



International Specialty Underwriters  
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**SPECIFIC STOP-LOSS CLAIM FORM**

\_\_\_\_\_ Initial Submission

\_\_\_\_\_ Subsequent Submission

Policyholder: _____
Policy Period: _____ Contract Basis: _____
Employee Name: _____ Social Security #: _____
Hire Date: _____ EE Effective Date of Coverage: _____
Claimant Name: _____ Date of Birth: _____
Claimant Effective Date: _____ Diagnosis: _____

Reimbursement Request must include the following information:

- Enrollment form (initial one with employer group including any change form)
- COBRA enrollment form (if applicable)
- Proof of COBRA premium payments
- Current Claim Form including Documentation of other insurance
- Documentation of Full-Time Student Status (if applicable)
- Pre-existing documentation and/or HIPPA certification
- Detailed claim report including itemized bills and explanation of benefit forms. Bills are to be attached to EOB's
- Proof of Pre-Certification for all hospitalizations
- Hospital Audit Reports
- Documentation of Potential Third Party Liability Recoveries (accident details, police report, subrogation forms, auto insurance)
- Large Case Management (yes/no)\_\_\_\_\_ If yes, provide copies of LCM Reports

Continuation of Coverage Information:

Last Date Actively at Work: \_\_\_\_\_ Return to Work Date: \_\_\_\_\_

FMLA dates From: \_\_\_\_\_ To: \_\_\_\_\_

COBRA effective date: \_\_\_\_\_ COBRA paid through date: \_\_\_\_\_

Extension of Benefits (specify how & dates): \_\_\_\_\_

Benefits Paid by Plan:	\$ _____
Less: Ineligible Claims:	- _____
Less: Specific Deductible (initial only)	- _____
Reimbursement Requested (this sub)=	\$ _____
Advance Funding Amount=	\$ _____

TPA Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I hereby certify to the best of my knowledge, the above information is correct and that the claim has been paid and funded in accordance with the Plan Sponsor's Plan Document.*