

# GROUP EXCESS MEDICAL



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 <b>XGNY1044</b>
Employee's Name (Last, First, Middle Initial)	Date Employed	Occupation
Employee's Social Security No.	Date Employee Insured	Date Dependents Insured
Employee's Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Type of Excess Coverage <input type="checkbox"/> Individual <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Patient's Name (Last, First, Middle)	Employee's Status <input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widower	
Patient's Date of Birth	Is Patient on Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## COMPLETE IF EMPLOYEE IS MARRIED

Name of Spouse	Spouse Social Security No.	Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Individual <input type="checkbox"/> Family	Are there any other health insurance benefits available from any other source? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give details in space below.

## COMPLETE IF CLAIM IS FOR YOUR DEPENDENT CHILD

Child's Name	Indicate if child is <input type="checkbox"/> Student <input type="checkbox"/> Married <input type="checkbox"/> Handicapped	Child lives at <input type="checkbox"/> Home <input type="checkbox"/> School
If Child is in school and between ages 18 and 25, give school name and address		
Is child employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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 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 release all information with respect to 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
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