SKYWARD SPECIALTY INSURANCE | Accident & Health

**SKYWARD SPECIALTY INSURANCE**
600 TOWNPARK LANE, SUITE 500, KENNESAW, GA 30144
713.935.4800 | 800.796.9165 (TOLL FREE) | CLAIMS FAX: 610.280.4299

# AGGREGATE CLAIM REQUEST FOR REIMBURSMENT

Policyholder: _____ Policy Period: _____

Carrier: _____ Contract Basis: ☐ 12/12 ☐ 12/15 ☐ Other _____
☐ 12/18 ☐ Paid

| | | |
|---|---|---|
| **A.** | Total Claims Paid: | $ _____ |
| **B.** | **LESS** Aggregate Deductible:<br>(The greater of: the Calculated or Minimum Aggregate Deductible) | -$ _____ |
| **C.** | **LESS** Amounts Excess of Per Person Limit: | -$ _____ |
| **D.** | **LESS** Exceptions, Admin Fees and other ineligible claims: | -$ _____ |
| **E.** | **LESS** Voids, Refunds and outstanding Overpayments: | -$ _____ |
| **F.** | **LESS** Claims not released and/or funded: | -$ _____ |
| | **SUBTOTAL:** | $ _____ |
| **G.** | **LESS** Previous Accommodation reimbursements: | -$ _____ |
| | **REQUESTED AMOUNT:** | $ _____ |

**PROOF OF LOSS**: Written proof of loss must be submitted to our office within **90 days of Expiration Date**, subject to the terms, conditions and limitations of the Policy.

**Send claims and required documentation to ah-aggregate@skywardinsurance.com or fax to 713.935.4801**

The following information is required when filing a year-end aggregate claim. Please submit reports in an Excel format when possible.

1. Medical Paid Claims Detail report
2. RX Paid Claims Detail report
3. Aggregate report
4. Specific report
5. Benefit Code / Service Code report
6. Void / Refund / Overpayment report
7. RX Invoices / RX Rebates
8. Subrogation Claims / Settlements
9. Eligibility Report (include Active, Terminated and COBRA participants)
10. Discount Fee report
11. Claims paid outside the aggregate (Exceptions, Medical Review fees, Admin fees, etc…)
12. Bank Statements for the policy period
13. Yearly Check Register

_____ _____
Preparer Date

_____
Claims Administrator

_____
Address

_____ _____ _____
Phone Fax Email