RBS Re
AN HM INSURANCE GROUP COMPANY

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

EMPLOYER STOP-LOSS SPECIFIC CLAIM FORM

[ ] Initial Request for Reimbursement [ ] Subsequent Request for Reimbursement

Employer:_____ Administrator: _____

Policy #: _____ Policy Effective Date: _____ - _____

Employee's Name: _____ Social Security #: _____ DOB:_____

Claimant's Name: _____ DOB: _____ Relationship: _____

Diagnosis(es): _____ Date Potential Notice Submitted: ___/___/___

Total Benefits Paid:	$_____
Less Specific Deductible:	$_____
Balance:	$_____
Percentage Payable (%)	$_____
Reimbursement Requested:	$_____
Estimated Future Expense:	$_____

Please include legible copies of the following:

1. A copy of the Enrollment Card including documentation reflecting the hired and effective dates.
2. Documentation that the employee or dependent meets the eligibility requirements at the time of claim, i.e., hours work, Actively-at-Work and COBRA election form with proof of COBRA payments.
3. Documentation of any other insurance available at the time of claim (Coordination of Benefits).
4. Accident details and Subrogation Agreements, when appropriate.
5. All medical records obtained through pre-existing investigations.
6. Operative reports and the calculation of the reasonable and customary fees.
7. Pre-certification documentation and Case Management reports.
8. Proof of applied deductible and out-of-pocket prior to this policy period.
9. Copies of all investigative material requested regarding this claim.
10. Legible copies of the itemized provider billings (UB92 for hospitals).
11. Legible copies of the Explanation of Benefits paid.
12. Legible copies of the checks or check register indicating the claims have been paid.

Submitted by: _____ Title:_____ Date: _____
Address: _____ Tel.#:_____Fax#: _____
The Specific Claim Reimbursement Form must be completed for both the Initial and the Subsequent Submissions.