



14755 North Outer Forty Dr, Ste 300
Chesterfield, MO 63017
636-449-7000
636-449-7199 Fax

Aggregate Reimbursement Request

Policy Term: _____

Total Net Paid To Date (a) \$ _____

Less any specific recovery
in excess of SIR) - _____

Less audited attachment point - _____

Less any SITF/Subro recovery
On claims within the policy term - _____

Less Prior reimbursements - _____

Sub total (b) - _____

Proposed Reimbursement Due (a-b) \$ _____

The following information must be included with the reimbursement request:

- Detailed loss run that applies to the aggregate policy period that includes all open and closed claims. (Include any credits or recoveries and outstanding reserves by category)

We certify the above amounts are accurate. We are requesting payment on the behalf of the insured, _____.

Checks will be payable to the named insured and mailed in care of the requesting party unless we are otherwise instructed. Please supply mailing address.

Signed By: _____ Date: _____

Phone: _____ E-mail: _____

MECC Claim Number: _____

Without the completed information above and the required documents requested, reimbursement will be delayed until received in full.

To expedite, you may submit this form and the documentation described above to ClaimTPA@mwecc.com showing the subject line: **“REIMBURSEMENT REQUEST”**

Washington Fraud Warning: "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

Copies of this form can be obtained through our website, www.mwecc.com