



FIRST NOTICE OF CLAIM

STOP LOSS CLAIM FORM

Complete this form when the claim exceeds 50% of the deductible or is a Large Case per the contract.

Canada Life Assurance Company
245 Perimeter Center Parkway
Atlanta, Georgia 30346
Toll Free: 877-472-1127, Fax: 770-290-9216

Group Name & Number: _____

Effective Date of Employer Stop Loss Coverage: _____

Name of Enrollee and Patient: _____ SS#: _____

Enrollee(s) Date of Birth _____ Patient(s) Date of Birth _____

Effective date of Enrollment (Enrollee & Patient): _____

Termination Date (if applicable): _____

Date of First Claim: _____ Date First Received: _____

Date of First Admission to Hospital: _____ Date of First Discharge: _____

Current case management vendor, Name/ Address / Phone: _____

Date(s) of Subsequent Admission(s): _____

Date(s) of Subsequent Discharge(s): _____

Carry Over Claim: YES ___ NO ___ If yes, amount claimed previous year: \$ _____

Other Coverage: COB: _____ TPL: _____ W/C: _____ Carrier: _____

Total Charges to Date for this Claim: \$ _____

Total Paid to Date for this Claim: \$ _____

Projected Total Charges Through: _____ \$ _____

Projected Total Payments Through: _____ \$ _____

Projected Requested Reimbursement: \$ _____

Diagnosis: _____

Prognosis: _____

Comments: _____

Signed: _____ TPA: _____ Date: _____

Title: _____ TPA

Address: _____ Phone: _____

Canada Life refers to insurance coverage and administrative services to self-funded plans that are provided, outside of NY, by Canada Life Assurance Company.