CARRIER_____

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

AGGREGATE STOP LOSS REIMBURSEMENT REQUEST

Mailing Address:
C/O Stop Loss Concepts, Inc.
5854 Heritage Landing Drive
East Syracuse, NY 13057

Employer/Policy Holder

Policy Number

Policy Type

Policy Period
From:
To:

TOTAL CLAIMS PAID DURING THE POLICY PERIOD	$ _____
Less Annual Aggregate Attachment Point	_____
Less Specific Claim Reimbursements Paid (provide details below)	_____
Less Specific Claims Pending (provide details below)	_____
Less Specific Claim Denials	_____
Less Benefits Paid Outside the Self Funded Plan	_____
Adjustments (provide explanation below)	_____
AGGREGATE REIMBURSEMENT REQUESTED	**$** _____

- Details of Specific Claims (Paid and Pending)

Name	Date	Total Amount

Other Adjustment Explanation:

The following items are required when submitting a claim (please check items included):

- ☐ Census Reports by month along with any retroactive census adjustments, including dependents, COBRA, etc.
- ☐ Large Claim Report (starting at $0)
- ☐ Refund/Void Report (Effective Date of Policy to Date)
- ☐ Proper documentation of adequate funding, i.e., bank statement from client (Policy Period)
- ☐ Check Register
- ☐ Information and documentation on all outstanding overpayments, subrogation or third-party liability
- ☐ Claim Benefits Summary (Policy Period)
- ☐ Claim and EOB for all claims over $5,000
- ☐ Cancelled Checks for all claim payments over $10,000 and for checks issued the last 2 months of policy period
- ☐ Lag Report
- ☐ Detailed report for Rx plan, if applicable
- ☐ Current Plan Document

Completed By:

_____ Third Party Administrator

( ) _____ Phone Number

_____ Date Completed

_____ Contact Person

Address:_____ City:_____ State_____ Zip_____