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

Submission Date: _____

◯ Claim Notification (50% Notice or trigger diagnosis) ◯ Initial Claim ◯ Subsequent Claim # ____ ☐ Final Claim

POLICYHOLDER INFORMATION:

Plan Sponsor (Group) Name: _____ Policy # _____

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

MEMBER INFORMATION:

Member Name: _____ Group ID/Soc Sec #_____ Date of Birth: _____

WORK STATUS: ***** Please provide copies of Hour Bank Report or Premium Payments, whichever applies *****

◯ Actively working Date of Hire: _____ Original Effective Date: _____ Medical Plan: _____

◯ Retired Retirement Date: _____ Under 65 65 & over

◯ Not actively working Date last worked: _____ Return to Work date: _____

◯ Disabled and unable to work Date last worked: _____ Return to Work date: _____

Is member terminated ◯ Yes ◯ No Termination Date: _____

If coverage is being continued, please mark all that apply:	From Date	To Date
☐ Sick Leave		
☐ Vacation		
☐ Leave of Absence		
☐ FMLA		
☐ COBRA		

CLAIMANT INFORMATION:

Claimant Name: _____ Date of Birth: _____

Gender: _____ Relationship to Member: ◯ Self ◯ Spouse ◯ Child ◯ Other _____

Original Effective Date: _____ Termination Date: _____

COBRA? ◯ Yes ◯ No COBRA Effective Date: _____ - _____ COBRA Premium Paid Thru 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: _____

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: _____

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

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

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Total Eligible Benefits this Submission: $ _____

Less Specific Deductible: ($ _____)

Balance: $ 0.00

Less Previous Claim Submission ($ _____)

Reimbursement Amount Requested (this claim): $ _____

Simultaneous (Advanced) Funding Requested: ◯ Yes ◯ No

Simultaneous Funding Amount being Requested: $ _____

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: _____

Printed Name: _____ E-Mail: _____

Title: _____ Phone: _____

Company Name_____ Relation to Policyholder: _____

Mailing Address: _____

_____

To expedite your request, please include copies of the following Documents (as applicable):

Proof of Eligibility
- Enrollment Form (initial/current)
- Copy of Hour Bank/Dollar Bank
- Proof of Premium Payments
- COBRA Election form & Proofs of payments
- Court Orders
- Election Form/Medicare Card
- Coordination of Benefits/Other Insurance

Complete Paid Claims Detail/History Report

Deductible/Coinsurance - Proof of satisfaction

Facility Universal Bill/DRG Code

Itemized Bills/Electronic Claim Data

R&C Calculations for Out of Network Claims

Copy of Contracted/Case rates

Proof of Precertification/Approval

Hospital Audits/Reviews findings

Hospital Records/Medical Reports

Large Case Management Reports

Proofs of Payment

Cumulative paid claims report

Investigative materials to support claim:
- Subrogation information
- Work Comp information
- Accident Details (police report, etc.)

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FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

California: For your protection, California Law requires the following to appear on this form: 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.

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.