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

HCC Life Insurance Company
Year-End Aggregate Reimbursement Claim Form

Policyholder____

Contract Basis_________________ Effective Date_______________ Expiration Date____________

Attachment Point

A. Minimum Attachment Point $_____________________

B. Annual Attachment Point (calculated) $_____________________

Total Paid Claims $_____________________

Less Attachment Point (greater of A or B) $_____________________

Less claims exceeding specific deductible/loss limit $_____________________

Less previous Monthly Accommodations $_____________________

Less ineligible claims $_____________________

Reimbursement request $_____________________

Refund due HCC Life Insurance Company $_____________________

Include the following information/documentation for the contract period to avoid delays:

1. Paid Claims Report showing the member name, incurred date, charge amount, payment date, payment amount with check numbers.
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type.
3. Proof of Funding (i.e. bank statement, or funding statement). Monthly statements should include one month following the policy expiration date.
4. Void / Refund report/ RX Rebates
5. Benefit / Service Code report
6. Year End Aggregate 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, PPO Fees, Medical Record Fees and Prescription Administration)
9. Check Register for the policy period.
10. Outstanding overpayment and Subrogation log
11. If RX is covered under the Aggregate Contract, provide RX detailed report from pharmacy vendor with supporting invoices.
12. Email **ALL** claim requests and documents to: stoplossaggregate@tmhcc.com

Please read the following 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 Employee benefit plan; (3) that all the indicated expenses have actually been unconditionally paid on behalf of the Plan as required by the Stop Loss Policy.

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.

You must file the reimbursement request within 90 days after the end of the time specified for payment of claims under the Stop Loss Policy. Failure to do so will result in a claim denial.

______________________________ ______________________________
Claims Administrator Address, City, State, ZIP

______________________________ ______________________________
Phone Number E-Mail Address

______________________________ ____________________ ______________
Name Title Date