

**Amalgamated Life Insurance Company  
Underwriting Department, 333 Westchester Avenue, White Plains, New York 10604**

**Aggregate Excess Loss Proof of Loss Claim Form**

Today's Date \_\_\_\_\_ Submitted to: \_\_\_\_\_

Group Name \_\_\_\_\_ Policy Period \_\_\_\_\_ Policy # \_\_\_\_\_

Submitted by: \_\_\_\_\_ Title \_\_\_\_\_

Organization (if different) \_\_\_\_\_ Relation to Group \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Aggregate Attachment \_\_\_\_\_ Recoveries Paid \_\_\_\_\_ Requested Amount \_\_\_\_\_

With this form we have submitted the following checked required reports in hard or electronic copy:  
(additional information than that shown below can be submitted to accommodate your current format)

- \_\_\_\_\_ Enrollment information including employee ID, number of dependents, date of hire, date of participation, date of termination (if any) and status (active, retired, disabled).
- \_\_\_\_\_ Claim information including employee ID, patient ID, relation to employee, date of service, date received, date of payment, amount paid, procedure code, diagnosis code(s) and check number.
- \_\_\_\_\_ Copy of Plan Document.

Policy Months and Year	Number of Employees	Number of Dependent Units	Total Policy Claims Paid	Total Policy Claims Pending	Total Policy Claims Due and Unpaid	Total Specific Claims Paid & or Submitted

For office use: Received by \_\_\_\_\_ Date \_\_\_\_\_