



## SPECIFIC NOTIFICATION / REIMBURSEMENT CLAIM FORM

50%/ Trigger Notification

Email to [Notifications\\_Atlanta@hcclife.com](mailto:Notifications_Atlanta@hcclife.com)

INITIAL CLAIM

Email to Claims [SpecificClaims@hcclife.com](mailto:SpecificClaims@hcclife.com)

SUPPLEMENTAL CLAIM

Final Request

### Policyholder Information

Plan Sponsor \_\_\_\_\_

Policy Year \_\_\_\_\_ Contract Basis \_\_\_\_\_ Specific Deductible \$ \_\_\_\_\_

### Employee Information

Last, First \_\_\_\_\_ Gender  M  F Social Security 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) Social Security Number \_\_\_\_\_

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 \_\_\_\_\_



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, 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 (7) seven calendar days after the expiration date of the Policy, in order for the Policyholder to be excused from actual payment according to the terms 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 Tokio Marine HCC Stop Loss Group on behalf of HCC Life Insurance Company Notification & Claims Guide for complete details on our filing procedures including our Simultaneous Funding criteria.

<b>Claim Administrator</b>	<b>Email</b>
<b>Mailing Address</b>	
<b>Telephone Number</b>	<b>Fax Number</b>
<b>Send Reimbursements to the attention of</b>	<b>Email</b>

**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 7 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**

Notice: The information in this document/ facsimile is confidential and intended for the named recipient(s) only. It may also contain privileged information. If you have received this material in error, we would greatly appreciate your phoning the sender at the number shown above. Please return the original to the sender by mail. We will reimburse you for the postage. Please do not disclose the contents to anyone. Thank you