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.

the first REHABILITATION LIFE INSURANCE COMPANY of AMERICA

GROUP EXCESS MEDICAL

In-Hospital Statement of Claim

Complete and return to:

ShelterPoint Life Insurance Co.
1225 Franklin Ave, Ste 475
Garden City, NY 11530

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 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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: _____

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