Ullico
SOLUTIONS FOR THE UNION WORKPLACE

SPECIFIC STOP LOSS CLAIM

INITIAL FILING *OR* NOTIFICATION FORM

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

☐ Initial Claim ☐ Claim Notification (50% Notice or trigger diagnosis)

POLICYHOLDER INFORMATION:

Plan Sponsor (Group) Name: _____ Policy # _____

Policy Period:_____ Contract Type: _____ Specific Deductible: _____

MEMBER INFORMATION:

Member Name: _____ Soc Sec #_____

Date of Birth: _____ Date of Hire: _____ Original Effective Date: _____ Plan #: _____

MEMBER'S WORK STATUS:

☐ Actively working ☐ Retired - Retirement Date: _____

☐ Disabled and unable to work from: _____ to _____

☐ Not actively working Date last worked: _____

Indicate how coverage is being continued (mark all that apply):

☐ Sick Leave: _____ to _____ ☐ Vacation: _____ to _____

☐ Leave of Absence: _____ to _____ ☐ FMLA: _____ to _____

☐ Hour Bank? ☐ Yes (**please provide copy of report**) ☐ No

☐ Self pay: _____ to _____ (**please provide proof of premium payments**)

☐ Coverage Terminated? ☐ Yes ☐ No Date: _____

☐ COBRA applicable? ☐ Yes ☐ No COBRA Effective Date: _____

COBRA Premium Paid Through: _____ COBRA Termination Date: _____

CLAIMANT INFORMATION:

Claimant Name: _____ Date of Birth: _____

Relationship to Member: ☐ Spouse ☐ Child ☐ Other **If child,** Full Time Student: ☐ Yes ☐ No

Original Effective Date: _____ Termination Date: _____

Is COBRA applicable? ☐ Yes ☐ No COBRA Effective Date: _____

COBRA Premium Paid Through Date: _____ COBRA Termination Date: _____

Is Claimant covered by any other insurance plan? ☐ Yes ☐ No

If yes, type of coverage (Auto, Work Comp, Group Plan, Medicare): _____

Carrier: _____ Effective Date: _____ Termination Date: _____

Is Pre-existing applicable? ☐ Yes ☐ No Pre-existing Condition: _____

Please provide pre-existing/HIPAA documentation

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CLAIM INFORMATION:

Diagnosis: _____ Date of Onset: _____ Prognosis: _____

Claimant injured? ☐ Yes ☐ No Date of Injury:_____ Place Injury Occurred: _____

How did injury occur? _____

Subrogation applicable? ☐ Yes ☐ No If "Yes", please provide details: _____

PPO? ☐ Yes ☐ No Name of PPO: _____

Case Management? ☐ Yes ☐ No Vendor Name & Phone: _____

Claims Paid to Date: $ _____ Claims Pending: $ _____

SPECIFIC STOP LOSS CLAIM FORM

Total Eligible Benefits this Submission: $ _____

Less Specific Deductible: $ _____

Less Aggregating Specific Deductible (if Applicable $ _____

Balance: $ _____

Percentage to be Reimbursed: % _____

Reimbursement Requested: $ _____

Simultaneous (Advanced) Funding Requested: ☐ Yes ☐ No

Simultaneous Amount being Requested: $ _____

YOUR REQUEST SHOULD INCLUDE COPIES OF THE FOLLOWING INFORMATION: (IF APPLICABLE)

Enrollment Form (initial/current)
Member Claim Form
Copy of Hour Bank/Dollar Bank
Proof of Premium Payments
COBRA Election form & Proof of payment Medicare Election Form/Medicare Card EOB/Claim checks/Registers
Deductible/Coinsurance Proof of satisfaction Divorce or Separation Decrees or Court Orders
Complete Paid Claims Detail/History Report
Itemized Bills/Electronic Claim Data
R&C Calculations
Precertification Forms

Hospital Audits/Reviews
Hospital Records
Large Case Management Reports
Cumulative paid claims report
Investigative materials to support claim:

- COB
- Full time student status
- Pre-existing/HIPAA Documents
- Physician's Statements
- Subrogation information
- Work Comp information
- Accident Details (police report, etc.)

TPA/Claims Administrator Name: _____

Address: _____

_____

Phone: _____ Fax: _____ E-Mail: _____

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I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ATTACHED *FRAUD NOTICE*, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

Authorized Signature: _____ Date: _____

SUBMIT TO:

THE UNION LABOR LIFE INSURANCE COMPANY
8403 Colesville Road, Suite 1300 Silver Spring, MD 20910
Toll Free Phone: 1-800-328-5837 • Fax: 1-202-682-6920 • E-mail: stoplossclaims@ullico.com

SPECIFIC STOP LOSS CLAIM FORM

FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Georgia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.