



The First Rehabilitation Life Insurance Company of America (First Rehab Life) changed its name to ShelterPoint Life Insurance Company (ShelterPoint Life) – same company, new 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 our new name, ShelterPoint Life. Our phone number remains the same:

ShelterPoint Life
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
800-365-4999

Our corporate web address has changed to reflect the name change:
www.shelterpoint.com

New email addresses are as follows:
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.

GROUP EXCESS MEDICAL



STATEMENT OF CLAIM
FROM ALL OTHER CARRIERS
FOR CO-INSURANCE BENEFITS

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

1225 Franklin Avenue, Suite 475
Garden City, NY 11530

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 <input type="checkbox"/> Active <input type="checkbox"/> Retired	Type of Excess Coverage <input type="checkbox"/> Individual <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Patient's Name (Last, First, Middle)	Employee's Status <input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widower	
Patient's Date of Birth	Is Patient on Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		

COMPLETE IF EMPLOYEE IS MARRIED

Name of Spouse	Spouse Social Security No.	Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Individual <input type="checkbox"/> Family	Are there any other health insurance benefits available from any other source? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give details in space below.

COMPLETE IF CLAIM IS FOR YOUR DEPENDENT CHILD

Child's Name	Indicate if child is <input type="checkbox"/> Student <input type="checkbox"/> Married <input type="checkbox"/> Handicapped	Child lives at <input type="checkbox"/> Home <input type="checkbox"/> School
If Child is in school and between ages 18 and 25, give school name and address		
Is child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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 containing 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
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**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 MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S I.D. No. (Soc. Sec. No)	
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Name and Address and Policy or Medical Assistance Number		7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. INSURED'S GROUP NO. (Or Group Name)	
		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S ADDRESS (Street, city, State, Zip code)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <i>I authorize the Release of any Medical information Necessary to process this claim.</i>			13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.		
SIGNED		DATE		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	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/> DATES OF PARTIAL DISABILITY	
FROM		THROUGH		FROM	
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION		ADMITTED	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES:		DISCHARGED	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, <u>RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE</u>					
1.					
2.					
3.					
4.					
24. A		B *		C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	
DATE OF SERVICE		PLACE OF SERVICE		D	
		PROCEDURE CODE (IDENTIFY)		DIAGNOSIS CODE	
		(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)		E	
				CHARGES	
				F	
25. SIGNATURE OF PHYSICIAN OR SUPPLIER				26. TOTAL CHARGES	
				27. AMOUNT PAID 28. BALANCE DUE	

SIGNED

DATE

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
- 2-(OH)- OUTPATIENT HOSPITAL
- 3-(O) - DOCTOR'S OFFICE

- 4 - (H) - PATIENT'S HOME
- 5 - DAY CARE FACILITY (PHY)
- 6 - NIGHT CARE FACILITY (PHY)

- 7 - (NH) - NURSING HOME
- 8 - (SNF) - SKILLED NURSING FACILITY
- 9 - AMBULANCE

- O - (OL) - OTHER LOCATIONS
- A - (IL) - INDEPENDENT LABORATORY
- B - OTHER MEDICAL/SURGICAL FACILITY