

ASG Risk Management, Inc.
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AGGREGATE EXCESS LOSS FORM

Plan Information

Plan Sponsor: _____ Policy Number: _____
Policy Period: _____ Contract Basis: _____
Plan Administrator: _____
Covered Benefits: _____ Separate Drug Plan Included? Yes No

Claim Information

1. Total Eligible Claims Paid _____
2. Minimum Annual Aggregate Attachment Point _____
3. Annual Aggregate Attachment Point _____
4. Subtract the Greater of #2 or #3 from #1 above _____
5. Less Total Specific Reimbursements Paid or Pended _____
6. Less Other Adjustments _____
7. Estimated Amount of Reimbursement Due Plan Sponsor _____

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE, ACCURATE AND COMPLETE AND THAT THIS CLAIM HAS BEEN PAID IN ACCORDANCE WITH THE PLAN SPONSOR'S PLAN DOCUMENT.

By: _____ Title: _____ Date: _____