ASSURANT®

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

CRITICAL / TERMINAL ILLNESS 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 CRITICAL / TERMINAL ILLNESS CLAIMS

☐ Have your family physician complete Section 3.

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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American Bankers Life Assurance Company of Florida

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	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.

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

CRITICAL / TERMINAL ILLNESS 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? MM DD YYYY	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

DATES OF TREATMENT FOR CURRENT ILLNESS		FREQUENCY OF VISITS
FIRST VISIT MM DD YYYY	LAST VISIT MM DD YYYY	☐ 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."