

EXTRAORDINARY BENEFITS REQUEST FORM



Completed by	Last Name		Name		Middle Initial
Date	MM / DD/ YY	Date received by the team	MM / DD/ YY	Case number	

Insured's name					
Policy number		Country of residence			
Annual deductible		Deductible met			
Product		Producer code			
Requested by					<input type="checkbox"/> Insured <input type="checkbox"/> Agent
General producer's name		Code			
Claim number (if applicable)					
Last 5 years premium		Policy claims paid (all)			
Effective date/Commencement date of policy	MM / DD/ YY				

Requested amount: US\$	
Reason for Denial (please check all that apply)	
<input type="checkbox"/> UCR <input type="checkbox"/> Filing limit <input type="checkbox"/> General policy exclusion <input type="checkbox"/> Individual policy exclusion	
<input type="checkbox"/> Policy condition <input type="checkbox"/> Out of network	
<input type="checkbox"/> Other:	

Other relevant information/comments:

Review date	MM / DD/ YY	Signature	
Decision			

SUBMIT