ASSURANT®

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

DISABILITY / DISMEMBERMENT 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 payments on your account 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 FOR ALL CLAIMS

☐ Complete and sign Section 1 & 2.

☐ **NOTE:** If you wish to authorize a family member or friend to speak on your behalf, please complete the 'Verbal Release of Information', part of Section 2. This authorization will allow them to discuss your claim with a representative of Assurant if you are not available.

2 FOR DISABILITY / DISMEMBERMENT CLAIMS

☐ Have your family physician complete Section 3.

☐ For Disability claims, have your current employer complete Section 4 or if self-employed, complete the Self-Employment Affidavit.

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 INFORMATION Please complete for all claims being submitted

CREDITOR NAME	ACCOUNT NUMBER

NAME OF CLAIMANT

LAST NAME	FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH MM	DD	YYYY	AGE

PREFERRED METHOD OF CONTACT ☐ MAIL ☐ EMAIL	EMAIL ADDRESS

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER ( )

NAME OF PRIMARY CARDHOLDER (FIRST NAME ON BILLING STATEMENT)

LAST NAME	FIRST NAME, MIDDLE INITIAL

RELATIONSHIP TO CLAIMANT	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, WHAT DATE DID YOU RETURN TO WORK? MM	DD	YYYY

SECTION 2

AUTHORIZATION Please certify that the information given here is true and correct.

I AUTHORIZE any current or former employer, worker's compensation body, physician, hospital, clinic, insurance company, law enforcement agency, fire department, or other entity or person, including the group policyholder, that has any personal, financial or medical records or knowledge in regard to the claimant/deceased, to release and provide full details (including furnishing copies) of all available personal, financial and medical information records and knowledge, including prior medical history, toxicological or pathological findings which they may possess to the above noted insurer(s) in regard to the claim, its authorized administrator (ASSURANT), its re-insurer, or their respective agents.

The information is to be used in the evaluation of an insurance claim and for the purposes relating to such claim. This consent shall be valid during the continuation of such claim.

I also authorize the insurer, its authorized administrator, its re-insurers, the group policyholder and their respective agents to exchange and or transmit information concerning this claim to the organization listed above as necessary to evaluate this claim.

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.

I confirm and understand that the information provided is true and accurate to the best of my knowledge. This claim shall be void if, whether before or after the loss, I concealed or misrepresented any facts, or if any documents submitted have concealed or misrepresented any fact or circumstance concerning this claim.

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

CLAIMANT SIGNATURE	DATE MM	DD	YYYY

VERBAL RELEASE OF INFORMATION

Customer privacy and the protection of private and confidential information is important to us. We do understand that in some cases, a claimant may wish to have someone speak to Assurant on his or her behalf. Please complete this authorization section if you wish to have another individual discuss the details of your claim. Without this authorization we are unable to speak to anyone other than the claimant.

I give my authorization to Assurant to speak to _____,

who is my _____, with regard to my claim.

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

CLAIMANT SIGNATURE	DATE MM	DD	YYYY

SECTION 3

PLEASE PRINT

DISABILITY / DISMEMBERMENT CLAIMS

To be completed by Licensed Physician without expense to the Insurance Company

PATIENT'S FULL NAME

LAST NAME	FIRST NAME, MIDDLE INITIAL	HEIGHT	WEIGHT	AGE	BLOOD PRESSURE

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? MM DD YYYY	IF ACCIDENT, PLEASE DESCRIBE CIRCUMSTANCES	WAS THE CLAIMANT OPERATING A MOTOR VEHICLE? ☐ YES ☐ NO

PRIMARY DIAGNOSIS	DATE OF DIAGNOSIS MM DD YYYY

DESCRIBE ANY OTHER DISEASE, INFIRMITY OR SECONDARY CONDITION AFFECTING PRESENT CONDITION: (ATTACH ADDITIONAL SHEET)

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO	IF YES, PLEASE DESCRIBE	GIVE DATE OF TREATMENT FOR SIMILAR CONDITION MM DD YYYY

IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO	IF YES, PLEASE DESCRIBE COMPLICATIONS	ESTIMATED DATE OF DELIVERY MM DD YYYY

DATES OF TREATMENT FOR CURRENT ILLNESS FIRST VISIT MM DD YYYY LAST VISIT MM DD YYYY	FREQUENCY OF VISITS ☐ WEEKLY ☐ OTHER, SPECIFY: ☐ MONTHLY

GIVE ALL DATES OF TREATMENT, SINCE ONSET OF CONDITION MM DD YYYY MM DD YYYY MM DD YYYY	NATURE OF TREATMENTS

HAS PATIENT BEEN HOSPITALIZED? ☐ YES ☐ NO	FROM MM DD YYYY	THROUGH MM DD YYYY	NAME OF HOSPITAL

DID PATIENT HAVE SURGERY? ☐ YES ☐ NO	IF YES, GIVE DATE PERFORMED MM DD YYYY	DESCRIBE SURGERY

GIVE NAMES, ADDRESSES & TELEPHONE NUMBERS OF OTHER TREATING PHYSICIANS FOR THIS CONDITION: (ATTACH ADDITIONAL SHEET)

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

WHEN WILL PATIENT RECOVER SUFFICIENTLY TO RETURN TO WORK? MM DD YYYY	☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS ☐ PERMANENT DISABILITY ☐ 4 MONTHS ☐ 5 MONTHS ☐ 6 MONTHS ☐ OTHER: _____	LIFE EXPECTANCY OF LESS THAN 12 MONTHS? ☐ YES ☐ NO

LICENSED PHYSICIAN INFORMATION

NAME (PLEASE PRINT)		PHYSICIAN'S ADDRESS STAMP
SPECIALTY		
MEDICAL ID #		
ADDRESS		
PHONE NUMBER		
FAX NUMBER		
TODAY'S DATE		
SIGNATURE		

PROGNOSIS / COMMENTS (PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL - ATTACH ADDITIONAL SHEET)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

SECTION 4

PLEASE PRINT

EMPLOYER'S STATEMENT

To be completed by Employer without expense to the Insurance Company

I am the employer of the named Insured, and for the purpose of furnishing information to the named Insurance Company to induce payment of claim of said employee, do certify as follows:

EMPLOYEE'S INFORMATION

EMPLOYEE'S NAME

LAST NAME	FIRST NAME, MIDDLE INITIAL	DATE HIRED (MM DD YYYY)

NUMBER OF HOURS WORKED PER WEEK	EMPLOYEE'S JOB TITLE

TYPE OF EMPLOYMENT	IF SEASONAL EMPLOYMENT, PLEASE PROVIDE DATES OF REGULAR SEASONAL EMPLOYMENT	FROM (MM DD YYYY)	TO (MM DD YYYY)
☐ PERMANENT ☐ SEASONAL ☐ TEMPORARY ☐ CONTRACT ☐ SELF-EMPLOYED (Complete the Self-Employment Affidavit)			

BRIEF DESCRIPTION OF DUTIES

DATE OF JOB LOSS NOTICE PROVIDED (MM DD YYYY)	LAST DAY WORKED (MM DD YYYY)	DATE RETURNED TO WORK (MM DD YYYY)	DID EMPLOYEE RECEIVE SEVERANCE?	DATE SEVERANCE ENDS (MM DD YYYY)
			☐ YES ☐ NO	

REASON FOR INTERRUPTION OF EMPLOYMENT

HAS EMPLOYEE RESUMED FULL DUTIES?	IF YES, PROVIDE NUMBER OF HOURS WORKED PER WEEK	IF NO, WHAT DUTIES ARE THEY ABLE TO PERFORM?
☐ YES ☐ NO		

ADDITIONAL COMMENTS

COMPANY INFORMATION

NAME OF COMPANY	CONTACT TELEPHONE NUMBER
	( )

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	FAX NUMBER
				( )

COMPLETED BY

TITLE

LAST NAME	FIRST NAME, MIDDLE INITIAL

EMAIL ADDRESS FOR COMPANY REPRESENTATIVE	SIGNATURE	DATE (MM DD YYYY)

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

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SECTION 5

PLEASE PRINT

SELF-EMPLOYMENT AFFIDAVIT

CREDITOR NAME	ACCOUNT NUMBER	DATE LAST WORKED MM DD YYYY

CLAIMANT'S NAME

LAST NAME	FIRST NAME, MIDDLE INITIAL

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

HOME TELEPHONE NUMBER	EMAIL ADDRESS (IF AVAILABLE)
( )	

ARE YOU STILL OFF WORK?	IF NO, DATE YOU RETURNED TO WORK MM DD YYYY	NUMBER OF HOURS WORKED PER WEEK	EXPECTED RETURN TO WORK DATE MM DD YYYY	MY OCCUPATION IS
☐ YES ☐ NO				

WHAT PERCENTAGE OF YOUR TIME WAS SPENT AT EACH OF THE FOLLOWING:	SUPERVISORY / ADMINISTRATIVE	MANUAL WORK	WHAT DATE DID YOUR BUSINESS START? MM DD YYYY	WHAT DATE DID YOUR BUSINESS CLOSE? MM DD YYYY
	%	%		

REASON FOR CLOSURE: ☐ BANKRUPTCY ☐ FINANCIAL REASONS ☐ SEASONAL ☐ LACK OF WORK ☐ INJURY/ILLNESS ☐ OTHER _____

BUSINESS INFORMATION

WAS BUSINESS INCORPORATED OR REGISTERED?	WHAT DATE WAS BUSINESS INCORPORATED OR REGISTERED? MM DD YYYY	BUSINESS NAME	MY BUSINESS IS OPERATED FROM MY RESIDENCE
☐ YES ☐ NO			☐ YES ☐ NO

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

BUSINESS TELEPHONE NUMBER	FAX NUMBER	BUSINESS LICENSE NUMBER	GST NUMBER
( )	( )		

CLAIMANT'S AUTHORIZATION

I certify that the above information is true and correct. I authorize any Employer, Physician, Hospital, Insurer or other organization, or person having my records, data or information concerning this claim, to furnish such record, data or information to Assurant or authorized representative if requested. I understand that in executing this authorization, I waive the right for such information to be privileged.

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

CLAIMANT'S SIGNATURE:	DATE MM DD YYYY

Subscribed and sworn before me, a Notary Public or Commissioner of Oaths for the Country of _____,

Signature: _____.

Province of _____ this date _____ of _____, 20_____.

NOTARY PUBLIC OR COMMISSIONER OF OATHS LEGAL SEAL STAMP

A COPY OF THIS FORM WILL NOT BE ACCEPTED.

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