

# 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**