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

HCC Life Insurance Company
Monthly Advance Reimbursement Claim Form

Policyholder_____

Contract Basis_____ Effective Date_____ Expiration Date_____

Instructions for completing this form:
To calculate the Minimum Deductible, divide the annual Minimum Deductible by 12, then multiply by the number of months the accommodation has been in effect. Enter this amount on line A. Your accommodation request on line 6 will be line 1, less the greater of line A or B, less any amounts listed in lines 3, 4 or 5.
Email ALL claim requests to: stoplossaggregate@tmhcc.com

Attachment Point

A. Minimum Monthly Aggregate Deductible through ___/___/_____ $_____

B. Annual Aggregate Deductible (calculated) through ___/___/_____ $_____

1. Total paid claims through ___/___/_____ $_____
2. Less Attachment Point (greater of A or B) $_____
3. Less previous Monthly Accommodations $_____
4. Less claims exceeding Specific Deductible/Loss Limit $_____
5. Less ineligible claims $_____
6. Total amount of accommodation requested $_____

Include the following information/documentation with your monthly request:
1. Paid claims analysis (show incurred date of each loss, payment date, payment amount and payee)
2. Monthly Loss Summary Report (showing monthly census and claims)

Please read the following before signing

Monthly Deductible Advance Reimbursement (MDAR) request must be received within **15 days** following the end of the month for which the accommodation is requested.

I certify that all checks totaling the amount entered on item 1 has been mailed to payee.

Name Title Date

Claims Administrator

Phone Number E-Mail Address