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 attach monthly census counts and monthly attachment point calculation)
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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.