

AGGREGATE MONTHLY ACCOMMODATION REIMBURSEMENT REQUEST

Policyholder: _____ Policy Period: _____

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

Accommodation: Monthly Weekly

A.	Total Claims Paid:	\$	_____
B.	LESS Aggregate Deductible: (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:	-\$	_____
	SUBTOTAL:	\$	_____
E.	LESS Previous Accommodation reimbursements:	-\$	_____
	REQUESTED AMOUNT:	\$	_____

NOTE: Monthly Accommodations MUST be submitted by the 15th of the month to be eligible for reimbursement. Accommodations are NOT eligible during the last month 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 an accommodation reimbursement request. Please submit reports in an Excel format when possible.

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|--------------------------------------|---------------------|
| 1. Medical Paid Claims Detail report | 2. Aggregate report |
| 3. RX Paid Claims Detail report | 4. Check Register |

Preparer

Date

Claims Administrator

Address

Phone

Fax

Email