ASSURANT®

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

INJURY OR SICKNESS 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.
- 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.
- For faster processing, we recommend you file your claim online at claims.assurant.com.

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

If your scheduled payment frequency is Bi-weekly or Semi-monthly, please return your form 7 days prior to your due date.

If your scheduled payment frequency is Monthly, please return your form 15 days prior to your due date.

3

PLEASE RETURN YOUR FORM AND/OR SUPPORTING DOCUMENTATION IN ONE OF THE FOLLOWING WAYS:

Upload your documents for faster processing.
Online: login at claims.assurant.com

Visit your easyfinancial branch

Call (855) 996-3279

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

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

All benefit payments are paid directly to your creditor.

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Please visit claims.assurant.com

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Financial Claims, P.O. Box 7000, Kingston, Ontario K7L 5V3
Telephone: 1-800-663-9822

SECTION 1

FOR FASTER CLAIM PROCESSING: Please complete form, save file and upload to claims.assurant.com

CLAIMANT INFORMATION Must be completed in full

Injury or Sickness

NAME	CLAIM NUMBER

☐ **CHECK HERE IF YOU ARE FILING A CLAIM FOR MORE THAN ONE LOAN/ACCOUNT**

PLEASE LIST ALL LOAN/ACCOUNT NUMBERS (You can find this information on your loan/account documents)

ADDRESS ☐ CHECK HERE IF ADDRESS HAS CHANGED

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)

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 ☐ FULL-TIME ☐ PART-TIME ☐ NO	MM DD YYYY		☐ WCB ☐ NO ☐ OTHER _____ PLEASE SPECIFY

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 the above noted insurer(s), American Bankers Life Assurance Company of Florida and/or American Bankers Insurance Company of Florida hereinafter collectively referred to as "Assurant", or their 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.

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	TELEPHONE NUMBER	DATE MM DD YYYY
	( )	

Assurant understands that easyfinancial employees and/or third parties acting on behalf of easyfinancial, may play an important role in assisting you with the claim process (e.g., filing your claim form, submitting other required claim documents and discussing your claim status). In order to protect your privacy, we require your explicit consent to discuss your claim with easyfinancial employees and/or third parties acting on behalf of easyfinancial. Your consent is specific to this claim only and you have the right to withdraw your consent at any time. You may choose to submit your claim information directly to Assurant as noted on this claim form.

I give permission to Assurant to share my claim status and claim details with easyfinancial employees and/or third parties acting on behalf of easyfinancial assisting me with my claim. I am aware and acknowledge that my claim status and claim details may include **sensitive personal information (medical and otherwise)**.

CLAIMANT SIGNATURE	DATE MM DD YYYY

SECTION 2

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

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	DID PATIENT HAVE SURGERY SINCE LAST REPORT?
	☐ WEEKLY ☐ MONTHLY ☐ OTHER _____	☐ YES ☐ NO

IF SO, DESCRIBE SURGERY	SURGERY DATE (MM / DD / YYYY)

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

LIST PATIENT'S FULL LIMITATIONS

PROGNOSIS	HAS PATIENT PROGRESSED?
	☐ YES ☐ NO

	FROM (MM / DD / YYYY)	TO (MM / DD / YYYY)		
GIVE EXACT DATES OF INABILITY TO WORK			☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION	
GIVE DATES OF PARTIAL INABILITY TO WORK (ABLE TO PERFORM SOME DUTIES)			☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION	# OF HOURS/WEEK

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT?	IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED?	LIFE EXPECTANCY OF LESS THAN 12 MONTHS?
☐ PERMANENTLY DISABLED ☐ TEMPORARILY DISABLED ☐ NON-DISABLED	☐ 1 MONTH ☐ 2-3 MONTHS ☐ 3-6 MONTHS ☐ 6 MONTHS ☐ OTHER: _____	☐ YES ☐ NO

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