SLG
BENEFITS & INSURANCE, LLC

9 Atlantic Avenue • Marblehead, MA 01945
Telephone: (978) 740-4538 • (800) 742-9279
Facsimile: (978) 740-9485

YEAR END AGGREGATE CLAIM FORM

Policyholder_____ Policy Number_____

Contract Basis | Effective Date | Expiration Date

A Total paid claims through: ____/____/____ $_____

B. Minimum Annual Aggregate Attachment Point $_____

C. Annual Aggregate Attachment Point (calculated) $_____

D. Enter the Greater of B or C $_____

E. Less all claim amounts exceeding the Specific Attachment Point and / or Individual Claim Limit $_____

F. Less the sum of all prior Aggregate Accommodations $_____

G. Less all claims paid outside of the Aggregate Excess Loss Coverage $_____

Reimbursement Due $_____

Refund due to Carrier $_____

* Reimbursement/Refund Amount is Equal to A – D – E – F – G.

PLEASE INCLUDE THE FOLLOWING SUPPORTING CLAIM DOCUMENTS:

1. Paid Claims Analysis showing claimant name, date of service, type of service, amount charged, Payee and date of each payment.
2. Eligibility listing which identifies date of birth, effective date, termination date and coverage type.
3. Proof of Funding, including bank statements and/or deposit slips.
4. Void and Refunded claim report.
5. Benefit / Service Code report.
6. Aggregate Report (Monthly Loss Summary Report).
7. Specific Report showing claimants that have exceeded the Specific Attachment Point/Individual Claim Limit.
8. Listing of payments made outside the Aggregate Policy (i.e. Dental, Weekly Income, Vision, PPO Fees, Medical Records Fees, Capitated Fees, PCS (RX Administrative) Fees).
9. Check Register
10. Outstanding overpayment and subrogation log.
11. RX invoices if RX Card is covered under the Aggregate Policy.

PLEASE READ BEFORE SIGNING

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 claims have been processed and are eligible in accordance with the Plan Sponsor Benefit Plan; and (3) that all indicated expenses have actually been unconditionally paid by, or on behalf of the Plan as required by the Stop Loss contract.

Authorized Signature | Title | Date

Claims Administrator | Address

City | State | Zip

Phone | Fax

©2004 SLG Benefits and Insurance, LLC