complete and include this cost proposal worksheet for bill review services. Proposals that do not contain this cost proposal may be rejected.

1. **Bill Review** (*indicate pricing under correct column)*

	Flat Fee	OR	% of Savings / CAP
Hospital Inpatient (Non-PPO)	$_____		%_____ / $_____
Hospital Inpatient (PPO)	$_____		%_____ / $_____
Hospital Outpatient (Non-PPO)	$_____		%_____ / $_____
Hospital Outpatient (PPO)	$_____		%_____ / $_____
Medical (Non PPO)	$_____		%_____ / $_____
Medical (PPO)	$_____		%_____ / $_____
Pharmacy	$_____		%_____ / $_____

2. **Other Services Associated with Bill Review (Specify service and cost, if any - i.e. specialty bill negotiations for bills outside of PPO/CA Fee Schedule & duplicate bills):**

_____

_____

_____

Submitted By:

_____

(Firm name)

_____

(Signature of Individual Authorized to Bind on Behalf of Firm) (date)

Attachment A-3 Utilization Review Services Cost Proposal

Complete and include this cost proposal worksheet for utilization review services. Proposals that do not contain this cost proposal may be rejected.

1. **Utilization Review**

Flat fee per review (nurse) $_____

Describe what constitutes this type of review:

_____

_____

Flat fee per review (doctor) $_____

Describe what constitutes this type of review:

_____

_____

Reviews containing more than one treatment request:

Is there an extra cost for multiple treatment requests on same request? ____Yes ___No

If yes, how is this billed?

_____

_____

Special reviews $_____

List types (i.e., peer to peer, etc.):

_____

_____

2. **Other Services Associated with Utilization Review** (Specify service and cost, if any):

_____

_____

Submitted By:

_____

(Firm Name)

_____

(Signature of Individual Authorized to Bind on Behalf of the Firm) (date)

Attachment A-4 Nurse Case Management Services Cost Proposal

Complete and include this cost proposal worksheet for nurse case management services. Proposals that do not contain this cost proposal may be rejected.

1. **Nurse Case Management**

   Per telephonic review: $_____

   Field review, per hour: $_____

2. **Other Services Associated with Nurse Case Management** (Specify service and cost, if any):

_____

_____

_____

Submitted By:

_____

(Firm Name)

_____

(Signature of Individual Authorized to Bind on Behalf of Firm) **(date)**

Attachment B **Proposal Exceptions**

Please indicate any exceptions to the proposed scope of work, general expectations, insurance requirements or other information contained within this Request for Proposal:

_____

_____

_____

_____

_____

_____

____ Check here if there are **NO** exceptions.

Submitted By:

_____

(Firm Name)

_____

(Signature of Individual Authorized to Bind on Behalf of Firm) (date)

Attachment C Client References

Please list five (5) current clients with full contact information to include name of company, contact person, and contact phone number from which similar types of claims-related services are provided by your proposed service team office. Also, list the same information for any clients that you have lost in the last 5 years.

CURRENT CLIENTS:

1)_____

2)_____

3)_____

4)_____

5)_____

CLIENTS LOST IN THE LAST FIVE YEARS:

1)_____

2)_____

3)_____

4)_____

5)_____

The District may contact these references to discuss the bidder's performance.