Amalgamated Life
Group • Stop Loss • Voluntary

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 _____