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A Division Of Companion Life Insurance Company

AGGREGATE CLAIM FORM

_____Year End Claim _____Month End Claim for the Month of _____

Group Name: _____ Policy Year: _____

Contract Type: _____

Total Eligible Claims: _____

Less Specific Claims: (_____)

Less Ineligible or Extracontractual Claims: (_____)

Less Refund/ Recoveries / Voids (_____)

Less RX Rebates (_____)

Total Eligible Towards Aggregate: _____

Attachment Point**: _____

***Higher of the Year-to-Date Attachment Point or Minimum Attachment Point. If this is a Month End Claim, use prorated Minimum Attachment Point.*

Less Previous Month's Advancement/ Reimbursement (_____)

Amount Requested: _____

If negative, amount due to Carrier _____

**I certify to the best of my knowledge that the information provided on this form is correct and that the claims have been paid in accordance with the plan sponsor's plan document. **

TPA: _____ Date:_____

Contact Name:_____ Phone Number:_____

Address:_____

E Mail Address:_____

Signature:_____

FRAUD NOTICE: For Your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.