ORIEN
RISK ANALYSTS

AGGREGATE EXCESS COVERAGE

AGGREGATE AND/OR ACCOMMODATION BENEFIT

NOTICE/PROOF OF LOSS

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1. Plan Name _____ 2. Basis: _____

3. Policy Year for this Claim: _____ 4. Expiration: _____

5. Total Eligible Claims Paid thru: _____/_____/_____ $_____
Month Day Year

6. Current Pro Rata Minimum Annualized Deductible: . . . . . $_____
(Attach Worksheet)

7. Accumulated Aggregate Attachment Point: . . . . . $_____
(Attach Worksheet)

8. Enter greater of (6) or (7): . . . . . $_____

9. Total Previous Accommodations or Payments: . . . . . $_____

Specific: . . . . . $_____

Aggregate: . . . . . $_____

10. New Reimbursement Requested: . . . . . TOTAL: $_____
Subtract Lines (8) and (9) from Line (5)

NOTE: Accommodations will not be made for less than $1,000.00

Please Attach the Following for accommodations. Please refer to Orien's Administration Manual for submitting a year end aggregate claim.

1) List of Paid Claims for the Policy Year-To-Date Sub-totaled by Claimant.
2) Aggregate Attachment Point Worksheet.

The Plan warrants that all monies necessary to pay for services and supplies have been paid to the respective providers of medical services or supplies to which this claim relates.

Authorized Signature: _____

Title: _____

TPA: _____

Address: _____

Telephone: _____

E-mail Address: _____

Mail Completed & Signed Form with Required Documentation To:

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