GROUP EXCESS MEDICAL

the first REHABILITATION LIFE INSURANCE COMPANY of AMERICA

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, Suite 475
Garden City, NY 11530

EMPLOYER'S CERTIFICATION

Employer's Name	Employer's Address (Street, City, State, Zip Code)	Policy Number XGMM-
Employee's Name(Last, First, Middle Initial)	Date Employed	Occupation
Employee's Social Security No.	Date Employee Insured	Date Dependents Insured
Employee's Status Active Retired	Type of Excess Coverage Individual Family	If Coverage is terminated, give date
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	
Patient's Date of Birth	Is Patient on Medicare? Yes No	Female Married Seperated Widower	

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 Individual Family	Are there any other health insurance benefits available from any other source? 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 ☐ Student ☐ Married ☐ Handicapped	Child lives at ☐ 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