



# Notification of Claim/Reimbursement Request

## GROUP

Group Name:			
Group Policy #			
Excess Loss Policy Year:		to	
Specific Deductible: \$		Terms:	

## EMPLOYEE

Employee Name:		SS #	
Employee's Current Status:			
If terminated, give date of termination:			
If on COBRA, Leave of Absence or Terminated, please advise last day worked:			
Was Employee Actively at Work on Excess Loss Effective Date?			
If no, please explain:			

## CLAIMANT

Claimant Name:		Date of Birth:	
Claimant's Current Status:			
If terminated, give date of termination:			
Was Claimant totally disabled on Excess Loss Effective Date?			
If yes, was he/she disclosed to us at the time of Underwriting?			
Original Effective Date of Coverage:			
Diagnosis:		Prognosis:	
Claims Paid Year to Date: \$		TPA Pending: \$	
Has Large Case Management been implemented?			
Specific Advance? (YES/NO)		Final Filing? (YES/NO)	

If yes, attach completed specific Advance Request **AMOUNT REQUESTED:** \_\_\_\_\_

## DOCUMENTATION

Please submit the following (originals or copies) along with this form for claim consideration:

1. Enrollment Card(s), original and any charge cards
2. Itemized Provider's Bills
3. Explanation of Benefit Forms
4. Benefit Checks or Drafts
5. Specific Reinsurance Accumulation Sheet
6. Copies of TPA billing statements for original effective month of employee if employee was not included on census submitted at underwriting.
7. Any other pertinent documentation (Claim Form, Hospital Pre-Certifications, Hospital Audit Results, COBRA Premium, Accident Details, Subrogation Verification, Large Case Management Reports)

### SUBMIT TO:

CANADA LIFE ASSURANCE COMPANY  
 245 PERIMETER CENTER PARKWAY ATLANTA, GEORGIA 30346  
 Toll Free: 1-877-472-1127, Fax: 770-290-9216

Submitted By:		Title:	
Company/TPA:			
Address:			
Telephone:		Fax:	
Date Submitted:			