EVOLUTION
RISK PARTNERS

Evolution Risk Partners, LLC
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www.evolutionrisk.com

AGGREGATE CLAIM FORM

Date of submission	Aggregate accommodation #	Year end filing
Policy holder		Policy #
Contract basis		Contract period

A. Total paid claims in contract period: $________

B. Minimum aggregate attachment point: $________

C. Aggregate attachment point: $________

D. Enter the greater of B or C: $________

E. Less all claim amounts exceeding the loss limit per person: $________

F. Less the sum of all prior aggregate accommodation requests: $________

G. Less all claims paid outside of the aggregate excess loss coverage: $________

Reimbursment due: $________

Refund due to carrier: $________

(Reimbursement/refund amount is equal to A-D-E-F-G)

PLEASE INCLUDE THE FOLLOWING SUPPORTING CLAIM DOCUMENTS:

1. Paid claims detail report showing claimant name, date of service, claim number, amount charged, payee and date of each payment
2. Eligibility listing which identifies date of birth, effective date, termination date and coverage type
3. Proof of funding, including the bank statements and/or deposit slips
4. Void and refunded claim report
5. Benefit/service code report.
6. Aggregate report (monthly loss summary report)
7. Specific report showing claimants that have exceeded the specific attachment point/individual claim limit.
8. Listing of payments made outside the aggregate policy (i.e., dental, weekly income, vision, PPO fees, medical record fees, capitated fees, PCS/Rx administrative fees)
9. Check register
10. Outstanding overpayment and subrogation log
11. Rx invoices if Rx card is covered under the aggregate policy
12. Rx rebates
13. Rx paid claims detail report

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PLEASE READ BEFORE SIGNING:

By signing this form, You or Your TPA on behalf of Your Plan, represent to us (1) that the information stated herein is correct; (2) that the claims have been processed and are eligible in accordance with the Plan Sponsor Benefit Plan; and (3) that all indicated expenses have actually been unconditionally paid by, or on behalf of, the Plan as required by Stop Loss contract.

Authorized Signature　　　　　　　　　　　　　　　　　　　　Date (MM DD YY)

Any person who knowingly and with intent to defraud any insurance company or other person files a 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

SUBMIT TO: **E-mail: claims@evolutionrisk.com**
Evolution Risk Partners, LLC
c/o Corporate Benefit Audits, Inc.
21 High Street, Suite 202
North Andover, MA 01845