SHELTERPOINT

Claim Form
ShelterPoint Life Insurance Company
600 Northern Boulevard, Ste. 310 | Great Neck, NY 11021
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
www.shelterpoint.com | Phone: 800.365.4999 (516.829.8100)
Formerly First Rehab Life

Long Term Disability (LTD)

EMPLOYER'S CERTIFICATION

EMPLOYER'S NAME		EMPLOYER'S ADDRESS (Street, City, State, Zip Code)		POLICY NUMBER
EMPLOYEE'S NAME (Last, First, Middle Initial)		DATE EMPLOYED	DATE EMPLOYEE INSURED	EMPLOYEE'S SOC. SEC. NO.
EMPLOYEE ☐ ACTIVE ☐ RETIRED	DATE LAST WORKED / DATE OF RETURN (If back to work)	IF COVERAGE IS TERMINATED, GIVE DATE	EMPLOYEE'S BASIC WAGES OR SALARY (If claim is for Weekly Disability) $ ☐ Annual ☐ Hourly ☐ Weekly	
JOB DESCRIPTION				
SIGNATURE AND TITLE OF AUTHORIZED PERSON			DATE	

EMPLOYEE'S STATEMENT (Complete for all claims)

EMPLOYEE'S NAME (Last, First, Middle Initial)

EMPLOYEE'S DATE OF BIRTH | EMPLOYEE'S SOCIAL SECURITY NO.

☐ MALE ☐ SINGLE ☐ DIVORCED
☐ FEMALE ☐ MARRIED ☐ WIDOWED

EMPLOYEE'S ADDRESS
Street _____
City _____ State _____ Zip _____
Telephone No. Area Code (_____) _____

HAVE YOU PREVIOUSLY BEEN TREATED FOR THIS OR A RELATED MEDICAL PROBLEM ? ☐ YES ☐ NO
IF YES, STATE WHEN AND GIVE NAME(S) AND ADDRESS(ES) OF DOCTOR(S) OR HOSPITAL(S)

WAS THIS ILLNESS OR INJURY SUSTAINED IN CONNECTION WITH ANY EMPLOYMENT? ☐ YES ☐ NO	NATURE OF ILLNESS OR INJURY	DATE OF FIRST TREATMENT
RESULT OF AUTOMOBILE ACCIDENT? ☐ YES ☐ NO	IF ACCIDENT INVOLVED, GIVE DATE, HOW, AND WHERE ACCIDENT OCCURRED	

COMPLETE THE FOLLOWING

ARE YOU RECEIVING, OR ARE YOU ENTITLED TO RECEIVE, BENEFITS FROM ANY OF THE FOLLOWING SOURCES?
EACH QUESTION MUST BE ANSWERED.

A. SALARY WAGES OR COMMISSIONS	☐ YES	☐ NO	E. VETERANS ADMINISTRATION	☐ YES ☐ NO
B. ANY GROUP INSURANCE,HEALTH OR WELFARE PLAN	☐ YES	☐ NO	F. RETIREMENT OR PENSION PLAN	☐ YES ☐ NO
C. WORKMEN'S COMPENSATION OR SIMILAR LEGISLATION	☐ YES	☐ NO	G. OTHER SOURCES (give details below)	☐ YES ☐ NO
D. SOCIAL SECURITY OR RAILROAD RETIREMENT ACT	☐ YES	☐ NO	_____	

FOR EACH QUESTION ANSWERED "YES " PLEASE FURNISH THE FOLLOWING INFORMATION:

NAME AND ADDRESS OF SOURCE	GROUP OR INDIVIDUAL BASIS	POLICY OR CLAIM NUMBER, IF ANY	EXACT DATE BENEFITS COMMENCED OR WILL COMMENCE	LENGTH OF BENEFIT PERIOD	AMOUNT OF EACH PERIODIC BENEFIT	TOTAL AMOUNT OF BENEFITS PAID

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.

I hereby authorize any Insurance Company, Prepayment Organization, Employer or provider of medical services to release all information with respect to 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 claims true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ EMPLOYEE SIGNATURE _____

Health Insurance
Claim Form
TO BE COMPLETED BY THE ATTENDING PHYSICIAN

PATIENT & INSURED (SUBSCRIBER) INFORMATION

PATIENT'S NAME *(First name, Middle, Initial, Last name)*

WAS CONDITION RELATED TO :
A PATIENT'S EMPLOYMENT
YES ☐ **NO**
B. AN AUTO ACCIDENT
YES ☐ **NO**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the Release of any Medical Information Necessary to process this Claim.

SIGNED *DATE*

PHYSICIAN OR SUPPLIER INFORMATION

DATE FIRST CONSULTED YOU FOR THIS CONDITION

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS ?
YES ☐ **NO**

DATE PATIENT ABLE TO RETURN TO WORK

DATES OF TOTAL DISABILITY
FROM **THROUGH**

FOR SERVICES RELATED TO HOSPITALIZATION DATES
ADMITTED: **DISCHARGED:**

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
1.
2.
3.
4.

DATE OF SERVICE	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		DIAGNOSIS (ICDA Code No.)
		PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	

1. Type of treatment being rendered _____
2. Result of any diagnostic tests performed _____
3. Frequency of patient visits to your office _____
4. Prognosis for the claimant returning to gainful employment _____
5. Estimated duration of total disability _____
6. Dates of treatment _____
7. Restrictions from claimant's present occupation _____

SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED **DATE**

PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

I.D.NO.

***** PLACE OF SERVICE CODES

1-(IH)- INPATIENT HOSPITAL
2-(OH)- OUTPATIENT HOSPITAL
3-(O) DOCTOR'S OFFICE
4(H) - PATIENT HOME
5- DAYCARE FACILITY
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