



Tokio Marine HCC - Stop Loss Group
 225 TownPark Drive, Suite 350
 Kennesaw, GA 30144 USA
 Tel: 800-447-0460

HCC Life Insurance Company Monthly Advance Reimbursement Claim Form

Policyholder _____

Contract Basis _____ Effective Date _____ Expiration Date _____

Instructions for completing this form:

To calculate the Minimum Deductible, divide the annual Minimum Deductible by 12, then multiply by the number of months the accommodation has been in effect. Enter this amount on line A. Your accommodation request on line 6 will be line 1, less the greater of line A or B, less any amounts listed in lines 3, 4 or 5.

Email ALL claim requests to: stoplossaggregate@tmhcc.com

Attachment Point

- | | |
|---|----------|
| A. Minimum Monthly Aggregate Deductible through ___/___/___ | \$ _____ |
| B. Annual Aggregate Deductible (calculated) through ___/___/___ | \$ _____ |

- | | |
|---|----------|
| 1. Total paid claims through ___/___/___ | \$ _____ |
| 2. Less Attachment Point (greater of A or B) | \$ _____ |
| 3. Less previous Monthly Accommodations | \$ _____ |
| 4. Less claims exceeding Specific Deductible/Loss Limit | \$ _____ |
| 5. Less ineligible claims | \$ _____ |
| 6. Total amount of accommodation requested | \$ _____ |

Include the following information/documentation with your monthly request:

1. Paid claims analysis (show incurred date of each loss, payment date, payment amount and payee)
2. Monthly Loss Summary Report (showing monthly census and claims)

Please read the following before signing

Receipt of the Monthly Deductible Advance Reimbursement (MDAR) request is preferred within **15 days** following the end of the month for which the accommodation is requested.

I certify that all checks totaling the amount entered on item 1 has been mailed to payee.

Name	Title	Date
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Claims Administrator

Phone Number _____

E-Mail Address _____