ORIEN
RISK ANALYSTS

AGGREGATE EXCESS COVERAGE

AGGREGATE AND/OR ACCOMODATION

NOTICE / PROOF OF LOSS

1. Plan Name: _____ 2. Basis: _____

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

5. Total Eligible Claims Paid thru: ____ / ____ / _____ $ _____
mo day year

6. Current Pro Rate 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: $ _____
Subject 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. Refer to Orien's Administration Manual for submitting a year end aggregate claim.

1) List of Paid Claims for the Policy Year-To-Date Subtotaled 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 of supplies to which this claim relates.

Authorized Signature: _____

Title: _____ Send Complete with Necessary Attachments to:

TPA: _____

Address: _____

Telephone: _____

E-mail Address: _____

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