Specific Claim Form A
Claim Notification or Initial Claim Filing

QBE Insurance

☐ Claim notification ☐ Initial claim

(50% notice/potential catastrophic loss)

Policyholder information

Policyholder name	Policy number	Policy year	Contract basis

Specific deductible/specific attachment point	Aggregating specific deductible (if applicable)

If filing for initial claim submission

Claims paid YTD	Total TPA paid
$	$

Claims pending YTD	Less specific deductible	Less aggregating specific deductible
$	$	

Estimated future liability	Payment requested
$	$

Employee information (Please answer all applicable questions)

Last/First/M.I. ☐ M ☐ F

Social security number	Employee ID number

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 considered (check one)

☐ Full-time ☐ Part-time ☐ Reduced hours

Retired Date of retirement	Disabled 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

Date of terminated coverage

Is COBRA applicable? ☐ Yes ☐ No

Qualifying event	COBRA effective date	COBRA termination date

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

Last/First/M.I. ☐ M ☐ F

Date of birth | Social security number

Relationship to employee | Original plan effective date | Termination date

Is COBRA applicable? ☐ Yes ☐ No

COBRA effective date | COBRA termination date

(If filing an initial claim, please include COBRA election form & premium payment verification)

Is the claimant covered under any other group health insurance plan? ☐ Medicaid ☐ Medicare ☐ Spouse's plan

If answering yes, please provide details

Effective date | Carrier

Eligible for Medicare? ☐ Yes ☐ No

Effective date | Parts elected

Disabling condition if under 65

Is Pre-existing applicable? ☐ Yes ☐ No

Condition (if yes)

Please provide Pre-ex/HIPAA documentation (if applicable)

Claim information (Please answer all applicable questions)

Diagnosis	Prognosis	Date of onset
Height / Weight	(Required for ESRD/ ICD9 584 diagnosis)	
Is the claim due to an accident or injury?	☐ Yes	☐ No
If accident or injury, when, where, & how did it occur?		
Third party liability investigated?	☐ Yes	☐ No
Subrogation applicable?	Please provide details	
Primary physician	Telephone number	
Has large case management been implemented?	☐ Yes	☐ No
Vendor		
ADVANCE REIMBURSEMENT REQUESTED	☐ Yes	☐ No

QBE A&H may consider, at our discretion, paying any Specific Excess Loss claim, relating to the above claimant and policyholder, at the same time that expenses are paid by the plan.

For us to consider advancing reimbursement, the following conditions must be satisfied:

1. The claim administrator prior to the expiration of the Specific Excess Contract has processed all eligible bills relating to this Advance Reimbursement request.
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 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. This section must be elected with each Specific Claim Advance Reimbursement request.

The Advance Reimbursement is a value added service that can be changed or withdrawn at our discretion without prior notice. QBE A&H must receive written notice of Advance Reimbursement requests no more than (10) ten calendar days after the expiration date of the Excess Loss Insurance Policy 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 QBE A&H prior to the end of the (10) ten day period after the expiration date of the Policy. 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 Stop loss contract, except as specifically disclosed in the Advance Reimbursement section.

Claims administrator			
Address	City	State	Zip
Phone	Fax		
Completed by	Signature		Date

Please submit claims/reimbursement requests to stoplossclaims@qbe.com

Please submit 50% notice/potential large dollar notices to riskmanagementnotices@qbe.com