SPECIFIC 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 # _____ **Contract** _____ Expiration Date _____

State - Fraud Warning Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

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

If Accident, Date _____ Location _____

Describe Accident _____

Nature of Injury _____

If Illness, Diagnosis _____

Date first consulted Physician_____ Does the Plan's pre-existing provision apply ☐ Yes ☐ No

Attending Physician's Name _____

Address / Hospital Name _____

City, State, Zip Code _____

☐ Claimant is still Hospitalized
☐ Claimant is continuing treatment
☐ Large Case Management is involved
☐ Subrogation is involved

☐ Claimant is covered by other Group Insurance
☐ Claimant is covered by other Automobile Insurance
☐ Claimant is covered by Workers Compensation
☐ Claimant is covered by Medicare

ICD9 Code _____
Prognosis _____

If LCM is involved, name and address of LCM Company

_____
_____

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Final Request ☐

1. Total Benefits Submitted to Date 0.00

   Incurred Dates of Service included in this report _____ to _____

2. Total Benefits Paid to Date _____
3. Less Specific Deductible _____
4. Reimbursable Claim 0.00
5. Less: Prior Reimbursements _____
6. Reimbursement Requested 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.

Administrator Submitted _____

Title _____ Date _____

DOCUMENTATION

Proper Proof of Loss must be submitted to Phoenix Excess Risk Underwriters, LLC within ninety (90) days following the end of the Contract to be considered for reimbursement under the terms of the Contract. Proof of Loss submitted later than ninety (90) days following the end of the Contract will not be considered eligible for reimbursement. No extension of the time period will be granted without prior written approval.

If this is an Initial Proof of Loss, please include copies of the following Documentation with your submission:

1. Administrator's Claim Form and Employee Enrollment Card
2. Administrator's Explanation of Benefits, EOB
3. Itemized Bills
4. Checks Paid to Providers
5. Hospital Audit
6. Attending Physician's Statement
7. Operative Report
8. Evidence of Insurability documentation, if applicable
9. Correspondence regarding Coordination of Benefits (COB), if applicable
10. Documentation of Third Party Liability, if applicable
11. Mandatory pre-certification for all applicable hospital admissions
12. COBRA election form, if applicable
13. Claimant or Claimant's sponsor payroll record or time card may be requested

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.