Specific Claim Advance Reimbursement Request Form

Specific Stop Loss Coverage Only

STARLINE

PLAN SPONSOR INFORMATION:

Plan Sponsor Name: _____

Carrier: _____ Policy Number: _____

Claimant: _____ Policy Period: _____

This request is for a Specific Claim Advance Reimbursement for the above referenced specific stop loss claimant. We understand that the stop loss policy is a reimbursement policy for eligible paid claims. This Specific Claim Advance Reimbursement Request is subject to the complete discretion of the reinsurer, and the request must conform to the terms and conditions listed below in order to be considered for specific claim advance reimbursement.

TERMS AND CONDITIONS:

1. The stop loss policy must be in force and the premium payments must be paid through the month in which you submit the advanced reimbursement claim.
2. All claims involving Specific Claim Advance Reimbursement must be processed through the administrator's claim processing system.
3. The Plan Sponsor must have funded and unconditionally released claim checks for all prior claims up to the Plan Sponsor's specific deductible level.
4. Specific Claim Advance Reimbursement is not available during the last thirty (30) days of the contract period / period of insurance.
5. You agree to release payment of the underlying claim simultaneously upon receipt of our reimbursement of the claim and provide us with payment evidence within 10 business days of receipt of Specific Claim Advance Reimbursement from us.

A Specific Claim Advance Reimbursement Request Form will need to be completed once for each claimant during each policy period and each request amount must be equal to or greater than $5,000.

ACKNOWLEDGEMENT AND SIGNATURE:

By signing this form, we acknowledge that we will adhere to the above Specific Claim Advance Reimbursement terms and conditions. All the provisions, limitations and exclusions in the stop loss policy will continue to remain in force. Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature: _____ Title: _____

TPA / Administrator Name: _____ Date: _____

Please email this form to slclaims@starlinegroup.com.