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 or specialist complete Section 2.

2

WHEN TO RETURN FORMS AND SUPPORTING DOCUMENTATION

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

3

SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

Assurant, Financial Claims
1945 King Street East, Suite 100, Hamilton, Ontario L8K 1W2

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.

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.

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Financial Claims, 1945 King Street East, Suite 100,
Hamilton, Ontario L8K 1W2 | Telephone: 1-800-361-5344

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 ☐ FULL-TIME ☐ PART-TIME ☐ NO	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 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.

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
	( )	

PLEASE PRINT

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

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