ROCKPORT BENEFITS LLC

Specific Notification/Reimbursement Claim Form

☐ **50% Notice/Potential Catastrophic Loss** ☐ **Initial Claim** ☐ **Supplemental Claim**
Email to: riskmanagement@rockportbenefits.com email to: claims@rockportbenefits.com

Policyholder Information

Plan Sponsor ______________________ Policy Number ______________

Policy Year __________ Specific Deductible $________ Contract Basis______________

Employee Information (Please answer all Applicable Questions)

Last/First/ ______________________________ Sex: M F

Employee ID # ____________________Date of Birth___/___/________

Date of Hire___/___/_____ Original Plan Effective Date__/___/______

Employee current work status:

Actively working the required number of hours per week to be eligible under the plan? ☐ Yes ☐ No
If answer to above is No: (information below must come from the Policyholder)

- Retired ☐ Yes ☐ No Date of Retirement ________
- Disabled ☐ Yes ☐ No Date of Disability__________ Reason for Disability______________
- Coverage is being continued under the following means: (complete as applicable)

  Sick Time __________to __________

  Vacation Time __________ to __________

  FMLA __________ to __________

  Leave of Absence __________ to __________

Terminated Coverage: Date ______________

Is COBRA applicable? Yes ☐ No ☐ COBRA effective date_______Premium paid through

COBRA termination date ________

(Provide COBRA election form and proof of premium payment verification)

Claimant Information (If claimant is employee, please write "same as above")

Last/First/M.I.________________________ Sex: M F Date of Birth___________

Relationship to Employee ______________________Original Plan Effective Date_________ Termination Date _____

Is COBRA applicable? Yes ☐ No ☐ COBRA Effective Date ___________ COBRA Termination Date_____

(Please include COBRA election Form & premium payment verification)

Is the Claimant covered under any other Group Health Insurance Plan? ☐ Yes ☐ No (Medicaid, Medicare, Spouse's Plan)

If answering yes above, please provide:

Effective date___________ Carrier____

Eligible for Medicare?___________ Effective Date ______________ Parts Elected_________________________

Disabling condition if under 65____

<u>**Claim Data**</u> (Please answer all applicable questions)

Diagnosis ___________________________ Prognosis ___________________ Date of Onset_____________________

Height: _______________________ Weight: _____________________ (Required for ESRD/ ICD9 584 diagnosis)

If accident or injury, when, where, & how did it occur?____

Third Party Liability investigated? Yes ☐ No ☐

Subrogation applicable?______________________ Please provide details______________________________

Primary Physician___________________________ Telephone #_____________________________________

Has Large Case Management been implemented? Yes ☐ No ☐ Vendor_______________________________

If covered under a PPO, is treatment being rendered In / Out of Network (Network Name)?___________________

Claims Paid YTD $__________ Claims Pending YTD $_________ Estimated Future Liability $ ______________

<u>If filing for Initial Claim Submission</u>

Total TPA Paid	$____________________________
Less Specific Deductible	$____________________________
Payment Requested	$____________________________

ADVANCE REIMBURSEMENT REQUESTED **Yes** ☐ **No** ☐

For Rockport Benefits, LLC to consider paying any Specific Stop-Loss claim, relating to the above Claimant and Policyholder, at the same time that expenses are paid by the Plan, the following conditions must be satisfied:

1.) The Policyholder or Claim Administrator must complete and submit a Specific Advance Reimbursement Form.
2.) Checks totaling at least the amount of the Specific Attachment Point have been processed, paid and released to the indicated providers prior to the expiration of the Specific Contract, or prior to this request, whichever is earlier.
3.) Premium has been paid through the month in which the claim is submitted.
4.) Advance Reimbursement requests **will not** be accepted if received within (30) thirty days of the date of the policy's cancellation or early termination.
5.) All eligible Expenses must be immediately released to providers upon our payment of the claim.
6.) The claim request for Advance Reimbursement must be greater than $1,000.
7.) All of the above steps must be completed with each Specific Claim Advance Reimbursement request.

Rockport Benefits, LLC must receive written notice of Advance Reimbursement requests before the end of the Policy Period in order for the Plan Sponsor to be excused from actual payment according to the terms of the Policy. Any special exceptions must be submitted in writing to Rockport Benefits, LLC prior to the end of the Policy Period.

By signing this form, You or Your TPA on behalf of Your Plan, represent to us (1) that the information stated herein is correct; (2) that the claim has been processed and is eligible in accordance with the Plan Sponsor Benefit Plan; (3) that all indicated expenses have actually been unconditionally paid by, or on behalf of the Plan as required by the Excess Loss Insurance Policy.

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 material 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 subjects such person to criminal and civil penalties.
Please refer to Rockport Benefits, LLC's Administration Guide for complete details on our filing procedures.

Claims Administrator________________________________email:

Address____

Phone ____ Fax _________

Completed By____

Signature ____ Date ______________________