Year End Aggregate Reimbursement Form

Please submit this form to:
medTRANS Insurance
Frontrunner Captive Management, inc.
303 West Main St. Suite 300
Freehold, NJ 07728
Phone: 732.414.2942
rbeckie@frontrunnercaptive.com

Policyholder Information:

Plan Sponsor (Group Name: ______________________ Policy # ______________

Policy Period: ______________ Contract Type: ______________ Specific Deductible ______________

Claims Information

A.	**Total Paid Claims**	$ ______________
B.	Less: Claims Paid outside the Aggregate Contract	$ ______________
C.	Less: Claims exceeding specific deductibles	$ ______________
D.	**NET CLAIM**	$ ______________
E.	Year-To-Date Attachment Point (*Monthly Accommodations*)	$ ______________
F.	Minimum Annual Attachment Point	$ ______________
G.	**Excess of Attachment Point**	$ ______________
H.	Less: Total Previous Reimbursements	$ ______________
I.	**Reimbursement Due**	$ ______________

Please include the following to avoid delay:

1. Paid Claim Analysis Report showing name of claimant, incurred date, charge, payment amount and date
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type
3. Proof of funding (including monthly bank statements and/or deposit slips)
4. Void / Refund report
5. Benefit / Service Code report
6. Aggregate Report – Monthly 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, etc)
9. Yearly Check Register
10. 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 Schedule of Benefit/Employee 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.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

YOU MUST FILE REIMBURSEMENT REQUESTS WITHIN 90 DAYS AFTER THE END OF THE TIME SPECIFIED FOR PAYMENT OF CLAIMS UNDER THE STOP LOSS POLICY. FAILURE TO DO SO WILL RESULT IN CLAIM DENIAL.

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FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

Fraud Notice to included on each claim/Application Form

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing

Georgia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive

Authorized Signature	Title	Date
TPA/Administrator	Address	
Phone	City	State / Zipcode
Fax	E-Mail Address	