



SPECIFIC STOP LOSS REIMBURSEMENT FORM

Third Party Administrator: _____

Name of Plan: _____

Employee: _____ Claimant: _____

Contract#: _____ Effective Date: _____

Type of Contract: _____ Specific Deductible: \$ _____

Requested Dollar Amount for Reimbursement: \$ _____

I am requesting that the Reimbursement Procedure be applied for the attached Specific Stop Loss Claim.

I verify that:

1. All applicable premiums for this group have been paid through the current period.
2. A prospective claim notification for this claim has been provided to Perico Life.
3. The specific deductible has been processed and funded, and checks have been released to all respective providers.
4. The employer is current in funding of all other claims for this group.

Signed: _____
Authorized Representative

Print Name: _____

Title: _____

Date: _____ Phone Number: _____

This form must be submitted with the Specific Claim Form for each Reimbursement requested.