

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: <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	
Coverage Period / / through / /		

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: <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	
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 <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

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Medical Management Contact Name

Telephone Number

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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:

HM Life Insurance Company
 P.O. Box 535057
 Pittsburgh, PA 15253-5057
 Fax: 412-544-1246