bardon insurance group, inc.

MONTHLY AGGREGATE ACCOMMODATION REIMBURSEMENT FORM

Plan Sponsor: _____ Carrier: _____

Contract Basis: _____ Contract Period: _____

1. Total paid claims through ____/_____/_____ $ _____
2. Minimum Monthly Aggregate Deductible through ____/____/_____ $ _____
3. Annual Aggregate Deductible (calculated) through ____/____/_____ $ _____
4. Less Previous Monthly Accommodations $ _____
5. Less Claims Exceeding Specific Deductible/Loss Limit $ _____
6. Less Ineligible Claims $ _____
7. Total amount of accommodation requested $ _____

INSTRUCTIONS FOR COMPLETING

To calculate the Minimum Deductible, divide the annual Minimum Deductible by 12, then multiply the number of months the accommodation has been in effect. Enter this amount on line 2. Your accommodation request on line 7 will be line1 less the higher of line 2 or 3, less any amounts listed in lines 4, 5, or 6.

PLEASE INCLUDE THE FOLLOWING TO AVOID DELAY

- Paid claim analysis report (showing incurred date of each loss, date of payment, amount of each payment and the payee)
- Monthly Loss Summary report (showing monthly claims and census)
- Prescription Drug Invoices indicating any administrative fees (if covered under the aggregate)
- Specific Report showing claimants that have exceeded the Specific Deductible/Loss Limit

PLEASE READ BEFORE SIGNING

Monthly accommodation reimbursement requests 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 have been mailed to payee.

Authorized Signature	Title	Date
Claims Administrator	Address	
City	State	Zip Code
Phone	Fax	Email