PERICO LIFE INSURANCE COMPANY

13358 Manchester Road, St. Louis, Missouri 63131
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Telephone: (317) 887-0030 Facsimile: (317) 888-7145

AGGREGATE CLAIM FORM

Policy Holder	**Contract Basis**	**Effective Date**	**Expiration Date**
______________________	__________	__________	__________

A. Total paid claims: $______________________
B. Minimum Aggregate Deductible (Prorated*): ______________________
C. Calculated Aggregate Deductible: ______________________
D. Less claims exceeding loss limit: ______________________
E. Less Previous Monthly Accommodations: ______________________
F. Less claims paid outside the aggregate contract: ______________________
G. Reimbursement Due: ______________________
H. Refund Due Carrier: ______________________

<u>Please Include the Following To Avoid Delay:</u>

* Items preceded by an asterisk are required for an aggregate accommodation filing. All Items listed are required for a year end filing.

*1. Paid Claims Analysis Report totaled by claimant, showing incurred date, charge, payment amount, payment date, including voids and refunds
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type
3. Proof of Funding (This must include monthly bank statements and or deposit slips)
4. Void/Refund report
5. Benefit/Service Code report
*6. Aggregate Report – Monthly Loss Summary Report
7. Specific Report showing claimants have exceeded the specific deductible/loss limit
8. Payments made outside the Aggregate Contract (i.e. Dental, Weekly Income, Vision, LCM fees, Medical Records Fees and Prescription Administration)
*9. Cummulative Check Register for the filing period
10. Listing of outstanding overpayments and subrogation issues
11. RX invoices with detail listing if covered under the aggregate contract

PLEASE READ BEFORE SIGNING

I hereby certify that, to the best of my knowledge, after reasonable inquiry: (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; and (3) that all the indicated expenses have actually been unconditionally paid on behalf of the Plan as required by the Stop Loss Contract.

You must file reimbursement requests within 180 days after the end of the time specified for payment of claims under the Excess Loss Policy. Failure to do so may result in claim denial.

______________________	______________________	______________
Authorized Signature	Title	Date
______________________	______________________________	
Claims Administrator	Address	
______________________	______________________	______________
City	State	Zip
______________________	______________	______________________
Phone	Fax	Email Address