ROCKPORT BENEFITS

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____

Claim Data (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 $ _____________

If filing for Initial Claim Submission

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

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

For Rockport Benefits 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. After the Specific Deductible per Covered Person for the Benefit Period has been satisfied, the Policyholder must make an additional claim payment of at least $1,000. The Company will not provide advance funding if required payments have not been issued.

2. Subsequent reimbursements will be made only after such subsequent claim payments reach $1,000, or every three

months, whichever comes first.

3. Claims submitted for advance funding must have been fully processed by the Administrator according to the terms of the Plan and must be ready for payment.

4. Normal specific claim audit procedures will be implemented prior to any payments being made by the Company.

5. The Policyholder's payment for Covered Benefits must be released to the providers of care within five (5) working days of receiving the advance funding check by the Company. Payment within this time period will be considered a paid claim within the Benefit Period. If these payments are not made within five (5) days, the advance funding check must be returned to the Company.

6. Any portion of the advance funding check not used to pay expenses, due to additional discounts or any other reason must be returned to the Company within five (5) days.

7. The request for advance funding must be received by the Company prior to fourteen (14) days before the end of the Policy Year. Requests received after that date are not eligible for advance funding.

Rockport Benefits must receive written notice of Advance Reimbursement requests prior to fourteen (14) days 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 prior to fourteen (14) days before 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' Administration Guide for complete details on our filing procedures.

Claims Administrator________________________________email:

Address____

Phone ____ Fax _________

Completed By____

Signature ____ Date ______________________