Aggregate Claim Form

Employer: ______________________ Policy Number: ______________________

Contract Basis: ______________________ Effective Date: ______________________ Termination Date: ______________________

ATTACHMENT POINT:

Minimum Attachment Point: $ ______________________ Annual Attachment Point (Calculated): $ ______________________

1. Total Paid Claims: $ ______________________
2. Less: Claims Exceeding Specific Deductible: $ ______________________
3. Less: Ineligible Claims: $ ______________________
4. Less: Refunds / Recoveries / Voids: $ ______________________
5. Less: RX Rebates: $ ______________________
6. Total Eligible Towards Aggregate: $ ______________________
7. Attachment Point (Greater of Minimum / Calculated): $ ______________________
8. Less Previous Month's Advancement / Reimbursement: $ ______________________
9. Amount Requested (5-6-7), If Negative, Amount Due Carrier: $ ______________________

REQUIRED ATTACHMENTS:

A. Paid Claim Analysis Report showing name of claimant, incurred date, charge, payment amount and date.
B. Eligibility listing which identifies birth date, effective date, termination date and coverage type.
C. Proof of funding (including monthly bank statements and / or deposit slips.
D. Void / Refund Report.
E. Benefit / Service Code Report.
F. Aggregate Report — Monthly Summary Report.
G. Specific Report showing claimants have exceeded the Specific Deductible / Loss Limit.
H. Payments made outside the Aggregate Contract (i.e., Dental, Weekly Income, Vision, etc.)
I. Yearly Check Register.
J. Outstanding overpayments and subrogation issues.
K. RX invoices with detail listing (if covered under the aggregate contract).

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 Schedule of Benefits or Employee 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.

Claims Administrator: ______________________ Telephone Number: ______________________

Address: ______________________ City: ______________________ State: __________ Zip: __________

Authorized Signature: ______________________ Print Name: ______________________ Date: __________

Please email this form to slclaims@starlinegroup.com.