TOKIO MARINE HCC

Tokio Marine HCC – A&H Group
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SPECIFIC NOTIFICATION / REIMBURSEMENT CLAIM FORM

☐ 50%/ Trigger Notification ☐ INITIAL CLAIM ☐ SUPPLEMENTAL CLAIM

Email to Stoplossnotifications@tmhcc.com Email to Claims Stoplossspecclaims@tmhcc.com ☐ Final Request

Policyholder Information

Plan Sponsor ______________________________

Policy Year ____________ Contract Basis ________ Specific Deductible $__________

Employee Information

Last, First ____________________ Gender ☐M ☐F SSN / Employee ID Number __________

Date of Birth __________ Date of Hire __________ Original Effective Date __________

Employee's Eligibility

☐ Actively working {☐ Full time (required number of hours/ week) ☐Part time ☐Reduced Hours} ☐ Retired (Date __________)

Coverage Terminated? ☐Yes (Date __________) ☐ No COBRA eligible? ☐No ☐Yes (premium paid through ______)

[If not actively working, please forward documentation from the Policyholder indicating how coverage is being continued (Sick Leave, Vacation/PTO, LOA, FMLA, COBRA]

COBRA Effective Date __________ COBRA Termination Date __________ Returned to Work Date __________

[Provide COBRA election form and proof of premium payments]

Claimant Information

Last, First ____________________ (If different from Employee) SSN/ Participant ID __________

Relationship to Employee ____________________ Date of Birth __________

Gender M ☐ F☐ Original Effective Date __________ Termination Date __________

(If different from Employee)
Is COBRA eligible? ☐Yes ☐No COBRA Effective Date __________ COBRA Termination Date __________

(If filing an *initial* claim, provide COBRA Election Form & complete premium verification)

Claimant covered by any other insurance plan? ☐Yes Type __________ ☐ No (If no, the date OI last verified ______)

Please provide details ____________________ Effective Date __________ Carrier __________

Medicare Eligible? ☐ Yes ☐ No Medicare Effective Date__________ Disabling condition (if under 65) __________

Is Pre-existing applicable? ☐Yes ☐No Pre-Existing Condition ____________________

(Provide Pre-Existing/HIPAA documentation)

Claim Information

Diagnosis____________________ Date Diagnosed __________ Prognosis __________

Claimant injured? __________ ☐No ☐Yes Date of injury __________ Place Injury Occurred __________

How did injury occur? ______________________________

(Provide accident details received from the employee/claimant and copy of police report)

Subrogation applicable? ☐ Yes ☐ No Please provide details____________________

Name of Primary Physician ____________________ Phone Number __________

Has Large Case Management been implemented? ☐ Yes ☐ No Vendor _____________

Claims Paid YTD $ ______________ Claims Pending YTD $ ______________

Claims Denied YTD $ ______________ Future Liability YTD $ ______________

If filing for Initial Claim Submission

Total TPA Paid [include Simultaneous Funding claims] $ _______________
Less Specific Deductible $ _______________
Reimbursement Requested $ _______________

SIMULTANEOUS FUNDING REQUEST

I am requesting Simultaneous Funding in the amount of $_____________* for the above referenced Specific Stop Loss claim. I understand Simultaneous Funding is subject to the complete discretion of HCC Life Insurance Company. The Claim Administrator and Plan Sponsor must adhere to the criteria listed below for access the Simultaneous Funding Reimbursement option.
*** (The amount indicated must correspond to the documentation provided with the claim submission.)**

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. *A fully completed and signed Specific Notification / Reimbursement Claim Form, including the **Simultaneous Funding section** 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 as specifically disclosed in the attached Simultaneous Funding form, if any.

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.

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

Filing Limit Acknowledgement: You must file reimbursement requests within 90 days after the end of the time specified for payment of claims under the Stop Loss Policy or within 10 days of the expiration date for Simultaneous Funding requests. Failure to do so will result in claim denial.

Completed by: Name & Title **Date**

Confidentiality Statement

Notice: The information in this document/ facsimile is confidential and intended for the named recipient(s) only. It may also contain privileged information. If you have received this material in error, we would greatly appreciate your phoning the sender at the number shown above. Please return the original to the sender by mail. We will reimburse you for the postage. Please do not disclose the contents to anyone. Thank you