

Specific Claim Form A
Claim Notification or Initial Claim Filing Form

CLAIM NOTIFICATION
(50% Notice/Potential Catastrophic Loss)

INITIAL CLAIM

Employer Information

Policyholder _____ Policy Number _____
Effective Date _____ Specific Deductible \$ _____ Contract Basis _____

Employee Information (Please answer all Applicable Questions)

Last/First/M.I. _____ Sex: M / F
Social Security # _____ Employee ID # _____
Date of Birth ____/____/____ Date of Hire _____ Original Plan Effective Date _____

Employee current work status:

____ Actively working the required number of hours per week to be considered (circle one): *Full-Time Part-Time Reduced Hours*
____ Retired Date of Retirement _____
____ Disabled Date of Disability _____ Reason for Disability _____

____ Coverage is being continued under the following means: (complete as applicable)

____ Sick Time _____ to _____
____ Vacation Time _____ to _____
____ FMLA _____ to _____
____ Leave of Absence _____ to _____
____ Terminated Coverage: Date _____

Is COBRA applicable? Y ___ N ___ Qualifying Event _____

COBRA effective date _____

COBRA termination date _____

Claimant Information (If claimant is employee, please write "same as above")

Last/First/M.I. _____ Sex: M / F Date of Birth _____ Social Security # _____

Relationship to Employee _____ Original Plan Effective Date _____ Termination Date _____

Is COBRA applicable? Y ___ N ___ COBRA Effective Date _____ COBRA Termination Date _____

(If filing an *initial* claim, please include COBRA Election Form & premium payment verification)

Is the Claimant covered under any other Group Health Insurance Plan? _____ (Medicaid, Medicare, Spouses Plan)

Claimant information continued

If answering yes, please provide details _____

Effective date _____ Carrier _____

Eligible for Medicare? _____ Effective Date _____ Parts Elected _____

Disabling condition if under 65 _____

Is Pre-existing applicable? _____ Condition (if yes) _____

Please provide Pre-ex/HIPAA documentation (if applicable):

Claim Data (Please answer all applicable questions)

Diagnosis _____ Prognosis _____ Date of Onset _____

Height: _____ Weight: _____ (Required for ESRD/ ICD9 584 diagnosis)

If accident or injury, when, where, & how did it occur? _____

Third Party Liability investigated? Y _____ N _____

Subrogation applicable? _____ Please provide details _____

Primary Physician _____ Telephone # _____

Has Large Case Management been implemented? Y _____ N _____ Vendor _____

If covered under a PPO, is treatment being rendered In / Out of Network (Network Name) _____

Claims Paid YTD \$ _____ Claims Pending YTD \$ _____ Estimated Future Liability \$ _____

Lifetime Plan Max paid to date: \$ _____

<u>If filing for Initial Claim Submission</u>	Total TPA Paid	\$ _____
	Less Specific Deductible	\$ _____
	Payment Requested	\$ _____

ADVANCE REIMBURSEMENT REQUESTED Yes No

SLG Benefits and Insurance may consider, at our discretion, paying any Specific Stop-Loss claim, relating to the above Claimant and Policyholder, at the same time that expenses are paid by the Plan.

For us to consider advancing reimbursement, the following conditions must be satisfied:

- 1.) The Claim Administrator prior to the expiration of the Specific Excess Contract has processed all eligible bills relating to this Advance Reimbursement request.
- 2.) Checks totaling at least the amount of the Specific Attachment Point have been processed, paid and released to the indicated providers prior to the expiration of the Specific Contract, or prior to this request, whichever is earlier.
- 3.) Premium has been paid through the month in which the claim is submitted.
- 4.) Advance Reimbursement requests **will not** be accepted if received within (30) thirty days of the date of the policy's cancellation or early termination.
- 5.) All eligible Expenses must be immediately released to providers upon our payment of the claim.
- 6.) The claim request for Advance Reimbursement must be greater than \$1,000.
- 7.) This section must be elected with each Specific Claim Advance Reimbursement request.

The Advance Reimbursement is a value added service that can be changed or withdrawn at our discretion without prior notice. SLG Benefits & Insurance, LLC must receive written notice of Advance Reimbursement requests no more than (7) seven calendar days after the expiration date of the Excess Loss Insurance Policy in order for the Plan Sponsor to be excused from actual payment according to the terms of the Policy. Any special exceptions must be submitted in writing to SLG Benefits prior to the end of the (7) seven day period after the expiration date of the Policy.

By signing this form, You or Your TPA on behalf of Your Plan, represent to us (1) that the information stated herein is correct; (2) that the claim has been processed and is eligible in accordance with the Plan Sponsor Benefit Plan; (3) that all indicated expenses have actually been unconditionally paid by, or on behalf of the Plan as required by the Stop loss contract, except as specifically disclosed in the Advance Reimbursement Section.

Claims Administrator _____

Address _____

Phone (_____) _____

Fax (_____) _____

Completed By _____

Signature _____ Date _____