



Specific Excess Loss Notification of Potential Large Claim

High Cost DX High paid or pending IP stay of 5+ days Potential transplant Dialysis

Policyholder: _____ Policy Period: _____

Specific Deductible: \$ _____ Contract Basis: _____

Employee Name: _____ ID: _____ Date of Birth: _____

Hire Date: _____ Effective Date: _____ Termination Date (if applicable): _____

Claimant Name: _____ Date of Birth: _____ Relationship: _____

Effective Date: _____ Termination Date (if applicable): _____

COBRA Effective Date (if applicable): _____ Eligible for Medicare? Yes No

Claimant "Actively-at-Work" on Effective Date? Yes No

Is Claimant Covered by any other Group Insurance? Yes No

If Yes, Name of Carrier and Policyholder: _____

Total Claims **Reported** To Date: \$ _____ Total Claims **Paid** To Date: \$ _____

Amounts **Pending**: \$ _____ Estimate of Future / Total Liability: \$ _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Date of Onset: _____ On-Going Condition? Yes No

Current Physician: _____ Surgical Procedures: _____

Date(s) of Hospitalization: _____ Facility Name: _____

Is Facility In-Network? Yes No Contracted Discount: _____

Subrogation Involved? Yes No **If the diagnosis is related to an accident, please provide accident details.**

Case Management? Yes No CM Vendor: _____ **Please provide current CM report.**

Prognosis and Expected Treatment: _____

TPA _____ Contact Name _____

Telephone _____ Email _____

Signature _____ Date _____

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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 may be subject to prosecution for insurance fraud.