



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.