National Underwriting Services, Inc.
14893 St. Hwy 16 N., Suite 1
Helotes, Texas 78023
(210) 695-2381 Fax (210) 695-2387

PROOF OF LOSS – AGGREGATE REIMBURSEMENT CLAIM FORM

Stop Loss Group Number ____________________ Stop Loss Claim Number __________________

Effective Date ______________________________ Expiration Date ___________________________
(of Claim Year) (of Claim Year)

1. Employer____
2. The total amount of mailed claim payments are: $____
3. The Minimum Aggregate Deductible is: $____
4. The Annual Aggregate Deductible is: (Calculated $____
5. Less the amount of specific payments: $____
6. Less the total amount of prior advances: $____
7. The total amount of the reimbursement is: $____

Instructions For Completing The Above:

The Minimum Aggregate Deductible is the amount stated in the contract. Enter that amount on Line 3. To calculate the amount to be entered on Line 4, multiply the Aggregate factors per Month by the actual enrollment of each month. Add the 12 months and enter the total on Line 4. The total you request on Line 7 will be the total on Line 2, less the Greater amount on either Line 3 or Line 4, and less the totals on Line 5 and Line 6, if any.

Please Read Before Signing:

Enclosed is the necessary information (refer to the NUS Aggregate Claim Checklist for the list of required items) in order to process our claim request. I certify that all checks were mailed to the payee on or before the last day of the Contract Year for which this claim has been presented.

______________________________ ______________________________ ______________
Authorized Signature Title Date

______________________________ ______________________________ ______________
Designated Third Party Administrator City State