RBS Re
An HM Insurance Group Company

Forward to: **RBS Re**
7301 SW 57th Court
Suite 450
South Miami, FL 33143
Attn: Claims Department
(305) 262-2662
(305) 262-9909 Fax

EMPLOYER STOP-LOSS AGGREGATE CLAIM FORM

Employer:_____ Administrator: _____

Policy #: _____ Policy Effective Date: _____ - _____

❑ Year End Claim Policy Year_____

❑ Accommodation Claim For the Month of _____

Minimum Attachment Point for the Policy Period _____

A.	Total Claims year-to-date	$ _____
B.	Less Claims in Excess of Specific Reimbursement	(-) _____
C.	Less Ineligible or Extra-Contractual Claims	(-) _____
D.	**Total Eligible toward Aggregate**	_____
E.	Attachment Point	_____
	Higher of the year-to-date Attachment Point or Minimum Attachment Point.	
	If this is an Accommodation claims, use prorata Minimum Attachment Point.	
F.	Less Previous Accommodations	**(-)** _____
G.	**Amount Requested (D-E-F)**	**$** _____
	(IF NEGATIVE, AMOUNT DUE CARRIER)	

ATTACHMENTS

1. Year-to-date monthly check register showing all payments, voids, reissues and refunds and identifying any non-claim payments (administration fees, extra contractual payments, etc.) The register should show check number, date of check, name of claimant, incurred date and check amount.
2. Year-to-date claim listing by coverages. Only include those coverages eligible for the Aggregate.
3. Listing of all Specific Stop Loss claims for the Agreement Period.
4. Policy Year eligibility listing.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

Submitted by: _____

Address: _____

Telephone #: _____ Fax Number: _____

Authorized Signature: _____ Date: _____