Nationwide Life Aggregate Accommodation Claim Form

Employer: ______________________ Policy Number: ______________

Policy Period: ______________________ Calculation through (enter month): ______________

A.	Total Claims Paid Year-To-Date:	$ ________
B.	Less: Claims Excess Specific Deductible:	$ ________
C.	Less: Ineligible or Extra Contractual Claims:	$ ________
D.	Less: Refunds / Recoveries / Voids:	$ ________
E.	Total Claims Eligible Toward Aggregate (A-B-C-D):	$ ________
F.	Accumulated Aggregate Retention Amount (see 1 below):	$ ________
G.	Prorated Minimum Aggregate Retention Amount (see 2 below):	$ ________
H.	Accrued Accommodation (E-greater of F or G, if less than zero, enter zero):	$ ________
I.	Minimum Accommodation Retention Limit (see 3 below):	$ 1,000.00
J.	Monthly Accommodation Amount (H-I):	$ ________
K.	Less: Previously Paid Accommodations (including repayments):	$ ________
L.	Monthly Accommodation Payable (J-K, see 4 below):	$ ________

NOTES FOR COMPLETING:

1. To calculate the Accumulated Aggregate Retention Amount, multiply the Monthly Aggregate Retention Factors by the number of Covered Units in each month from the beginning of the Policy Period to the current date.
2. To calculate the Prorated Minimum Aggregate Retention Amount, divide the Minimum Aggregate Retention Amount by the total number of months in the Policy Period and then multiply the amount by the number of months from the beginning of the Policy Period to the current date.
3. This amount is a minimum of $1,000.
4. If the Monthly Accommodation Amount at line L is negative, then the amount shown must be repaid within 15 calendar days of the end of the month to which the calculation relates.

REQUIREMENTS:

Please include the following reports: Policy Period claims paid report (a report by claimant name listing provider name, service date(s), CPT, charge amount, paid amount, payee and date of each payment) together with a Monthly Loss Summary Report showing monthly census and paid claims.

PLEASE READ BEFORE SIGNING:

I hereby apply for an Aggregate Accommodation and I certify that all checks totaling the amount entered on item A have been issued, funded and mailed to the payee(s).

Claims Administrator: ______________________ Telephone Number: ______________

Address: ______________ City: ______________ State: ________ Zip: ________

Authorized Signature: ______________ Print Name: ______________ Date: ________

Please email this form to slclaims@starlinegroup.com.

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