

## 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:	
Coverage Period / / through / /	<input type="checkbox"/> 12/12	<input type="checkbox"/> 15/12 <input type="checkbox"/> Paid
	<input type="checkbox"/> 12/15	<input type="checkbox"/> 24/12 <input type="checkbox"/> Other
	<input type="checkbox"/> 12/18	

**EMPLOYEE INFORMATION**

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

**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			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> _____			
Is the Dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the individual have coverage through COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No	COBRA Effective Date	COBRA Premium Paid to	
Large Case Management <input type="checkbox"/> Yes <input type="checkbox"/> 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](mailto:stoplossmail@hmig.com)

*Or mail to:*  
 HM Life Insurance Company of New York  
 P.O. Box 535057  
 Pittsburgh, PA 15253-5057  
 Fax: 412-544-1246