Amalgamated Life
Group • Stop Loss • Voluntary

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

Specific Excess Loss Proof of Loss Claim Form

Today's Date _____ Submitted to: _____

Type of Notification: ☐ Claim for Reimbursement ☐ 50% Threshold ☐ Diagnostic Trigger

Group Name _____ Policy Period _____ Policy# _____

Submitted by: _____ Title _____

Organization (if different) _____ Relation to Group _____

Address _____

Phone _____ Fax _____ Email _____

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Employee Name _____ DOH _____ Term Date (if any) _____

Patient Name _____ Patient Relation to Employee _____ DOB _____

Employee and Patient Status (Active, Retired, Disabled, COBRA): EE _____ PAT _____

Employee SSN _____ Patient SSN (write none if none) _____

If Employee, last date the Employee worked FT: _____ Date returned to FT work: _____

If Spouse, spouse works? _____ Place and Phone _____

Accident? _____ If so, is subrogation a possibility? _____ Accident Report? _____

Patient Diagnosis Code(s) _____ Prognosis _____

Patient Onset Date _____ Date & Method Notice of Patient Received _____

Treatment(s) _____

_____

Check and attach: ☐ any and all pre-admission certs ☐ case management reports
☐ other reports _____ ☐ other _____

Is care in-network? Discuss _____

Physician Name and Phone Number _____

Hospital Name and Date of Admission (specify if other) _____

Specific Deductible _____ Amount Paid _____ Last Payment Date _____

Amount of Recoveries Received _____ Requested Amount _____ Estimate of Total Amount _____

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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)

_____ Claim information including employee's ID, patient's ID, relation to employee, date of service, date received, date of payment, amount paid, procedure code, diagnosis code(s) and check number. Claims pending but unpaid should also be submitted. If not on the system, then a manual accounting should be taken.

_____ Copy of both employee and patient (if different) enrollment cards or other proof of enrollment.

_____ Copy of Plan Document

For office use: Received by _____ Date _____