PartnerRe

Claim Reporting Form
Employer Excess of Loss Insurance

Claim Reimbursement Request: Select Simultaneous Funding: Select

Policyholder: _____ Claims Basis: Select

Policy #: _____ Policy Period: _____ to _____

Subscriber Benefit Plan Name: _____

Name of Subscriber: _____ Subscriber DOB: _____
(Last Name, First Name)

Subscriber Unique ID #: _____ Subscriber Effective Date: _____

Current Status: Select Claim Basis Terminated or COBRA Effective Date: _____

Name of Claimant: _____ Claimant DOB: _____
(Last Name, First Name)

Relationship to Subscriber: Select Claimant Effective Date: _____

Claim is Due to: Select Work Related Claim: Select

Automobile Accident: Select Third Party Subrogation Applies: Select

Diagnosis: _____

Will Medical Expenses be Paid by:

Auto Insurance: Select Workers Compensation: Select Other (COB etc.): Select

Medicare: Select Reason for Medicare Eligibility: Select Medicare Effective: _____

Prognosis: _____
(please include expected treatment)

Amount Reported This Claim: _____ Expenses Incurred Thru Date: _____

Less Specific Deductible: _____ Expenses Paid Thru Date: _____

Coinsurance Percentage: _____ Estimated Additional Costs: _____

REIMBURSEMENT REQUEST: _____

Signature: _____ Title: _____ Date: _____

Direct inquiries to: PartnerRe America Insurance Company, Attn: Claims Department, 6900 Wedgwood Road North, Maple Grove, MN 55311
1 612 234 4920 claimshealth@partnerre.com

INSURANCE FRAUD WARNING
Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties as defined by your state statutes.

These forms contain personal and Protected Health Information under HIPAA and may be transmitted only in a HIPAA compliant medium. **DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION.**

PartnerRe America Insurance Company
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