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, 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 address and phone number remain 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

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, Ste. 475
Garden City, NY 11530

EMPLOYER'S CERTIFICATION

Employer's Name	Employer's Address (Street, City, State, Zip Code)	Policy Number
Nyack Union Free School District	13A Dickinson Avenue, Nyack NY 10960	**XGMM-** 1127

Employee's Name(Last, First, Middle Initial)	Date Employed	Occupation

Employee's Social Security No.	Date Employee Insured	Date Dependents Insured

Employee's Status	Type of Excess Coverage	If Coverage is terminated, give date
☐ Active ☐ Retired	☐ Individual ☐ Family	

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	Are there any other health insurance benefits available from any other source?
	☐ Individual ☐ Family	☐ 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	Child lives at
	☐ Student ☐ Married ☐ Handicapped	☐ Home ☐ School
If Child is in school and between ages 18 and 25, give school name and address		
Is child employed? ☐ Yes ☐ 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 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 MALE FEMALE	6. INSURED'S I.D. No. *(Soc. Sec . No)*
	7. PATIENT'S RELATIONSHIP TO INSURED 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: A. PATIENT'S EMPLOYMENT YES NO B. AN AUTO ACCIDENT YES NO	11. INSURED'S ADDRESS *(Street, city, State, Zip code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *I authorize the Release of any Medical information Necessary to process this claim.* *SIGNED* *DATE*		*13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.* *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? YES NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION 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? 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 PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER 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