ASSURANT®

American Bankers Insurance Company of Florida
American Bankers Life Assurance Company of Florida

DISABILITY CONTINUING CLAIM FORM

WE'RE HERE TO HELP! Please note the following important information regarding filing a claim with Assurant.

- It is important that you complete all required sections and include documentation to avoid delays in processing your claim.
- If required, use a separate sheet of paper to include the name and account numbers of multiple accounts also covered by Assurant.
- You are responsible for continuing to make your regular scheduled payments until a decision is made by us on any claim submitted under the Certificate.

Complete sections for your claim type as identified below:

Review the checklist to make sure that you have provided all required documentation and have completed, signed and obtained signatures for all required sections in full.

1

☐ Complete and sign Section 1.

☐ Have your family physician complete Section 2.

2

WHEN TO RETURN FORMS AND SUPPORTING DOCUMENTATION

The Continuing Claim Form must be completed by your family physician if your loss will continue beyond the last payment date.

3

SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

Mail:
Assurant, Financial Claims,
P.O. Box 7000 Kingston, ON K7L 5V3

Fax:
1-800-645-9405

Online:
cardbenefits.assurant.com

We recommend that you retain copies of all documentation submitted to us for review.

Once your claim has been submitted, please allow 15 business days for processing. All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

WE'RE HERE TO HELP!

Call us if you have a question about submitting a claim.

Call toll-free: **1-800-361-5344** or Fax: **1-800-645-9405**

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Financial Claims, P.O. Box 7000, Kingston, Ontario K7L 5V3
Telephone: 1-800-361-5344
Fax: 1-800-645-9405

PLEASE PRINT

SECTION 1

CLAIMANT'S INFORMATION

MUST BE COMPLETED IN FULL

CLAIMANT'S NAME	CLAIM NUMBER	ACCOUNT NUMBER

ADDRESS ☐ **CHECK HERE IF ADDRESS HAS CHANGED**

STREET	CITY	PROVINCE	POSTAL CODE

CREDITOR NAME

PREFERRED METHOD OF COMMUNICATION	EMAIL ADDRESS (IF AVAILABLE)
☐ MAIL ☐ EMAIL	

DESCRIBE YOUR CURRENT ACTIVITIES OR ANY CHANGES IN YOUR CONDITION

HAVE YOU RETURNED TO WORK?	IF YES, WHAT DATE	# OF HOURS/WEEK	ARE YOU RECEIVING WCB OR OTHER DISABILITY BENEFITS?
☐ YES ☐ NO ☐ FULL-TIME ☐ PART-TIME	MM DD YYYY		☐ WCB ☐ NO ☐ OTHER, SPECIFY: _____

ARE YOU RECEIVING CPP / QPP?	
☐ YES ☐ NO	**IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR ACCEPTANCE LETTER OR VERIFICATION THAT YOU ARE RECEIVING CPP / QPP.**

I certify that the information given here is true and correct. I AUTHORIZE any employer, physician, hospital, insurer, law enforcement agency, fire department or other organization, or person having any records, data or information concerning this claim to furnish such records, data or information to ASSURANT or its authorized representative as requested. I understand that in executing this authorization, I waive the right for such information to be privileged.

A photocopy of this authorization shall be considered as effective and valid as the original.

This authorization shall remain valid for the duration of the claim.

☐ By checking this box, I acknowledge that the above statement is true as of _____

CLAIMANT'S SIGNATURE	TELEPHONE NUMBER	DATE
	( )	MM DD YYYY

SECTION 2

PLEASE PRINT

PHYSICIAN'S STATEMENT

TO BE FURNISHED WITHOUT EXPENSE TO THE INSURANCE COMPANY

PATIENT'S FULL NAME

LAST NAME	FIRST NAME, MIDDLE INITIAL	AGE

PATIENT'S ADDRESS

STREET, APT#	CITY	PROVINCE	POSTAL CODE

OBJECTIVE DIAGNOSIS / FINDINGS

DIAGNOSTICS CODE(S)
☐ ICD-9 _____ ☐ CPT _____ ☐ DSM III _____

DATES OF TREATMENT FOR THE LAST 6 MONTHS

1	MM	DD	YYYY	2	MM	DD	YYYY	3	MM	DD	YYYY	4	MM	DD	YYYY	5	MM	DD	YYYY
6	MM	DD	YYYY	7	MM	DD	YYYY	8	MM	DD	YYYY	9	MM	DD	YYYY	10	MM	DD	YYYY

DATE OF NEXT VISIT MM DD YYYY

FREQUENCY OF VISITS
☐ WEEKLY ☐ MONTHLY ☐ OTHER _____

DID PATIENT HAVE SURGERY SINCE LAST REPORT?
☐ YES ☐ NO

IF SO, DESCRIBE SURGERY

SURGERY DATE MM DD YYYY

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
☐ YES ☐ NO

IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK MM DD YYYY

IF NO, DATE PATIENT WAS RELEASED FROM YOUR CARE MM DD YYYY

LIST PATIENT'S FULL LIMITATIONS

PROGNOSIS

HAS PATIENT PROGRESSED?
☐ YES ☐ NO

GIVE EXACT DATES OF INABILITY TO WORK
FROM MM DD YYYY TO MM DD YYYY
☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION

GIVE DATES OF PARTIAL INABILITY TO WORK (ABLE TO PERFORM SOME DUTIES)
FROM MM DD YYYY TO MM DD YYYY
☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION
OF HOURS / WEEK

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT?
☐ PERMANENTLY DISABLED ☐ TEMPORARILY DISABLED ☐ NON-DISABLED

IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED?
☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS ☐ OTHER: _____
☐ 4 MONTHS ☐ 5 MONTHS ☐ 6 MONTHS

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

PHYSICIAN'S NAME (PLEASE PRINT)		PHYSICIAN'S ADDRESS STAMP
ADDRESS		
MEDICAL ID #		
TELEPHONE NUMBER		
FAX NUMBER		
PHYSICIAN'S SIGNATURE	DATE MM DD YYYY	

FORM MUST BE SIGNED OR STAMPED BY DOCTOR'S OFFICE