SHELTERPOINT
Claim Form

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

IN-HOSPITAL STATEMENT OF CLAIM

You may be eligible for additional benefits! Read below for more details!

Re: In-Hospital Benefit Claim
Claim No.:
Claimant:

Important news! If you were hospital confined during your disability, you **may** be eligible for additional **In-Hospital benefits**. Your employer's Disability Benefits Law Policy (DBL) includes **In-Hospital Coverage**, which is a benefit **in addition** to standard disability. These **additional** policy benefits are provided to you by your employer, and are subject to the terms of your employer's Disability Policy with ShelterPoint Life. Please refer to your employer's DBL policy for details regarding benefits and exclusions. **You may be eligible for up to an additional benefit of $170.00** per week while hospital confined, as long as you were disabled beyond the 7-day waiting period for disability.

Simply fill out the below required information and return to us for processing.

Part 1: (Claimant to complete)

Admission date: _____ Discharge date: _____

I authorize any individual or organization to release any information to ShelterPoint Life Insurance Company for any services or benefits received or payable to me or on my behalf.

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.

Claimant's Signature: _____ Date: _____

Part 2: (Medical Records Librarian or Authorized Treating Practitioner to complete)
Note: this part does not need to be completed if Health Insurance Voucher is returned with this form showing admission/discharge dates and treating facility.

1. Name of Hospital: _____
   Address: _____
   street address city state zip code
2. Patient Name: _____
   (first) (middle) (last)
3. Admission Date: _____ Discharge Date: _____ # of Days Hospitalized: _____
4. Authorized Signature: _____ Date: _____