SHELTERPOINT

GROUP EXCESS MEDICAL

In-Hospital Statement of Claim

Complete and return to:
ShelterPoint Life Insurance Company

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 ShelterPoint Life Insurance Company 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: _____