Tokio Marine HCC – A&H Group
225 TownPark Drive, Suite 350
Kennesaw, GA 30144 USA
Tel: 800-447-0460

SIMULTANEOUS FUNDING REQUEST

Policyholder Information

Plan Sponsor_____ Policy #_____

Policy Year _____ Contract Basis _____ Specific Deductible _____

Employee Information

Last, First _____ SSN / Employee ID Number_____

Claimant Information

Last, First _____ (If different from Employee) _____

Relationship to Employee_____ Date of Birth _____

I am requesting Simultaneous Funding in the amount of $_____ **for the above named claimant.** I understand Simultaneous Funding is subject to the complete discretion of HCC Life, The Claim Administrator and Plan Sponsor must adhere to the criteria listed below for access the Simultaneous Funding Reimbursement option.

I verify and acknowledge that:

1) The Claim Administrator, prior to the expiration of the Stop Loss Policy, processed all eligible bills relating to this Simultaneous Funding request.
2) The Plan Sponsor has unconditionally paid all other claims for the Claimant.
3) The Simultaneous Funding option is a value added service that can be changed or withdrawn at the discretion of HCC Life without prior notice.
4) Simultaneous Funding requests **will not** be accepted if received within (30) thirty days of the date of the policy's cancellation or premature termination.

For Initial requests:

5) **Checks totaling at least the amount of the Specific Deductible were processed, paid and released to the indicated providers prior to the expiration of the Stop Loss Policy, or prior to this request, whichever is earlier**

HCC Life must receive written notice of Simultaneous Funding requests no more than (10) ten calendar days after the *expiration date* of the Policy, in order for the Policyholder to be excused from actual payment according to the terms of the Policy. *A completed* ***Simultaneous Funding form*** *is required for each Simultaneous Funding request and should be in amounts equal to or greater than $500.*

I hereby certify that, to the best of my knowledge and after reasonable inquiry; (1) the information stated herein is correct; (2) The claim has been processed and is eligible in accordance with the Employee benefit plan; (3) All the indicated expenses have actually been unconditionally paid by, or on behalf of the plan as required in the Stop Loss Policy, except expenses specifically disclosed in this Simultaneous Funding form.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Please refer to the HCC Life Insurance Company Notification & Claims Guide for complete details on our filing procedures including our Simultaneous Funding criteria. The HCC Life Insurance Company Notification & Claims Guide can be found on our website at www.tmhcc.com/AHGroup. **Email completed form to stoplossspecclaims@tmhcc.com.**

Claim Administrator		**Email**	
Mailing Address			
Telephone Number		**Fax Number**	
Send Reimbursements to the attention of		**Email**	