USBenefits
Insurance Services, LLC

Aggregate Excess Reimbursement Request Form

Contract Holder: _____ ☐ Year End Claim ☐ End of Month Claim

Contract Number:_____ Effective Date:_____ Contract Type: _____

Aggregate includes: ☐ Medical ☐ Dental ☐ Vision ☐ Rx ☐ Run-in $_____ ☐ Run-out $_____

Monthly Factors: Employees: $_____ Dependents: $_____ Employee +1: $_____

Employee + Family: $_____ Employee +Spouse $_____

Minimum Annual Attachment Point: $_____

Total Claims Paid During The Policy Year: $_____

Less Adjustments - Claims Paid Outside The Benefit Plan

Voids & Returns:	$_____	
Pending Additional Info:	$_____	
Not Covered:	$_____	
Payment Errors:	$_____	
Additional Adjustments:	$_____	
Underfunded Miscellaneous:	$_____	
Total Adjustments:		$0.00
Total Eligible Paid Claims:		$0.00

Specific Claims Paid and Pending

a) _____	$_____	
b) _____	$_____	
c) _____	$_____	
d) _____	$_____	
e) _____	$_____	$0.00

Less:

Net claims subject to annual deductible:	$0.00
Aggregate deductible for the year:	$_____
Previous month reimbursement:	$_____
Reimbursement requested:	**$0.00**

Attachments:

1. Contract year-to-date monthly check register showing all payments, voids, reissues, and refunds; identifying any non-claim payments (e.g. administration fees, etc.). The register should show check number, date of check, name of claimant, incurred date, and check amount.
2. Contract year-to-date claim listing by coverage's and claimant (by month, if monthly). Only include those coverage's eligible for the Aggregate.
3. Listing of all specific Stop Loss claims for the agreement period.
4. Contract year eligibility listing by month.
5. Attachment point calculation.
6. Prescription Drug Card registers.
7. Check register report.

Clear Form

I certify that the above information is correct and that the claims have been paid in accordance with the Plan Document.

TPA/Company Name:_____

Address:_____

Email:_____ Phone:_____ Fax:_____

Authorized Signature:_____ Title:_____

877.877.4USB (4872)
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