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

In-Hospital Statement of Claim

Complete and return to:
The First Rehabilitation Life Insurance Company of America

600 Northern Blvd.
Great Neck, NY 11021-5202

PART 1 TO BE COMPLETED BY INSURED

Name _____ Employed By _____

Address: _____ Town, State: _____

Birth Date _____ Sex _____ SS# _____

Admission Date: _____ Discharge Date: _____

I authorize any individual of organization to release any information to First Rehabilitation Life Insurance Company of America for any services or benefits received or payable to me or on my behalf.

NOTICE: Any person who includes false or misleading information on an application for an insurance policy is subject to civil and criminal penalties.

Signature of Eligible Insured _____ Date _____

PART 2 TO BE COMPLETED BY HOSPITAL IN LIEU OF BC / BS VOUCHER

1. Name of Hospital _____

   Location _____

2. Patient _____ Hospital No. _____
   Last Name First Name Middle Name

   Age _____ Sex _____ If minor, Name of Guardian _____

3. Admitted (Date) _____ Discharge (Date) _____

   Total Days Hospitalized _____

4. Was patient in Intensive Care Unit during hospitalization? _____ Yes _____ No

   If yes, furnish dates of such I.C.U. confinement

   From _____ To _____

5. If patient is still hospitalized, please indicate expected duration of current hospitalization. _____

6. Diagnosis: _____

_____

Date: _____ 20 _____ Medical Records Librarian Authorized Designee _____

PART 3 TO BE COMPLETED BY: (BENEFITS ADMINISTRATOR)

Name _____ Group# _____

Effective Date: _____ Term Date: _____

_____ Date: _____