YEAR END AGGREGATE REIMBURSEMENT FORM

Plan Sponsor: _____ Carrier: _____

Contract Basis: _____ Contract Period: _____

1. Total paid claims through $ _____
2. Minimum aggregate deductible $ _____
3. Annual aggregate deductible (calculated) $ _____
4. Less claims exceeding specific deductible/loss limit: $ _____
5. Less previous monthly accommodations: $ _____
6. Less claims paid outside the aggregate contract: $ _____
7. Reimbursement Due: $ _____
8. Refund Due Carrier: $ _____

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)
- Eligibility listing, which identifies birth date, effective date, termination date and coverage type
- Aggregate Report – Monthly Loss Summary Report
- Proof of funding (Bank Statements and / or deposit slips)
- Yearly Check Register
- Void / Refund report
- Benefit / Service Code report
- Payments made outside the Aggregate contract (i.e. Dental, weekly income, Vision, PPO fees, Medical Records fees, and Prescription Drug fees)
- Outstanding overpayments and subrogation issues
- Prescription Drug Invoices (if covered under the aggregate)

PLEASE READ 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 Plan Sponsor Benefit Plan; and (3) that all the indicated expenses have actually been unconditionally paid on behalf of the Plan as required by the Stop Loss Contract.

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