TRU Services, A Liberty
Mutual Company
152 Conant Street
2nd Floor
Beverly, MA 01915
Phone: (978)564-0200
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AGGREGATE INSURANCE AND MONTHLY AGGREGATE ACCOMODATION CLAIM REQUEST FOR REIMBURSEMENT

PLAN SPONSOR: _____ CARRIER: _____

POLICY NUMBER: _____ CONTRACT BASIS: _____

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

MINMIMU AGREGGATE DEDUCTIBLE: _____

1. Total Paid Claims: $_____
2. Annual Aggregate Deductible (calculated) OR Minimum Aggregate Deductible: $_____
   (Please provide monthly census counts and monthly attachment point calculation as attachment)

3. Claims Exceeding Specific Deductible: $_____
4. Claims Paid Outside the Aggregate Contract: $_____
5. Reimbursement Requested: $_____

PLEASE INCLUDE THE FOLLOWING TO AVOID DELAY:

1. Paid claims analysis report showing name of claimant, incurred date, charge, payment amount and paid date;
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type (single or family);
3. Proof of funding. This must include monthly bank statements and/or deposit slips;
4. Void/Refund report for the policy period and two months following;
5. Benefit/Service code report;
6. Aggregate report – monthly loss summary report;
7. Specific report showing claimants who have exceeded the specific deductible and amounts paid;
8. Payments made outside the aggregate contract (dental, weekly income, vision, PPO Fees, medical records fees, RX admin);
9. Yearly check register;
10. Outstanding overpayments and subrogation issues;
11. RX invoices, if RX is a covered benefit.

PLEASE READ BEFORE SIGNING

I hereby certify that, to the best of my knowledge, after reasonable inquiry: (1) that the information stated herein is correct; (2) that the claim has been processed and is eligible in accordance with the Plan Sponsor's Benefit Plan; and (3) that all the indicated expenses have actually been unconditionally paid on behalf of the Plan as required by the Stop Loss Contract.

_____

Authorized Signature Title Date

_____

Claims Administrator Address

_____

City State Zip

_____

Phone Fax E-mail

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties..