



# GROUP EXCESS MEDICAL

In-Hospital Statement of Claim

Complete and return to:  
The First Rehabilitation Life  
Insurance Company of America  
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 First Rehabilitation Life Insurance Company of America 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: \_\_\_\_\_