HM LIFE INSURANCE COMPANY
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

For your protection **Arizona** law requires the following statement to appear on this form: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal or civil penalties." Any person who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Authorized Signature	Date
Title	

Send Claims to: stoplossmail@hmig.com

Or mail to:
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