

HM Stop Loss Specific Stop Loss Claim Form

Please complete the form and save as PDF, or print in blue or black ink.

Check appropriate type of claim:

Initial Claim
 Subsequent Reimbursement
 Potential Large Case
 Other _____

EMPLOYER INFORMATION

Group Name		
Group Number	Plan Type:	
Coverage Period / / through / /	<input type="checkbox"/> 12/12	<input type="checkbox"/> 15/12
	<input type="checkbox"/> 12/15	<input type="checkbox"/> 24/12
	<input type="checkbox"/> 12/18	<input type="checkbox"/> Paid
		<input type="checkbox"/> Other

EMPLOYEE INFORMATION

Last Name		First Name	M.I.
<input type="checkbox"/> Male	Date of Birth	Social Security Number	
<input type="checkbox"/> Female			
Date of Hire	Effective Date of Insurance	Current Employment Status:	
Last Day Worked		Termination Date	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Military Duty <input type="checkbox"/> Terminated <input type="checkbox"/> Family Medical Leave

CLAIMANT INFORMATION I (If the claimant is other than Employee, please complete this section)

Last Name		First Name	M.I.
Date of Birth		Effective Date of Insurance	
Relationship to Insured			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> _____			
Is the Dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name, address and telephone number of Employer:			

CLAIMANT INFORMATION II (Must be completed)

Date of Accident/Illness		Diagnosis ICD Code	
Prognosis		Does Claimant have any other insurance?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the individual have coverage through COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No	COBRA Effective Date	COBRA Premium Paid to	
Large Case Management <input type="checkbox"/> Yes <input type="checkbox"/> No	Vendor for Large Case Management (if applicable)		

Total eligible benefits for this submission	\$ _____
Less specific deductible	\$ _____
Balance	\$ _____
Reimbursement requested	\$ _____
Estimated future liability	\$ _____

Your reimbursement request should include the following information:

Copies of:

Enrollment form (initial/current)
 COBRA election form and proof of payment
 EOBs/claim checks/registers
 Itemized bills
 Deductible/coinsurance proof
 Pre-certification forms

Investigation Materials for (if applicable):

COB (include divorce, separation, and/or court orders)
 Full-time student status
 Pre-existing conditions
 Large case management reports
 Subrogation (include reimbursement agreement and accident details)
 Workers' Compensation

TPA INFORMATION	
TPA Name	
Address (Street, City, State, Zip)	
Contact Name	Telephone Number ()
Medical Management Contact Name	Telephone Number ()

FRAUD NOTICE

For your protection **Arizona** law requires the following statement to appear on this form: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal or civil penalties." Any person who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Authorized Signature	Date
Title	

Send Claims to: stoplossmail@hmig.com

Or mail to:
 HM Life Insurance Company
 P.O. Box 535057
 Pittsburgh, PA 15253-5057
 Fax: 412-544-1246