ASSURANT®

American Bankers Insurance Company of Florida

American Bankers Life Assurance Company of Florida

LIFE 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 LIFE CLAIMS

☐ Attach a copy of death certificate.

☐ Complete the enclosed estate authorization form or include a copy from the page of the Will indicating the executor of the Estate.

☐ Have a physician complete Section 3.

3

MAIL OR FAX THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

- **Mail:** Assurant, Financial Claims, P.O. Box 7000, Kingston, ON, K7L 5V3
- **Fax:** 1-800-645-9405

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-fee: 1-800-361-5344 or Fax: 1-800-645-9405

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Financial Claims, P.O. Box 7000, Kingston, ON, 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 / YY	AGE:

PREFERRED METHOD OF CONTACT	EMAIL ADDRESS:
☐ Mail ☐ Email	

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:

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.

CLAIMANT SIGNATURE:	DATE: ____ / ____ / ____ MM / DD / YY

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.

CLAIMANT SIGNATURE:	DATE: ____ / ____ / ____ MM / DD / YY

American Bankers Life Assurance Company of Florida (ABLAC) and American Bankers Insurance Company of Florida (ABIC), their subsidiaries, and affiliates carry on business in Canada under the name of Assurant®. ®Assurant is a registered trademark of Assurant, Inc.
ABIC and ABLAC, use and share personal information provided to them by you and obtained from others with your consent. They may use the information to establish and serve you as a customer or when required or permitted by law. Your information may be processed and stored in another country and may be subject to access by government authorities under applicable laws of that country.

SECTION 3

PLEASE PRINT

LIFE CLAIMS

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

FULL NAME OF DECEASED:	
LAST NAME	FIRST NAME, MIDDLE INITIAL
DATE OF BIRTH: ____ / ____ / ____ (MM / DD / YY) DATE OF DEATH: ____ / ____ / ____ (MM / DD / YY)	PLACE OF DEATH:

IF HOSPITAL OR INSTITUTION, GIVE NAME AND ADDRESS:			
NAME OF HOSPITAL OR INSTITUTION:			DATE ADMITTED: ____ / ____ / ____ (MM / DD / YY)
STREET	CITY	PROVINCE	POSTAL CODE

HOW LONG DID YOU KNOW THE PATIENT? **FROM**: ____ / ____ / ____ (MM / DD / YY) **TO**: ____ / ____ / ____ (MM / DD / YY)

CAUSE OF DEATH	IMMEDIATE CAUSE:	UNDERLYING CAUSE:	DATE OF DIAGNOSIS: ____ / ____ / ____ (MM / DD / YY)

DATES OF MEDICAL TREATMENT, EXAMINATION OR ADVICE RELATED TO THE CAUSE OF DEATH DURING THE LAST 3 YEARS: ____ / ____ / ____ (MM / DD / YY) ____ / ____ / ____ (MM / DD / YY) ____ / ____ / ____ (MM / DD / YY)

IS DEATH DUE TO: ACCIDENT? ☐ YES ☐ NO HOMICIDE? ☐ YES ☐ NO SUICIDE? ☐ YES ☐ NO DRUGS & ALCOHOL? ☐ YES ☐ NO

BRIEFLY DESCRIBE CIRCUMSTANCES SURROUNDING DEATH:	WAS THE CLAIMANT OPERATING A MOTOR VEHICLE?	☐ YES ☐ NO

WAS AUTOPSY PERFORMED?	☐ YES ☐ NO	IF YES, PLEASE SUMMARIZE RESULTS AND ATTACH REPORTS

TO YOUR KNOWLEDGE, DID THE DECEASED RECEIVE MEDICAL TREATMENT DURING THE LAST 3 YEARS FROM ANY OTHER PHYSICIAN OR HOSPITAL FOR THE CAUSE OF DEATH LISTED ABOVE?

☐ YES ☐ NO ***IF YES, PLEASE FURNISH THE FOLLOWING:***

NAME OF PHYSICIAN OR HOSPITAL:

LICENSED PHYSICIAN INFORMATION:

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

PHYSICIAN'S ADDRESS STAMP:

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."

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PLEASE PRINT

ESTATE FORM

In an effort to protect the privacy of our customer, we respectfully request the following information when completing a Life claim:

CREDITOR NAME:	CLAIM NUMBER:	ACCOUNT NUMBER:

☐ **WILL INCLUDED**

I hereby declare that _____ is the person acting in the capacity of Executor of the Estate of _____.

Relationship to the customer: _____.

☐ **NO WILL**

I hereby declare that _____ is the person acting in the capacity of Executor of the Estate of _____.

Relationship to the customer: _____.

☐ **FAMILY MEMBER REQUEST**

I hereby declare that I, _____, am requesting the information in the capacity of [spouse / child / grandchild] of the deceased.

Relationship to the customer: _____.

CAUSE OF DEATH:

CLAIMANT'S AUTHORIZATION

I certify that the above information is true and correct.

CLAIMANT'S SIGNATURE:	DATE: ____ / ____ / ____ MM / DD / YY
WITNESS' SIGNATURE:	DATE: ____ / ____ / ____ MM / DD / YY

Please include this document when returning your claim forms.

PLEASE PRINT

CREDITOR INFORMATION

Please complete for all claims being submitted

NAME OF CREDITOR / LIENHOLDER			ACCOUNT NUMBER / CERTIFICATE NUMBER:
BRANCH ADDRESS:			
STREET	CITY	PROVINCE	POSTAL CODE

EFFECTIVE DATE OF LOAN	1ST PAYMENT DATE	WHEN IS YOUR NEXT SCHEDULED PAYMENT DUE?	EXPIRY DATE OF LOAN
____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY

PAYMENT INFORMATION		
FREQUENCY OF PAYMENT	PAYMENT AMOUNT	MONTHLY PAYMENT DUE DATE
☐ MONTHLY ☐ SEMI-MONTHLY ☐ BI-WEEKLY ☐ WEEKLY	$	____ / ____ / ____ MM / DD / YY

CONTACT INFORMATION			
BRANCH REPRESENTATIVE NAME:	EMAIL ADDRESS:	CONTACT TELEPHONE NUMBER:	FAX #
		( )	( )