



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: _____