



SPECIFIC REINSURANCE ADVANCE REIMBURSEMENT REQUEST

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 _____

EMPLOYEE

Employee _____ Social Security No _____
Employment Date _____ Original Effective Date _____ Termination Date _____

Eligibility Status Active _____ Disabled/Last Day Worked _____
On Leave/FMLA _____ Cobra Effective Date _____

CLAIMANT

Claimant _____ Relationship to Employee _____
Date of Birth _____ Effective Date _____ Termination Date _____

CLAIM

Requested Amount of claim for Immediate Reimbursement (\$3,000 Minimum) _____

REPRESENTATION AND DISCLOSURE

I verify that:

- 1) The Specific deductible totaling _____ has been processed and funded and checks have been released to the indicated providers.
2) The employer has funded all other claims for this group.
3) Checks for the Specific Reinsurance Advanced Reimbursement of this claim will be released to the providers or other indicated payees at least one (1) working day prior to deposit of carrier reimbursement checks.
4) Proof of payment of any portion of this claim will be promptly provided to Phoenix Excess Risk Underwriters, LLC in the format requested.

Specific Reinsurance Advanced Reimbursement is subject to the complete discretion of the Reinsurer. It is intended to provide relief for large shock expenses. Specific Reinsurance Advanced Reimbursement must be received in writing before the expiration date of the contract and written approval must be received by Phoenix Excess Risk Underwriters, LLC prior to the expiration of the contract before the employer is excused from the actual payment according to the terms of the contract.

Administrator _____

Submitted _____

Title _____ Date _____