AGGREGATE CLAIM PROOF OF LOSS

3730 Roswell Road, Suite 275, Marietta, GA 30062 Tel 770.977.9601 Fax 770.977.9582

Group Name _____ Effective Date _____
Policy # _____ Expiration Date _____
Administrator _____ Contract _____

Reimbursement Request Type ☐ Annual Aggregate ☐ Monthly Accommodation

Total Claims Paid _____

- The Greater of (a) Minimum Annual Aggregate Deductible, or _____

(b) Calculated Annual Aggregate Deductible _____

- Claims in Excess of Specific Deductible _____

- Ineligible Amounts _____

= Total Requested Reimbursement 0.00

REPRESENTATION AND DISCLOSURE

I hereby represent that to the best of our knowledge, the information provided is complete and correct, and the claim has been paid in accordance with the Insured's Employee Benefit Plan which has been made a part of, and attached to the Contract. I certify that all checks were mailed to the payee on or before the last day of the Contract Year for which this claim has been presented.

Administrator _____

Submitted By _____

Title _____ Date _____

DOCUMENTATION

Please include copies of the following Documentation with your submission:

1. Eligibility listing and/or current census
2. Paid claims analysis showing the incurred date of each loss, date of payment, amount of each payment, and the payee
3. Check registers showing check numbers and amounts
4. Report of all voided checks and refunds or credits

Other documentation, which may have had an effect upon the consideration and payment of this claim, may be requested if necessary in the judgment of the Claims Auditor.