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
Aggregate Stop Loss Claim Form

To be completed by the Employer. Please print in blue or black ink.

EMPLOYER INFORMATION

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

TPA INFORMATION

TPA Name		
Address		
City	State	Zip Code
Telephone Number ( )	Fax Number ( )	

CALCULATIONS

1. Annual Aggregate Deductible	$
2. Minimum Attachment Point 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. Attachment Point (Either the Year-to-Date Attachment Point or the Minimum Attachment Point, whichever is higher)	$
G. Amount Requested (E-F)	$

ATTACHMENTS

Your reimbursement request should include the following information:

1. Census listing for all individuals covered during the policy period. The list must contain all types of coverages (single, family, COBRA, etc.) and must contain all additions, terminations and changes (Excel format preferred).
2. Claim detail report showing employee name, patient/claimant name, incur date, paid date, provider information, amount paid, check number, payee name and diagnosis code 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 payments/pay by exceptions 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.

TPA SIGNATURE

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.

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

Authorized Signature	Date
Title	

Send Claims to: stoplossmail@hmig.com

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