



**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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.