SHELTERPOINT
Claim Form

ShelterPoint Life Insurance Company
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CLAIM #: _____ **DATE:** _____

NAME _____

SUPPLEMENTARY CLAIM REPORT

This report must be completed in full and returned by _____ in order to process your claim.

CLAIMANT'S STATEMENT (MUST BE COMPLETED)

1 - Are you still totally unable to work? _____

A - If not, when did you or will you return to work? _____

B - If yes, what prevents your return to work now? _____

2 - When did you or will you receive Social Security benefits? _____ **AMOUNT:** _____ **PER MONTH.**

3 - I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person,that has any records or knowledge of me or my health, to give to ShelterPoint Life Insurance Company, any and all information about me with reference to my health and or my medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photostatic copy of this authorization shall be as valid as the original.

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 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.

Date _____ **Signature of Claimant** _____
Parent if a Minor

ATTENDING HEALTH CARE PRACTITIONER'S STATEMENT

FOR PREGNANCY:

(a) Estimated date of delivery: _____ (b) Type of Delivery _____

(c) Complications: _____

PRESENT CONDITION:

(a) Subjective Symptoms _____

(b) Objective findings Include results of current X-rays E.K.G's or any other diagnostic tests: _____

(c) Is patient Ambulatory? ☐ Bed Confined? ☐ House Confined? ☐ Hospital Confined? ☐

DIAGNOSIS(ES):

TREATMENT:

(a) Date of first visit: _____ Date of last visit: _____

Frequency of visits..... Weekly ☐ Monthly ☐ Other _____

(b) When did you last examine patient? ..... Date _____

PROGRESS: Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

EXTENT OF DISABILITY:

(a) Is patient now totally disabled and unable to do any work? Yes ☐ No ☐

(b) If "No", when was patient able to do any work? Date _____

(c) If "Yes", when do you think patient will be able to resume any work?

Approximate Date: _____ Indefinite ☐ Never ☐

(MUST BE COMPLETED)

MENTAL CONDITION:

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes ☐ No ☐

REMARKS:

Date | Signature (Attending Health Care Practitioner) | Degree | Telephone

Street Address | City or Town | State or Province | Zip Code

W. C. B. Authorization Registration #: _____ **W. C. B. Rating Code** _____

APS-NY

THIS FORM MUST BE RETURNED TO PROCESS YOUR CLAIM