



225 TownPark Drive, Suite 145 Kennesaw, GA 30144
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AGGREGATE CLAIM FORM

Policy Holder	Contract Basis	Effective Date	Expiration Date
A. Total paid claims:		\$ _____	
B. Minimum Aggregate Deductible (Prorated*):		_____	
C. Calculated Aggregate Deductible:		_____	
D. Less claims exceeding loss limit:		_____	
E. Less Previous Monthly Accommodations:		_____	
F. Less claims paid outside the aggregate contract:		_____	
G. Reimbursement Due:		_____	
H. Refund Due Carrier:		_____	

Please Include the Following To Avoid Delay:

* Items preceded by an asterisk are required for an aggregate accommodation filing. All Items listed are required for a year end filing.

- *1. Paid Claims Analysis Report totaled by claimant, showing incurred date, charge, payment amount, payment date, including voids and refunds
- 2. Eligibility listing which identifies birth date, effective date, termination date and coverage type
- 3. Proof of Funding (This must include monthly bank statements and /or deposit slips)
- 4. Void/Refund report
- 5. Benefit/Service Code report
- *6. Aggregate Report – Monthly Loss Summary Report
- 7. Specific Report showing claimants that have exceeded the specific deductible/loss limit
- 8. Payments made outside the Aggregate Contract (i.e. Dental, Weekly Income, Vision, LCM fees, Medical Records Fees and Prescription Administration)
- *9. Cummulative Check Register for the filing period
- 10. Listing of outstanding overpayments and subrogation issues
- 11. RX invoices with detail listing if covered under the aggregate contract

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 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.

You must file reimbursement requests within 180 days after the end of the time specified for payment of claims under the Excess Loss Policy. Failure to do so may result in claim denial.

 Authorized Signature

 Title

 Date

 Claims Administrator

 Address

 City

 State

 Zip



Phone

Fax

Email Address