TOKIO MARINE HCC

Stop Loss Group
225 TownPark Drive, Suite 350, Kennesaw, GA 30144 USA
Tel: 800-447-0460

SPECIFIC NOTIFICATION / REIMBURSEMENT CLAIM FORM

☐ 50%/ Trigger Notification ☐ INITIAL CLAIM ☐ SUPPLEMENTAL CLAIM
Email to Stoplossnotifications@tmhcc.com Email to Claims Stoplossspecclaims@tmhcc.com ☐ Final Request

Policyholder Information

Plan Sponsor _____

Policy Year _____ Contract Basis _____ Specific Deductible $_____

Employee Information

Last, First _____ Gender ☐M ☐F SSN / Employee ID Number _____

Date of Birth _____ Date of Hire _____ Original Effective Date _____

Employee's Eligibility

☐Actively working {☐Full time (required number of hours/ week) ☐Part time ☐Reduced Hours} ☐ Retired (Date _____)

Coverage Terminated? ☐Yes (Date _____) ☐ No COBRA eligible? ☐ No ☐ Yes (premium paid through _____)

[If not actively working, please forward documentation from the Policyholder indicating how coverage is being continued (Sick Leave, Vacation/PTO, LOA, FMLA, COBRA]

COBRA Effective Date _____ COBRA Termination Date _____ Returned to Work Date _____

[Provide COBRA election form and proof of premium payments]

Claimant Information

Last, First _____ (If different from Employee) SSN/ Participant ID _____

Relationship to Employee _____ Date of Birth _____

Gender M ☐ F☐ Original Effective Date _____ Termination Date _____

(If different from Employee)
Is COBRA eligible? ☐ Yes ☐ No COBRA Effective Date _____ COBRA Termination Date _____

(If filing an *initial* claim, provide COBRA Election Form & complete premium verification)

Claimant covered by any other insurance plan? ☐ Yes Type _____ ☐ No (If no, the date OI last verified _____)

Please provide details _____ Effective Date _____ Carrier _____

Medicare Eligible? ☐ Yes ☐ No Medicare Effective Date_____ Disabling condition (if under 65) _____

Is Pre-existing applicable? ☐ Yes ☐ No Pre-Existing Condition _____

(Provide Pre-Existing/HIPAA documentation)

Claim Information

Diagnosis_____ Date Diagnosed _____ Prognosis _____

Claimant injured? _____ ☐No ☐Yes Date of injury _____ Place Injury Occurred _____

How did injury occur? _____

(Provide accident details received from the employee/claimant and copy of police report)

Subrogation applicable? ☐ Yes ☐ No Please provide details_____

Name of Primary Physician _____ Phone Number _____

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Has Large Case Management been implemented? ☐ Yes ☐ No Vendor _____

Claims Paid YTD $ _____ Claims Pending YTD $ _____

Claims Denied YTD $ _____ Future Liability YTD $ _____

If filing for Initial Claim Submission

Total TPA Paid [include Simultaneous Funding claims] $ _____
Less Specific Deductible $ _____
Reimbursement Requested $ _____

SIMULTANEOUS FUNDING REQUEST

I am requesting Simultaneous Funding in the amount of $_____ ***** for the above referenced Specific Stop Loss claim. I understand Simultaneous Funding is subject to the complete discretion of HCC Life Insurance Company. The Claim Administrator and Plan Sponsor must adhere to the criteria listed below for access the Simultaneous Funding Reimbursement option.

*** (The amount indicated must correspond to the documentation provided with the claim submission.)**

I verify and acknowledge that:

1) The Claim Administrator, prior to the expiration of the Stop Loss Policy, processed all eligible bills relating to this Simultaneous Funding request.
2) The Plan Sponsor has unconditionally paid all other claims for the Claimant.
3) The Simultaneous Funding option is a value added service that can be changed or withdrawn at the discretion of HCC Life without prior notice.
4) Simultaneous Funding requests **will not** be accepted if received within (30) thirty days of the date of the policy's cancellation or premature termination.

For Initial requests:

5) Checks totaling at least the amount of the Specific Deductible were processed, paid and released to the indicated providers prior to the expiration of the Stop Loss Policy, or prior to this request, whichever is earlier

HCC Life must receive written notice of Simultaneous Funding requests no more than (10) ten calendar days after the *expiration date* of the Policy. *A fully completed and signed Specific Notification / Reimbursement Claim Form, including the* ***Simultaneous Funding section*** *is required for each Simultaneous Funding request and should be in amounts equal to or greater than $500.*

I hereby certify that, to the best of my knowledge and after reasonable inquiry; (1) the information stated herein is correct; (2) the claim has been processed and is eligible in accordance with the Employee benefit plan; (3) all the indicated expenses have actually been unconditionally paid by, or on behalf of the plan as required in the Stop Loss Policy, except as specifically disclosed in the attached Simultaneous Funding form, if any.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Please refer to the HCC Life Insurance Company Notification & Claims Guide for complete details on our filing procedures including our Simultaneous Funding criteria.

Claim Administrator		**Email**	
Mailing Address			
Telephone Number		**Fax Number**	
Send Reimbursements to the attention of		**Email**	

Filing Limit Acknowledgement: You must file reimbursement requests within 90 days after the end of the time specified for payment of claims under the Stop Loss Policy or within 10 days of the expiration date for Simultaneous Funding requests. Failure to do so will result in claim denial.

Completed by: Name & Title **Date**

Confidentiality Statement