10. Claim Administration Procedure Manual

CLAIMS ADMINISTRATION PROCEDURE MANUAL (CAPM)

The CAPM is a listing of the general claim handling procedures followed by the Group Claims Department. It is reviewed yearly as part of the Plan of Risk Management.

New Jersey School Boards Association Insurance Group

CLAIM ADMINISTRATION PROCEDURE MANUAL

2012/2013

A. CLAIMS RESPONSE AND RESERVING

1. CLAIM DEPARTMENT STATEMENT

a. Customer Service

The goal is to provide extraordinary claim service to all member districts, as our membership ultimately determines the degree of success of our department. Of significance is the strong need to have all our members feel a partnership in developing case conclusions.

b. Quality Services

Departmental procedures in the claim handbook have been developed to meet the present and future needs of our members. Such procedures are constantly reinforced with pride in "doing things right the first time", thereby building membership loyalty. Getting consistent results is the clearest measure of quality services.

c. Productivity through People

The department's services are truly "people intensive" as people are considered the highest value. All business begins with people as clients. Likewise, the support staff of the department will provide extraordinary member service as partners with the membership.

d. Integrity

There are no degrees of integrity. "Doing what we say and when we say it will be delivered" is the cornerstone of integrity as is honesty, fairness, ethics and legality. There is never room for compromise around integrity.

e. Reporting

In addition to the following reporting and other requirements, any member district shall have access to their files in our computer system.

STANDARDS OF PERFORMANCE

2. GENERAL LIABILITY/AUTO/E&O

a. Coverage's

Claims will be promptly reviewed for coverage with the expected result being a prompt, accurate coverage determination. If there is a question on coverage the issues will be documented and the matter reviewed. If issues of coverage remain, the matter will be referred to general legal counsel or coverage counsel with a request for a timely determination. Excess and/or reinsurance carriers will be informed as needed. Upon determination of coverage any remaining questions or issues will be documented and communicated to the covered party with a reservation of rights document.

b. Initial Technical Processing

New losses are assigned promptly and entered into the claim system within one business day of receipt. Appropriate initial reserving is completed. All bodily injury/emotional distress cases are filed with ISO Claim Search.

c. Clerical Processing

An insured acknowledgement letter is sent out upon file set up with a copy to the broker.

d. Insured/Claimant Contact

1. All insureds must be contacted within one business day of assignment to the claim handler.

2. Unrepresented claimants should be verbally contacted within two business days of assignment.

3. Claimant attorneys should be contacted verbally within three business days of assignment, followed up by a confirmation letter.

e. Investigation

1. All claims involving serious exposure, and/or questionable liability, whenever possible a statement that is either written or recorded will be obtained from an unrepresented claimant(s).

2. All cases where there is an expectation that a claim will be made, it will require a full detailed investigation relative to exposure, liability and subrogation/mitigation.

3. In cases involving serious exposure and/or discrepancies of fact(s), if a witness exists, a statement should be taken, as soon as their identity is known or within (30) thirty days of assignment.

f. Reporting and Communication

1. The claim file should be posted with all significant file developments. General correspondence should be answered in a reasonable timely fashion depending on the request.

2. All reserves over $75,000 should be reviewed and approved by the supervisor and/or management.

3. All reserves over $125,000 should be reviewed with and approved by the assistant or claim manager.

4. Claims that are 50% of retention, catastrophic losses or that meet the criteria under any of our reinsurance or excess reporting guidelines shall be reported to the reinsurer/excess carrier immediately.

5. All files must be on supervisor's diary. All files must be on the claim handler's diary. Updates must be provided to the insured or their broker upon request.

g. Direction

Initial and subsequent supervisory direction should be noted in file. Reserves should be updated when appropriate. Effective diary control shall be maintained. Supervisor approval is required for any independent experts needed and not on our approved vendor listing and the claim handler must obtain the qualification and rate structure.

h. Recovery/Subrogation/Contribution

1. Subrogation recovery and /or contribution potential for all claims shall be properly recognized and investigated and documented in the claim file.

2. Any subrogation, compromise or closure without recovery must be approved by management. Recovery/contribution shall be properly followed up on and concluded conducive toward maximizing the Insured's/Group's objectives and interests.

j Disposition

All claims should be finalized at the earliest possible time or after special damages are verified, and liability is known. Evaluation/authority should reflect liability, damages and mitigation. Negotiations should commence as soon as the above occurs.

j. General

1. Proper initial loss codes shall be utilized. Loss Control is to be notified as to any condition which should be corrected to prevent future occurrences. Loss Control will do a follow up to make sure the condition is brought to the attention of the appropriate district representative.

2. For all physical damage automobile losses where damages exceed $1,999 the vehicle must be inspected by an independent auto appraiser within five business days of assignment and concluded within ten business days. Two estimates must be obtained where damages are less than $2,000 and reviewed for reasonableness by the claim handler before payment is made.

3. CMS reporting under Section III will be complied with in all qualifying cases.

3. WORKERS' COMPENSATION

a. Coverage's

Coverage issues are promptly recognized, reviewed with management, and resolved properly.

b. Initial Technical Processing

New losses are assigned promptly and entered into the claim system within one business day of receipt. Appropriate initial reserving is completed. All lost time cases are filed with ISO Claim Search.

c. Clerical Processing

An insured acknowledgement letter is sent out upon file set up with a copy to the claimant. A medical authorization request letter and medical only acknowledgement letter are sent within two business days of request.

d. Insured/Claimant Contact

All insureds must be contacted on lost time cases, within two business days of assignment.

e. Investigation

1. All claims involving questionable medical casualty, serious exposure, or subrogation, the claimant should be interviewed or statement obtained.

2. All cases involving questionable medical casualty, serious exposure, or subrogation, detailed insured investigation should be accomplished.

3. In cases involving discrepancies of fact(s), if a witness exists a statement should be taken as soon as their identity is known or within (30) days of assignment.

f. Reporting and Communication

1. The claim file should be posted with all significant file developments. General correspondence should be answered as dictated by the claim file or on diary, whichever is first.

2. All reserves combined over $75,000 should be reviewed and approved by the supervisor and/or management.

3. All reserves combined over $150,000 should be reviewed with claim manager.

4. Claims that are at 50% retention, catastrophic losses or that meet criteria under any of our reinsurance or excess reporting guidelines shall be reported to the reinsurer/excess carrier immediately.

5. Insured should be periodically updated as to status of all loss time cases. Light duty must be explored in all cases.

Direction

Initial and subsequent supervisory direction should be noted in file. Reserves should be updated when appropriate. Effective diary control shall be maintained. Expense control should be maintained through proper utilization of outside services. Outside services must provide a pricing list for their services indicating charges as well as proof of insurance, if not on the approved vendor list.

h. Recovery/Subrogation/Contribution

1. Subrogation potential for all claims shall be properly recognized and investigated and documented in the claim file.

2. Subrogation/contribution shall be properly followed up on and concluded conducive toward maximizing the Insured's/Group's objectives and interests.

i. General

1. Proper initial loss codes shall be utilized. Loss Control is to be notified as to any condition which should be corrected to prevent future occurrences. Loss Control will do a follow up to make sure the condition is brought to the attention of the appropriate district representative.

2. Compensability analysis shall be proper and in accordance with State Law.

3. Initial indemnity payment on all loss time cases shall occur within twenty one business days of receipt of loss.

4. Medical bills should be process/paid within ten business days of receipt.

5. Lost wages/permanency are to be properly calculated based on current law and disability chart. Disability is updated by the state annually.

6. Physician contact and control is completed based on the treatment plan through our managed care company along with our in-house team.

7. CMS reporting under Section III will be complied with in all qualifying cases. FROI and SROI must be complied with in accordance with state law.

4. PROPERTY

a. Coverage's

Claims will be promptly reviewed for coverage with the expected result being a prompt, accurate coverage determination. If there is a question on coverage the issues will be documented and the matter reviewed. If issues of coverage remain, the matter will be referred to general legal counsel or coverage counsel with a request for a timely determination. Excess and/or reinsurance carriers will be informed as needed. Upon determination of coverage any remaining questions or issues will be documented and communicated to the covered party with a reservation of rights document.

b. Initial Technical Processing

New losses are assigned promptly and entered into the claim system within one business day of receipt. Appropriate initial reserving is completed. Any loss involving asbestos, mold or any environmental hazard must be reported to the environmental impairment liability carrier.

c. Clerical Processing

An insured acknowledgement letter is sent out upon file set up with a copy to the broker.

d. Insured Contact

An insured acknowledgement letter is sent out upon file set up with a copy to the insured. Verbal contact with the insured business administrator within one business day of assignment and scope of damages must be documented in the claim file.

e. Investigation

An independent property appraiser from our approved vendor list should be assigned to verify damages, cause of loss and provide appraisal estimate for repair or replacement. This physical inspection must be completed within three business days of assignment. If no inspection is warranted receipts, purchase orders or other substantiated documentation must be obtained to verify and pay the loss. A police report must be obtained where there may be subrogation. All losses that may exceed $35,000 must be assigned to subrogation counsel.

f. Reporting and Communication

1. The claim file should be posted with all significant file developments. General correspondence should be answered in a reasonable timely fashion.

2. All reserves over $75,000 should be reviewed and approved by the supervisor.

3. All reserves over $150,000 should be reviewed and approved by the assistant or claim manager.

4. Status/updates must be provided to the business administrator at no longer than (30) thirty day intervals.

5. Claims that are reserved at 50% or more of retention or where there is a major loss must be reported to our excess/reinsurance carriers as soon as possible.

g. Direction

Initial and subsequent supervisory direction should be noted in the claim file. Reserves should be updated, when appropriate. Effective diary control shall be maintained. Expense control should be accomplished through proper utilization of outside services/experts. Supervisor approval is required for any independent experts needed and not on our approved vendor listing.

h. Recovery/Subrogation

Subrogation potential for all claims shall be properly recognized, investigated and documented in the claim file.

Subrogation shall be properly followed up on and concluded toward maximizing the Insured's/Group's objectives and interests. Any subrogation compromise or closure without recovery must be approved by the claim manager.

i. Disposition

1. Loss and damage information shall be properly verified.

2. Statement of loss prepared where necessary and authorization requests in the file shall be timely and of good quality.

3. Depreciation shall be considered and applied, where appropriate.

4. Proper deductible shall be applied.

j. General

Proper initial loss codes shall be utilized. Loss Control shall be notified as to any losses/occurrences which could constitute a future risk, that is another loss/occurrence which may happen if there is no intervention or correction of the risk. Loss Control will notify the insured of the correction needed and follow up to make sure it is addressed.

5. PRODUCTIVITY/PENDING STANDARDS

a. Pending Guidelines

Claim Representative	to 150
Field Claim Representative	to 75
Sr. Claim Representative	to 175
Claim Examiner	to 200
Medical Claim Assistant	to 125

Claim Supervisor shall have up to six adjusters under their direct supervision, with all adjuster files on an "override" diary.

b. Productivity Guidelines

1. The goal is for all technical personnel to maintain a "one for one" on average for files opened/closed, conducive with maintaining a stable pending within the pending guidelines.

2. All technical personnel, on average, can receive two new files assignments per day. Claim Assistant, can receive three to six new assignments per day.

6. LEGAL CLAIM HANDLING

a. Counsel Billing

1. Counsel billings must be on a per case basis. The itemized bill must contain a description of each charged activity, the date of service and the time allocated for each activity. The bill must indicate the total time spent, the hourly approved rate, and the total charges. The file handler is expected to audit each bill and communicate

with counsel on overcharges in terms of rates or activities conducted.

b. Legal Handling

1. On a general note, legal handling of counsel should be confined to the work, which only a lawyer is qualified to do. Investigative activities, etc. should generally be conducted by the file handler. As to negotiations, once suit is filed, generally defense counsel will handle. However, if a particular claim and the circumstances are such that it would be more advantageous to have the claim handler negotiate, then the claim handler should negotiate the claim. All negotiations should be documented in the file and formal notification will go out to the defense attorney to advise him/her of same.

7. CLAIM PAYMENT PROCEDURES

a. All indemnity payments, other than medical on all lines, are to be requested via completion of the input payment screen in the risk management information system (RMIS). Use of the repetitive payment option is recommended on long term compensation claims.

b. On bill payments, once a medical, legal, or service bill is determined to be proper, the claim handler highlights the amount to be paid, initials and dates it, indicates the payment and coverage kind and sends it to the bill processor for payment. A check of prior payments must be made to eliminate duplicate payments. Bills are to be paid within 10 calendar days of receipt, unless further clarification is necessary. IRS numbers found in the rolodex are to be used with all payments.

8. INCOMING/OUTGOING CORRESPONDENCE

a. All incoming mail is date stamped on same day received and placed in ImageRight as a task for the respective claim handler. Before the end of the business day, the claim handler will process the task, and determine if it needs to be worked on as a priority or work it on diary.

b. Any correspondence not identified within two business days will be brought to the attention of the claim handler's supervisor for further action.

c. If after two business days of receipt such correspondence still cannot be matched, supervisor will confer with the claim manager to decide upon a duplicate file set up.

d. All outgoing correspondence when typed will be "proofread" by the claim handler, signed and placed in the out bin or copied to the file. The claim handler or file clerk will then make sure a copy of such outgoing correspondence is placed into the ImageRight file, and place into the mail the original correspondence. This entire procedure should take no longer than one business day.

9. SURVEILLANCE & ACTIVITY CHECKS

a. This activity is conducted on cases of extended disability ~~cases~~ where the medical information does not coincide with the claimant's reported activity and cases on which fraud is suspected. Discuss planned checks with the insured prior to initiation.

b. Activity checks on benefit recipients in fatal and permanent total compensation cases must be conducted every six to twelve months.

c. All cases where surveillance is indicated, supervisory authorization must be approved and indicated in the claim file.

10. OUTSIDE INDEPENDENT ADJUSTERS ASSIGNMENTS

a. First level of priority for files needing "Field Work" shall be our internal staff.

b. If internal staff is unable to handle due to "volume" or lack of specialty in a particular claim area, approval for outside assignment must be given by file handler's supervisor. If supervisor agrees with outside recommendation, such approval shall be indicated in the claim file and shall further be recorded in the independent assignment log.

c. Only Independents on the Group's "approved" list shall be utilized.

d. The claim handler maintains direction and control of the independent. The claim handler based on the independents submission will make a liability assessment, reserve adjustments and determine the need for further work. Updates by independents are required at 30 day intervals.

11. REPORTING GUIDELINES

Claim handling reporting should be entered into the attachment screen of the claim file. These reports should be brief and to the point. Long dissertations,

except in unusual circumstances, are both unnecessary and unwarranted.

Time limitations are as follows:

For workers compensation/lost time cases, the report should be on the attachment screed within ten business days from receipt of the claim by the claim handler.

For general liability it will be fifteen business days; and for property it will be fifteen business days.

12. REPORTING GUIDELINES WORKERS' COMPENSATION

Workers' Compensation (Lost Time Cases) within ten business days from receipt by the claim handler.

1. Occurrence/Accident Description
2. Compensability Accepted/Denied – if denied explanation
3. Accepted/Injury
4. Subrogation
5. Follow up action plan (treatment, disability petition)
6. Reserve

The above information should be entered into the attachment screen with the category noted in the claim file. This information should be brief and to the point with an explanation in each category.

13. REPORTING GUIDELINES GENERAL LIABILITY/AUTO /E&O

General Liability/Auto /E&O within fifteen business days from receipt by the claim handler.

1. Description of Loss/Occurrence
2. Liability
3. Damages
4. Follow-up action plan
5. Reserves

The above information should be entered into the attachment screen with the category noted in the claim file. This information should be brief and to the

point with an explanation in each category.

14. REPORTING GUIDELINES – PROPERTY WITHIN FIVE BUSINESS DAYS FROM RECEIPT BY THE CLAIM HANDLER.

Property

1. Description of loss/Occurrence
2. Coverages
3. Damages/Scope
4. Follow-up action plan
5. Reserve

The above information should be entered into the attachment screen with the category noted in the claim file. This information should be brief and to the point with an explanation in each category.

15. REHABILITATION GUIDELINES - ADMINISTRATIVE CONTROLS

a. Criteria to be used in determining when a file should be referred for medical rehabilitation.

1. The following cases should mean immediate referrals:

- Spinal Cord Injuries
- Serious Head Injuries
- Amputations
- Severe Burn Cases
- Crush Injuries
- Heart Problems
- Stress -Related Disorders
- Serious Eye Injuries
- Complex Regional Pain Syndrome (RSD)

2. Other possible referrals within the first 8-10 weeks post-injury could include:

- Herniated Disc
- Multiple Fractures
- Exacerbation of Pre-existing Condition
- Exacerbation of Congenital Condition
- Extensive Over-treatment for an Obvious Soft Tissue Injury

A focus of rehabilitation is to assist the claimant in positive re-direction of his abilities, as well as to coordinate the medical aspects of the disability. Early identification and resolution of the barriers preventing a return to the labor market.

All referrals are to be made to our staff rehabilitation nurse. If our staff is unable to handle due to "volume" outside assignment shall be discussed with the supervisor, who will provide approval on the assignment, and enter in the rehabilitation nurse assignment log.

16. COMPLAINT HANDLING AND PROCEDURES

Complaint Handling

A consumer complaint may come from members, claimants, insurance departments, media, various organization and business.

There are reasons that create a complaint. Review of the following may assist in reducing the number of complaints:

a. First -Time Communication

1. Improper conduct by employee or the independent adjuster-appraiser.

2. Questionable claim handling.

3. Unreasonable delays.

4. Questionable business practices.

b. Second - Time Communication

1. Ineffective explanation as to how the claim was adjusted, to policy owner, claimant, etc., etc.

2. Inadequate file documentation

3. Mistakes on the file

4. Failure to follow-up with member, claimant, and other interested parties when requested.

A complaint is an opportunity to re-sell our position and to demonstrate the organization's commitment to service. This does not necessarily require a change in our position, but it most certainly requires a very prompt response.

Resolution should occur within a few hours; surely within one business day. If the matter cannot be resolved in this length of time the person complaining must be contacted with an explanation of the time they will receive a response.

If possible, the person charged with the responsibility of the file should resolve the complaint. If we've made a mistake, admit it, and rectify it immediate and willingly.

Mail or phone inquiries from the Insurance Department office and those complaints that can be handled on initial contact, need not be logged, all other complaints must be responded to within one business day. The following should be documented in case there is a re-opening of the inquiry.

Those verbal complaint-inquires that cannot be initially resolved and those received in writing should be handled in accordance with the following complaint procedure.

Responses to complaints must be factual with no subjective comments. Supervisor must avoid becoming "Super Adjusters". However, they are responsible for prompt and just resolution of the complaint.

Complaints are always reduced when the file is handled well the first time.

17. COMPLAINT PROCEDURE

a. Origin of the Complaint

b. Date Complaint is received in our Claim Department.

c. Our Completion and Routing

It is very important for the initial completion to be timely, accurate and with prompt follow up routing. Please handle as follows.

1. When the complaint is received, the person receiving the complaint will complete all applicable sections except the final disposition action. Please provide a clear, concise description of the complaint. All documents that accompany the complaint will be attached to the original, with a copy made for the Claims Manager.

2. Compliant Form Distribution - Original and one copy, with attachments, to claim handler's Supervisors for review and comments to claim handler on how the complaint can be used as a training tool.

3. Other Distribution - Claim Manager
Complaint Log

c. Update and Diary

1. Supervisor should diary for a complaint resolution within two business days.

2. Claim Manager should diary after five business days to determine that all complaints are properly handled.

d. Resolution

1. When the complaint is resolved, fill-out the steps taken/final resolution section, including the following:

a. Brief description of resolution; be specific and relate the facts of complaint only.

b. Attach copies of any letters or file notes that will become part of the permanent complaint file.

REMEMBER:

The complaint files are permanent records and subject to review by authorized individuals, such as State Insurance Department, attorneys, etc.

c. Claim Manager should diary review all correspondence before it is sent out.

2. If complaintant is not satisfied with our response they can go up the chain of command for resolution or clarification. The claim manager is responsible for making sure all are aware of the issues. This should be done via telephone or/and email to the NJSBAIG Board President or designee as soon as possible.

18. GENERAL COMMENTS

1. Complaints from the media, consumer groups, outside vendors, or other external customers must be immediately referred to the Director. Any reply must be reviewed and authorized by the Claim Manager.

2. Response to Insurance Department complaints should be immediate, with a written response no later than two business days after receipt.

3. Other complaints also need immediate response and again, should be resolved within two business days.

19. DISCRETIONARY SETTLEMENT AUTHORITY

As part of their service contracts with the Group, The Group will pay workers' compensation medical and wage loss benefits when such payments are warranted and within the requirements of the law and the guidelines and policy of the Group or as ordered by a court. In the majority of cases, it will be whether or not liability exists in a particular case, and proper statutory benefits will be paid promptly.

There will be some claim, however, where either liability or the amount of benefit due is contested. It is unnecessary and unproductive to litigate every such case, as the administrative procedures are lengthy and costly. Therefore, the Claims Department and the Director must have the authority to settle such cases with claimants on behalf of the Group.

Therefore, the Board establishes the following procedures for the settlement of contested claims:

Workers' Compensation Settlement Authority

Settlement Authority		Grade Level
$1—$ 500	Bill Processor, Medical Claim Assistant & Medical Claim Team Leader	5—9
$501—$30,000	Claim Rep. & Senior Claim Rep.	10—10A
$30,001—$80,000	Claim Examiner, Claim Legal Examiner & Field Claim Rep.	11—12A
$80,001—$110,000	Claim Supervisor	13
$110,001— $150,000	Assistant Claim Manager	15
$150,001—$200,000	Claim Manager	17
$200,001 - Up	Board of Trustees	

All of the above authorities would be given based on Claim Manager's discretion.

Note, it is recognized that where the Board of Trustees has approved authority and certain contingencies arise that it may be impossible to reconvene the Trustees in a timely manner to further consider previously recognized authority, that the Trustees authorize the Claim Manager, Archer & Greiner or designate to contact the school business official Trustee for the purpose of extending additional incremental authority on such previously extended cases, in an amount not to exceed 120% of the original extended authority. All such situations falling within the parameters of this scenario shall be reported by the Claim Manager to the Trustees at the next regularly scheduled Trustees meeting.

DISCRETIONARY SETTLEMENT AUTHORITY

On all liability lines the following authority levels will apply:

	Settlement Authority	Grade Level
$1—$5,000	Bill Processor	6
$5,001-$20,000	Claim Rep. & Senior Claim Rep.	10—10A
$20,001-$40,000	Claim Examiner, Claim Legal Examiner & Field Claim Rep.	11—12A
$40,000-$60,000	Claim Supervisor	13
$60,001-$80,000	Claim Manager	17
$80,001-$100,000	Claim Manager & Group Attorney	17
$100,001-$125,000	Claim Manager, Group Attorney & School Business Official Trustee	17
$125,001 —Up	Board of Trustees	

All of the above authorities would be given based on Claim Manager's discretion.

Note, it is recognized that where the Board of Trustees has approved authority and certain contingencies arise that it may be impossible to reconvene the Trustees in a timely manner to further consider previously recognized authority, that the Trustees authorize the Claim Manager, Archer & Greiner or designate to contact the school business official Trustee for the purpose of extending additional incremental authority on such previously extended cases, in an amount not to exceed 120% of the original extended authority. All such situations falling within the parameters of this scenario shall be reported by the Claim Manager to the Trustees at the next regularly scheduled Trustees meeting.

Errors & Omission Settlement Authority

Settlement Authority		Grade Level
$1—$5,000	Bill Processor, Medical Claim Assistant & Medical Claim Team Leader	6—9
$5,001—$20,000	Claim Rep. & Senior Claim Rep.	10—10A
$20,001—$40,000	Claim Examiner, Claim Legal Examiner & Field Claim Rep.	11—12A
$40,001—$60,000	Assistant Claim Manager	15
$60,001—$80,000	Claim Manager	17
$80,001—$100,000	Claim Manager & Group Attorney	17
$100,001-$120,000	Claim Manager, Group Attorney & School Business Official Trustee	17
$120,001—Up	Board of Trustees	

Note, it is recognized that where the Board of Trustees has approved authority and certain contingencies arise that it may be impossible to reconvene the Trustees in a timely manner to further consider previously recognized authority, that the Trustees authorize the Claim Manager or Archer & Greiner to contact the school business official Trustee for the purpose of extending additional incremental authority on such previously extended cases, in an incremental amount not to exceed 120% of the original extended authority. All such situations falling within the parameters of this scenario shall be reported by the Claim Manager to the Trustees at the next regularly scheduled Trustee meeting.

Establishment of Claims Committee: In the event settlement authority is needed before the next regularly scheduled meeting, a Claims Committee shall be established. The Claims Committee shall be comprised of the claim manager, the group attorney and up to three Board of Trustee members. The Claims Committee shall have authority to approve claims at or above the threshold established for the Board of Trustees, provided that the amount is recommended by both the claim manager and the group attorney. All three Trustee participants (NJSBAIG Chairman, NJSBAIG Vice-Chairman and NJSBAIG ASBO Representative) will be notified of any such meetings, however, only one Trustee is required to participate in order to extend settlement authority, in addition to the claim manager and legal counsel. Agreement by a simple majority of attendees, along with the recommendation of the claim manager and legal counsel, will be sufficient to establish claim settlement value.