GROUP EXCESS MEDICAL
STATEMENT OF CLAIM FOR CO-INSURANCE BENEFITS

TO FILE: ATTACH COPIES OF PAYMENT STATEMENTS FROM ALL OTHER CARRIERS

600 NORTHERN BLVD
GREAT NECK NY 11021-5202

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)		Employee's Address (Street, City, State & Zip Code)	
Employee's 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 ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Widower	
Patient's Date of Birth	Is Patient on Medicare? ☐ Yes ☐ No		

COMPLETE IF EMPLOYEE IS MARRIED

Name of Spouse	Spouse's 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 a 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."

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