Intermediary Insurance Services, Inc.

SPECIFIC EXCESS LOSS INSURANCE CLAIM FORM

Please refer to procedures listed on Page 2 for guidance in completing this form and for full details of supporting documentation necessary to ensure prompt processing of the claim.

This request represents: ☐ Standard Reimbursement ☐ Advanced Funding (Please complete item #14 below)
☐ Discount at risk if not paid by _____

☐ An Initial Submission --The following must be attached 1. Complete Copy of Individual's Claim File
2. Copy of Employee's Original Enrollment Card

☐ Subsequent Submission # _____

Attach Copy of Balance of Individual's Claim File

1. Policyholder's Name: _____
2. Policy Number: _____ 3. Policy Period for this Claim: _____
4. Original Effective Date: _____
5. Basis of Coverage: ☐ 12/12 ☐ 12/15 ☐ Other (Describe):_____
6. Employee's Name:_____ Identification #: _____
7. Individual:_____ Relation to Employee: _____
8. Employee's Hire Date:_____
9. Employee's Original Effective Date of Coverage with Employer:_____
10. Individual's Original Effective Date of Coverage with Employer:_____
11. Total Amount of Eligible Claims Expense of Policyholder: (This Submission) $_____
12. Specific Deductible Amount: (First Submission Only) $_____
    Policyholder or its authorized representative warrants that the specific deductible has been satisfied by actual payment to the providers of medical services or supplies to which this claim relates.
13. Amount actually paid by Policyholder and eligible for reimbursement: $_____
14. Amount not yet paid by Policyholder but eligible for reimbursement: $_____
15. Total amount requested by Policyholder: $_____
16. If hospitalization involved, provide facility's name _____
    And, PPO contract being utilized_____
17. Diagnosis: _____
18. ICD9 Diagnosis code(s):_____ 19. Prognosis:_____
20. Status: ☐ Last day worked? Date:_____ ☐ Extension of Benefits? Date:_____
    ☐ Returned to work: Date:_____ ☐ Sick Leave? Date:_____
    ☐ COBRA? Date: _____ ☐ Leave of Absence? Date:_____
21. Estimated Addt'l Cost (This Policy Period): $_____ 22. This Claim is: ☐ Still Open with Addt'l Charges ☐ Closed
23. Other Insurance Coverage: ☐ Medicare ☐ Other Ins.Effective Date:_____
    Plan Name: _____ Insured's Name/ID # _____

Policyholder or its authorized representative, as evidenced by its signature below, warrants that:

a) The amounts stated in #12 and #13 have been paid to the respective providers of medical services or supplies to which this claim relates; and
b) Any reimbursement made in respect of the amount shown in #14 above will be paid as soon as possible .

Authorized Signature	Title	Date
Administrator		Phone
Address		City, State and Zip Code

Direct any Inquiries to: IISI, 731 Sansome Street, 2nd Floor, San Francisco, CA 94104 • (415) 398-6603 phone • (415) 398-6851 fax
Email: claims@iisinet.com

FILING A SPECIFIC EXCESS LOSS CLAIM

A claim should be filed when total benefits paid for a covered person exceed the specific deductible amount. These benefits must have been paid both within the terms of the employee benefit plan, and the excess loss insurance coverage in force. Please refer to the excess loss insurance contract for full details.

A. COMPLETION OF FORM

Please ensure that all questions are answered in full. The following is offered as guidance:

- **Original Effect Date**
  The effective date of coverage of the first excess loss policy period.

- **Policy Period**
  The period of excess loss coverage during which the covered person had exceeded the specific deductible.

- **Basis of Coverage**
  As stated by the excess loss insurance contract for the above policy period. This details the period during which incurred dates and paid dates must fall, in order to be considered under the excess loss insurance contract. Please identify run-in and run-out limitations if applicable.

- **PPO Affiliation**
  When a single or multiple hospitalizations are involved, please state the name of the hospital and the hospital's PPO affiliation being utilized.

- **Prognosis and Estimated Additional Cost**
  This will assist us in establishing reserves; your best estimate is most appreciated. Prognosis should be determined from information in the claims file, such as billing indications, medical reports, or Attending Physician's Statements. Estimated Additional Cost should take into account the Basis of Coverage and expiry date of the policy period, as well as Condition and Prognosis. It is recognized that this is only an estimate and will be subject to change as the claim develops.

B. DOCUMENTATION / WRITTEN PROOF OF LOSS (PAYMENT)

On an initial submission, a complete and legible copy of the entire individual's claim file together with a copy of the Employee's **original** enrollment card must be attached. The file should be reflective of the policy period covered. However, evidence of calendar year deductibles and credits must be submitted to document correct payment during the applicable period. Evidence of pre-existing condition and coordination of benefits investigations, and any subrogation procedures must also be submitted if applicable, regardless of date carried out.

All bill copies should be attached to the appropriate worksheet triggering payment, and either check copies or computer verification noting check numbers and dates of payments should also be attached. Where previously approved, copies of computerized payment runs will suffice. Upon submission of a claim for reimbursement, IISI assumes that all payments have been mailed to the payee, but may verify payee receipt of payment. Copies of the checks or a check register should accompany those benefit calculations **pending** receipt of carrier funds. It is important that the unmailed checks are mailed to the **payees** (and check copies are sent to IISI) immediately upon receipt of carrier funds.

On any additional submissions for a given individual, a complete and legible copy of the balance of the individual's claim file must be attached.

C. CLAIMS HELD FOR AUDIT

Please give notice of any claim or portion of a claim held pending an audit, particularly if this delay may lead to actual payment occurring beyond the date provided for in the excess loss insurance contract. Such claims will be considered for reimbursement if, ordinarily, they would have been paid within the terms of coverage provided.

D. POST REIMBURSEMENT FUNDS

Any refunds received from providers or subsequent third party recoveries which would reduce the amount reimbursed under the excess loss insurance contract should be reported and refunded immediately upon discovery.