ONE80 INTERMEDIARIES
National Underwriting Services, Inc.

If you are a California resident, you have certain rights under California privacy laws regarding your personal information. To view your rights, please review our California Privacy Notice and Notice at Collection located at www.fslins.com

50% Notification/Specific Excess Loss Claim

CLEAR FORM

☐ 50% Notification ☐ Initial Claim ☐ Supplemental Claim ☐ Final Request

Employer/Group Name: _____

Current Policy Period: _____ Specific Deductible: _____

Employee Information

Employee: _____ Social Security Number: _____

Date of Birth: _____ Date of Hire: _____ Original Effective Date: _____

What is the employee's work status?

☐ Actively working the required number of hours per week to be considered full-time

☐ Retired (date retired: _____) ☐ Disabled

Coverage is being continued through the following:

☐ Leave of Absence ☐ FMLA ☐ Sick Time ☐ Vacation ◦ Coverage Termination Date: _____

Is COBRA applicable? ☐ Yes* ☐ No ◦ COBRA effective date: _____ ◦ COBRA termination date: _____

Claimant Information

Name: _____ Original Effective Date: _____

Date of Birth: _____ Relationship to Employee: _____ Gender: Select one

Is claimant covered by any other insurance (i.e., Worker's Compensation, Auto, and Group Plan)? ☐ Yes* ☐ No

◦ Effective Date: _____ ◦ Carrier: _____

Claim Data

Requested Amount: _____ TPA Paid to Date: _____

Incurred Dates for this request: _____ to _____ Paid Dates: _____ to _____

Diagnosis Code: _____ Description: _____

Was claimant listed on NUS Disclosure Statement? ☐ Yes ☐ No* *If No, Why? _____

Was patient I/P confined? ☐ Yes* ☐ No *If Yes, list DOS and procedures: _____

Pre-Certification needed? ☐ Yes* ☐ No *If Yes, Enclosed? _____

Hospital Audit performed? ☐ Yes* ☐ No *If Yes, Enclosed? _____

Will this claim be Subrogated? ☐ Yes* ☐ No *If Yes, Enclosed? _____ *If accident, please provide the complete accident details and a police report.*

Is Pre-existing Condition applicable? ☐ Yes* ☐ No *If Yes, is HIPPA certification enclosed? _____

(Continue on Page 2)

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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UR/LCM Information

Are Case Management services active? ☐ Yes* ☐ No *If Yes, Enclosed? _____

UR/LCM Vendor Name: _____

Mailing Address: _____ City: _____ State: Select a State Zip: _____

Contact Name: _____ Phone Number: _____ Email: _____

Completed By: _____ Phone Number: _____ Date: _____

Failure to complete this form could delay claim payments.

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