INTERNATIONAL SPECIALTY UNDERWRITERS
6621 Southpoint Drive, North, Suite 325
Jacksonville, FL 32216
Telephone: (904) 281-2151 ***Fax: (904) 281-0384***

Aggregate Excess Loss Claim Form **Submit to: ISUClaims@isu-inc.net**

_____Aggregate Accommodation _____ Final Aggregate Submission

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Policyholder Group Name:_____

Policy Period:_____

A.	Total Claims Paid Year-to Date	$_____
B.	Less Claims Excess Specific Deductible	($_____)
C.	Less Ineligible or Extracontractual Claims	($_____)
D.	Less Refunds/Recoveries/Void	($_____)
E.	Total Eligible towards Aggregate (Sum charges A-E)	($_____)
F.	Less Attachment Point Attachment Point is the greater of : Year to Date based on Census_____ Minimum Attachment Point_____	($_____)
G.	**Amount Requested (E-F)**	**$_____**

Required Documentation:

- Aggregate Monthly Census, Paid Claims & Loss RatioWorksheet
- Contract year-to-date monthly check register showing all payments, voids, reissues and refunds. The Check register should have the check number, payment date, name of provider, name of claimant
- Contract year-to-date detailed claim report by claimant. The report should include: name of claimant, date of service, date paid, amount charges, diagnosis, amount paid, deductible and coinsurance, name of provider and type of service.
- Detailed eligibility report. Report should include all active, terminated and COBRA claimants covered during the policy year
- Summary service code report. This report should summarize claim payments made by service code (i.e. hospital, surgical, lab, drug….)
- Bank statements showing all disbursements and deposits made during the policy year plus one month after the policy period
- Prescription drug invoices for the Policy Period (if RX card eligible under aggregate)
- Listing of subrogation claims
- Listing of voids and refunds applied after the end of the Policy Period but applicable to the Policy Period

Administrator's Name:_____
Address:_____
Phone Number:_____Fax:_____
Contract:(Print)_____
Signature:_____