ASG Risk Management, Inc.
Two Monument Square, Ste. 520
Portland, ME 04101

Please fax completed form to: (207) 773-0044
Telephone No. (207) 775-2332

SPECIFIC EXCESS LOSS 50% NOTIFICATION AND PRELIMINARY NOTIFICATION OF POTENTIAL LARGE CLAIM

Plan Information

Plan Sponsor: ______________________ Policy Number: ______________________

Policy Period: ______________________ Specific Deductible: $______________________

Employee Information

Name: ______________________ DOB: ______________ Eff. Date: ______________

SSN: ______________________ Hire Date: ______________ Term. Date: ______________

Claimant Information

Name: ______________________ DOB: ______________ Eff. Date: ______________

Relationship: ______________________ Hire Date: ______________ Term. Date: ______________

COBRA Eff. Date: ______________________ Eligible for Medicare? ❑ Yes ❑ No

Covered under any other group insurance? ❑ Yes ❑ No

"Actively at Work" on Eff. Date? ❑ Yes ❑ No

If Yes, name of carrier and policyholder: Carrier: ______________________

Policyholder: ______________________

Diagnosis (if accident, provide details): ______________________

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Current Physician: ______________________ Telephone Number: ______________________

Current Facility: ______________________ Telephone Number: ______________________

Date of Onset: ______________________ Date(s) of Hospitalizations: ______________________

Pre-Existing Condition? ❑ Yes ❑ No
Coordination of Benefits? ❑ Yes ❑ No

Ongoing Condition? ❑ Yes ❑ No
Case Management? ❑ Yes ❑ No
Subrogation Involved? ❑ Yes ❑ No

Prognosis and Expected Treatment: ______________________

Paid Claim Amount: ______________________ **Pending Claim Amount:** ______________________

TPA: ______________________

Signature: ______________________ Date: ______________________