# SHELTERPOINT

*ShelterPoint Life, formerly First Rehab Life*

**The First Rehabilitation Life Insurance Company of America (First Rehab Life) changed its name to ShelterPoint Life Insurance Company (ShelterPoint Life)** – same company, different name.

Effective with the name change, your Excess Major Medical policy became a closed block of business and hence remains under the First Rehab Life name. **Your Excess Major Medical policy/certificate remains valid as is. Reprints continue to show First Rehab Life.** All claim/change forms also remain in the First Rehab Life name and are still valid.

**Please note:** While your Excess Major Medical forms continue to carry the First Rehab Life name, all correspondence must be directed to ShelterPoint Life:

Mail:
**ShelterPoint Life**
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530

Phone:
**800-365-4999**

Web:
**www.shelterpoint.com**

Email:
**customerservice@shelterpoint.com**
**excessmajorclaims@shelterpoint.com**

If you have any questions, please contact your Plan Administrator.

*We look forward to servicing your needs over the years to come.*

the first REHABILITATION LIFE INSURANCE COMPANY of AMERICA

# GROUP EXCESS MEDICAL

## STATEMENT OF CLAIM FOR CO-INSURANCE BENEFITS

*TO FILE:*
ATTACH COPIES OF PAYMENT STATEMENTS FROM ALL OTHER CARRIERS

600 NORTHERN BLVD
GREAT NECK NY 11021-5202

### EMPLOYER'S CERTIFICATION

| Employer's Name | Employer's Address (Street, City, State, Zip Code) | Policy Number **XGMM-** |
|---|---|---|
| Employee's Name(Last, First, Middle Initial) | Date Employed | Occupation |
| Employee's Social Security No. | Date Employee Insured | Date Dependents Insured |
| Employee's Status ☐ Active ☐ Retired | Type of Excess Coverage ☐ Individual ☐ Family | If Coverage is terminated, give date |
| Signature & Title of Authorized Person | | Date |

### EMPLOYEE'S STATEMENT *(Complete for all claims)*

| Employee's Name (Last, First, Middle Initial) | | Employee's Address (Street, City, State, Zip Code) |
|---|---|---|
| Employee Date of Birth | Employee's Social Security No. | Telephone No. |
| Claims for ☐ Self ☐ Spouse ☐ Child | Patient's Name (Last, First, Middle) | Employee's Status ☐ Male ☐ Single ☐ Divorced ☐ Widow ☐ Female ☐ Married ☐ Seperated ☐ Widower |
| Patient's Date of Birth | Is Patient on Medicare? ☐ Yes ☐ No | |

### COMPLETE IF EMPLOYEE IS MARRIED

| Name of Spouse | Spouse Social Security No. | Is Spouse Employed? ☐ Yes ☐ No |
|---|---|---|
| If you answered " Yes" to the previous question, give name, address and phone number of spouse's employer | | |
| | | |
| Name(s) and Address(es) of spouse's health insurance carrier(s) | | Policy Number(s) |
| | | |
| | | |
| Spouse's Insurance I.D..Number | Spouse's Coverage ☐ Individual ☐ Family | Are there any other health insurance benefits available from any other source? ☐ Yes ☐ No If "Yes" please give details in space below. |
| | | |

### COMPLETE IF CLAIM IS FOR YOUR DEPENDENT CHILD

| Child's Name | Indicate if child is ☐ Student ☐ Married ☐ Handicapped | Child lives at ☐ Home ☐ School |
|---|---|---|
| If Child is in school and between ages 18 and 25, give school name and address | | |
| Is child employed? ☐ Yes ☐ No<br>If "Yes" give name and address of employer. | | |
| Employer's Phone No. | Name of child's health insurance carrier and policy number | |

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containg any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

### COMPLETE FOR ALL CLAIMS

*I hereby authorize any Insurance Company, Prepayment Organization, Employer or provider of medical services to releases all information with respect of myself or my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information given by me in support of this claim is true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original.*

| Dependent Signature (If patient and not minor) | **Date** | **and Employee Signature** |
|---|---|---|

**Health Insurance**
**Claim Form**

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN** ***(If benefits to be assigned)***

## PATIENT & INSURED (SUBSCRIBER) INFORMATION

| | | |
|---|---|---|
| 1. PATIENT NAME *(First name, middle initial, last name)* | 2. PATIENT'S DATE OF BIRTH | 3. INSURED'S NAME *(First name, middle initial, last name)* |
| 4. PATIENT'S ADDRESS *(Street, city, state, Zip Code)* | 5. PATIENT'S SEX<br>MALE FEMALE | 6. INSURED'S I.D. No. *(Soc. Sec . No)* |
| | 7. PATIENT'S RELATIONSHIP TO INSURED<br>SELF SPOUSE CHILD OTHER | 8. INSURED'S GROUP NO. *(Or Group Name)* |
| 9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Name and Address and Policy or Medical Assistance Number | 10. WAS CONDITION RELATED TO:<br>A. PATIENT'S EMPLOYMENT<br>YES NO<br>B. AN AUTO ACCIDENT<br>YES NO | 11. INSURED'S ADDRESS *(Street, city, State, Zip code)* |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE<br>*I authorize the Release of any Medical information Necessary to process this claim.*<br>*SIGNED* *DATE* | | *13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.*<br>*SIGNED (Insured or Authorized Person)* |

## PHYSICIAN OR SUPPLIER INFORMATION

| | | | |
|---|---|---|---|
| 14. DATE OF; | ILLNESS (FIRST SYMPTOM) OR INJURY(ACCIDENT) OR PREGNANCY (LMP) | 15. DATE FIRST CONSULTED YOU FOR THIS CONDITION | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?<br>YES NO |
| 17. DATE PATIENT ABLE TO RETURN TO WORK | 18. DATES OF TOTAL DISABILITY<br>FROM THROUGH | | DATES OF PARTIAL DISABILITY<br>FROM THROUGH |
| 19. NAME OF REFERRING PHYSICIAN | | | 20. FOR SERVICES RELATED TO HOSPITALIZATION<br>ADMITTED DISCHARGED |
| 21. NAME 7 ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)* | | | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?<br>YES NO CHARGES: |

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

| 24. A DATE OF SERVICE | B * PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN<br>PROCEDURE CODE (IDENTIFY) | *(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES )* | D DIAGNOSIS CODE | E CHARGES | F |
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| 25. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>SIGNED DATE | | 26. TOTAL CHARGES | 27. AMOUNT PAID | 28. BALANCE DUE |
| | 29. YOUR SOCIAL SECURITY NO. | 30. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. | | |
| 31. YOUR PATIENT'S ACCOUNT NO. | 32. YOUR EMPLOYER I.D. NO. | I.D. NO. | | |

* PLACE OF SERVICE CODE

| | | | |
|---|---|---|---|
| 1- (IH) - INPATIENT HOSPITAL | 4 - (H) - PATIENT'S HOME | 7 - (NH) - NURSING HOME | O - (OL) - OTHER LOCATIONS |
| 2 -(OH)- OUTPATIENT HOSPITAL | 5 - DAY CARE FACILITY (PHY) | 8 - (SNF) - SKILLED NURSING FACILITY | A - (IL ) - INDEPENDENT LABORATORY |
| 3 -(O) - DOCTOR'S OFFICE | 6 - NIGHT CARE FACILITY (PHY) | 9 - AMBULANCE | B - OTHER MEDICAL/SURGICAL FACILITY |