AGGREGATE WORKSHEET/REIMBURSEMENT FORM

Important: Please check one: Monthly report for Underwriting Department ☐
Reimbursement Request: Monthly ☐ Annually ☐

_____ _____/_____/_____ _____
Group Name Policy Effective Date Policy Number

Aggregate Factors Single: $ _____ Family: $ _____ Composite: $ _____

Covered Benefits: ☐ Medical ☐ Dental ☐ Disability Income ☐Prescription Card Service ☐ Vision
(check all that apply)

Aggregate Contract:_____Minimum Attachment Point:_____

Month & Year	# of EE	# of FAM	Loss Fund Monthly	Loss Fund YTD	Gross Claims Paid Monthly	Less Specific Reimbursed & Ineligible Claims	Net Claims Paid Monthly	Net Claims Paid YTD
Totals								

Total Claims Paid Year to Date:_____

Less Refunds and Voids:_____

Less Claims Paid Outside Loss Fund:_____

Less Specific Reimbursements (Paid):_____

Less Specific Reimbursements (Pending):_____

Less Aggregate Attachment Point:_____

Reimbursement due to Policyholder:_____

Authorized Examiner:_____Date:____/____/____

TPA:_____Address:_____

Please remit to: IISI, 731 Sansome Street, 2nd Floor , San Francisco, CA 94111
Telephone (415) 398-6603 Fax (415) 398-6851
Email – claims@iisinet.com