Standard Life & Accident Insurance Company
Galveston, Texas

Care of:
Arbor Benefit Group
281 Farmington Ave, Second Floor
Farmington, CT 06032
(860)674-9748 phone - (860)674-9132 fax

Specific Excess Risk Coverage Verification and Claim Calculation

Group No.	Specific Deductible	Claim Basis: ☐ 15/12 ☐ 24/12 ☐ 12/12 ☐ 12/15 ☐ 12/18 ☐ 12/24
Group Name	Co-Insurance Plan Deductible	COB: ☐ Yes ☐ No
TPA	Plan Eff.	Cobra: ☐ Yes ☐ No _____/_____/_____
Employee	EE Eff.	Subrogation or Third Party Recovery Potential: ☐ Yes ☐ No
Patient	Plan Year	Date Accident/Illness Occurred _____/_____/_____
Date of Birth	Original Plan Effective Date	Is claimant deceased? Date of death _____/_____/_____

This form supplements our customary requirements for proof of loss. Some claims may require additional investigation by our staff or an outside agency.

FLORIDA law requires claimants be advised that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

IDAHO law requires claimants be advised that any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NEW JERSEY law requires claimants to be advised that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

OHIO law requires any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SECTION A - Verification

Employee	Soc. Sec. No.	Eff. Date of Policy	Date Premium Paid To	Has Employee/Dependent Terminated? If So, Give Date:	
Dependent Relationship	Soc. Sec. No.	Eff. Date of Policy	Date Premium Paid To	Employee	Dependent

Was Employee at Work (in Active Service) on the Effective Date ☐ Yes ☐ No	If No, Date Last Worked	Total Paid / Payable to Date	Estimate of Future Liability

Diagnoses: Explain in Detail	Benefits Paid by Plan $_____ Less Specific Excess Deductible - _____ Reimbursement Requested $_____

Notes:

SECTION B - Additional Claim Information

Large Case Management: ☐ Yes ☐ No. If yes, please indicate name and address of management firm. Date Activated ____/____/____

NOTE: Reimbursement requests cannot be processed without legible copies of claim checks, EOB's and copies of all medical bills.

SECTION C - Calculation

Name of Administrator	Address	Phone No.	Date
		Signature	