HM LIFE INSURANCE COMPANY OF NEW YORK
HM INSURANCE GROUP

P.O. Box 535057
Pittsburgh, PA 15253-5057
Tel: 800-328-5433
Fax: 412-544-1246
hmig.com

HM Stop Loss
Specific Stop Loss Claim Form

Please complete the form and save as PDF, or print in blue or black ink.

Check appropriate type of claim:
☐ Initial Claim ☐ Subsequent Reimbursement ☐ Potential Large Case ☐ Other_____

EMPLOYER INFORMATION

Group Name	
Group Number	Plan Type: ☐12/12 ☐15/12 ☐Paid ☐12/15 ☐24/12 ☐Other ☐12/18
Coverage Period / / through / /	

EMPLOYEE INFORMATION

Last Name	First Name	M.I.
☐ Male ☐ Female	Date of Birth	Social Security Number
Date of Hire	Effective Date of Insurance	Current Employment Status: ☐ Full Time ☐ Part Time ☐ Laid Off ☐ Retired ☐ Military Duty ☐ Terminated ☐ Family Medical Leave
Last Day Worked	Termination Date	

CLAIMANT INFORMATION I (*If the claimant is other than Employee, please complete this section)*

Last Name	First Name	M.I.
Date of Birth	Effective Date of Insurance	

Relationship to Insured
☐ Spouse ☐ Child ☐ _____

Is the Dependent employed? ☐ Yes ☐ No If yes, name, address and telephone number of Employer:

CLAIMANT INFORMATION II *(Must be completed)*

Date of Accident/Illness	Diagnosis ICD Code	
Prognosis	Does Claimant have any other insurance? ☐ Yes ☐ No	
Does the individual have coverage through COBRA? ☐ Yes ☐ No	COBRA Effective Date	COBRA Premium Paid to
Large Case Management ☐ Yes ☐ No	Vendor for Large Case Management (if applicable)	

Total eligible benefits for this submission	$ _____
Less specific deductible	$ _____
Balance	$ _____
Reimbursement requested	$ _____
Estimated future liability	$ _____

Your reimbursement request should include the following information:

Copies of:

Enrollment form (initial/current)
COBRA election form and proof of payment
EOBs/claim checks/registers
Itemized bills
Deductible/coinsurance proof
Pre-certification forms

Investigation Materials for (if applicable):

COB (include divorce, separation, and/or court orders)
Full-time student status
Pre-existing conditions
Large case management reports
Subrogation (include reimbursement agreement and accident details)
Workers' Compensation

TPA INFORMATION	
TPA Name	
Address (Street, City, State, Zip)	
Contact Name	Telephone Number ( )
Medical Management Contact Name	Telephone Number ( )

FRAUD NOTICE

Applicants applying for accident and health insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

We certify that the above information is correct and that the claims have been paid in accordance with the plan.

Authorized Signature	Date
Title	

Send Claims to: stoplossmail@hmig.com

Or mail to:
HM Life Insurance Company of New York
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Fax: 412-544-1246