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

Hospital Cash Statement of Claim

Required documents for claim submission:

1. Fully completed claim form
2. One or more of the following:
    i. *An Explanation of Benefits or Voucher from the claimant/patient's major medical insurance carrier showing hospital admission and discharge dates; or*
    ii. *A bill or other formal document from the hospital or skilled nursing facility in which the claimant/ patient was hospitalized, showing dates of admission and discharge.*

Submit FULLY COMPLETED claim form and required documentation by any of the below methods:

Mail:
ShelterPoint Life Insurance Company
Attn: Hospital Cash Claims
1225 Franklin Ave, Suite 475
Garden City, NY 11530

Fax:
516-504-6414

Email:
claimforms@shelterpoint.com

Phone:
1-800-365-4999

PLEASE ALLOW 5-10 DAYS FOR PROCESSING OF YOUR CLAIM. ANY MISSING OR INCOMPLETE INFORMATION MAY RESULT IN DELAYS.

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Hospital Cash Statement of Claim

Claimant Statement (Insured employee/patient completes all sections of this part)

EMPLOYEE INFORMATION (Please Print or Type)

1. Last Name:_____ First Name: _____MI: ___
2. Mailing Address (Street & Apt #): _____

City:_____ State: _____ Zip: _____ Country: _____

3. Daytime Phone #: _____ 4. Email Address:_____
5. Social Security #: _____-____-_____ 6. Date of Birth: ____ / ____/ _____ 7. Gender: ☐ Male ☐ Female
8. Name of Employer (Business): _____ 9. Policy #: _____

PATIENT INFORMATION (If other than employee) (Please Print or Type)

10. Last Name: _____ First Name: _____ MI ___
11. Date of Birth: ____ / ____/ _____ 12. Gender: ☐ Male ☐ Female
13. Relationship to employee: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other (specify)_____

HOSPITALIZATION DETAILS (Please Print or Type)

14. Name of Hospital: _____
15. Address of Hospital: _____
16. Admission Date: ____ / ____/ _____ 15. Discharge Date: ____ / ____/ _____
17. Reason for hospital stay: _____

*Claimants must submit **one or more** of the following:*
1. An Explanation of Benefits or Voucher from their major medical insurance carrier showing hospital admission and discharge dates; or
2. A bill or other formal document from the hospital or skilled nursing facility in which they were hospitalized, showing dates of admission and discharge.

AUTHORIZATION

I give my consent for ShelterPoint Life Insurance Company (the "Company") to obtain from any hospital, physician, medical practitioner, clinic, medically related facility or insurance company and for that individual or entity to disclose to the Company any information relating to health care services or items that I (or my dependent if dependent is a minor) has received, in order for the Company to be able to evaluate this claim for payment purposes.

***NOTICE**: 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.*

_____	_____
Signature of Employee	Date (MM/DD/YYYY)
_____	_____
If a spouse or dependent claim, signature of spouse or adult dependent	Date (MM/DD/YYYY)