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
Aggregate Stop Loss Claim Form

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

EMPLOYER INFORMATION

Group Name

Group Number

Coverage Period
/ / through / /

Plan Type:
☐ 12/12 ☐ 15/12 ☐ Paid
☐ 12/15 ☐ 24/12 ☐ Other
☐ 12/18

TPA INFORMATION

TPA Name

Address

City | State | Zip Code

Telephone Number
( )

Fax Number
( )

CALCULATIONS

1. Annual Aggregate Deductible	$
2. Minimum Aggregate Deductible for the Policy Period	$
A. Total Claims Year-to-Date	$
B. Less amounts exceeding the maximum aggregate eligible claims expense	$
C. Less Ineligible or Extra-Contractual Claims	$
D. Less Refunds/Recoveries/Voids	$
E. Total Eligible toward Aggregate	$
F. Aggregate Deductible (Enter the greater of the amounts shown on Line 1 or Line 2)	$
G. Amount Requested (E-F)	$

ATTACHMENTS

Your reimbursement request should include the following information:

1. Census listing for all Employees and Dependents covered during the policy period. The listing must contain Member ID, dates of birth, all types of coverages (single, family, composite, COBRA, etc.) and include effective and term dates for all employees and dependents on the group as of the effective date or added, termed or had a coverage change(s) during the policy term. (Excel format preferred).
2. Claim detail report: Member ID, Employee name, Patient name, incur date, paid date, amount billed, amount paid, provider name, diagnosis code, procedure code, check number, for all claims declared under the Aggregate policy (Excel format preferred).
3. List of all refunds received for this account.
4. List of all non-contractual or exception payments that were made during the policy period with a comprehensive explanation of the payment.
5. Proof of funding, including banking or funding reports that substantiate that the group has funded all claims.
6. Subrogation Listing for third party liability claims.

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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Pittsburgh, PA 15253-5057
Fax: 412-544-1246