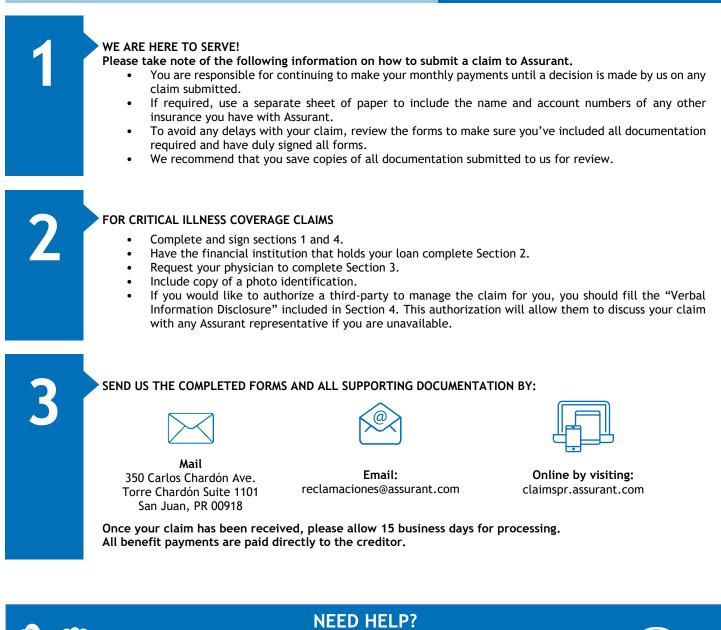
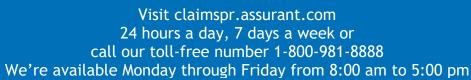


#### PERSONAL LOANS PROTECTION PLAN FORM

### CRITICAL ILLNESS COVERAGE CLAIMS









THIS SECTION IS REQUIRED TO EVALUATE YOUR CLAIM. Please complete the form in legible font.												
FINANCIAL INSTITUTION'S NAME				LOAN NUMBER								
INSURED'S FULL NAME				DATE		OF					AGE	
					BIRTH		MONTH		DAY	YEAR		
PHYSICAL ADDRESS												
MAILING ADDRESS												
FULL SOCIAL SECURITY	NUMBER					LIC	ense numbe	ER				
MOBILE NUMBER		SECONDARY NUMBER					ALTERNATE NUMBER					
DO YOU AUTHORIZE US	TO SEND Y	OU EMAILS?	□ YES □ NO									
EMAIL												
WE AND OTHERS ACTING ON OUR BEHALF MAY USE THE INFORMATION WE GATHER TO OPERATE OUR PRODUCT AND OUR SERVICE. FOR EXAMPLE, WE MAY USE THE INFORMATION WE COLLECT OR RECEIVE TO TRY AND CONTACT YOU THROUGH EMAIL TO PROVIDE SUPPORT AND ASSISTANCE DURING THE CLAIM PROCESS, AS PERMITTED BY LAW.												
HAVE YOU HAD ANY CLAIMS UNDER THIS LOAN NUMBER PREVIOUSLY?												
IF YOU ANSWERED YES,	INCLUDE T	HE CLAIM NUM	MBERS									



To be completed by financial institution. Please attach a copy of the certificate/policy if you have it available.								
NAME OF THE FINANCIAL INSTITUTION	THE BRANCH W	WHERE THE INSURANCE WAS PURCHASED						
BRANCH ADDRESS		ł						
LOAN NUMBER	LOAN TERM			APR%				
EFFECTIVE DATE	FIRST PAYMENT'S DUI	E DATE		EXPIRATION DATE	Ξ			
MONTH DAY YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR		
ORIGINAL LOAN AMOUNT				\$				
NET PAY-OFF BALANCE AT THE DATE EVENT OCCU	IRREED			\$				
UNEARNED INTEREST AT THE DATE EVENT OCCUR		\$						
MONTHLY PAYMENTS				\$				
PRE-PAID PAYMENTS				\$				
AMOUNT CLAIMED TO THE COMPANY				\$				
OVERDUE PAYMENTS				\$				
"I certify that all the information provided here	e is correct and reliable	e."						
NAME				CONTACT NUMBER				
SIGNATURE								
				MONTH	DAY	YEAR		
If you are unable to provide an original signature, please read and complete the following section to confirm your consent:								
I declare I have provided reasonable and relevant information with regards to the critical illness claim form that the insured is about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process the insured's claim. Furthermore, I certify I have read and completed in all its parts the section of the form that applies to me, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.								

 $\hfill\square$  In witness whereof, I sign this declaration by checking the box here provided.



# SECTION 3: PHYSICIAN'S DECLARATION

This is meant to be filled by a licensed physician free of any fees to the company. If you would like to submit a medical certificate that contains the same information that the form requires, the certificate must be on a physician's stationary or prescription paper, must be dated and signed, and must include the medical license number.							
PATIENT'S FULL NAME	GENDER	HEIGHT	WEIGHT	AGE			
PATIENT'S ADDRESS		PATIENT'S CONT	ACT NUMBE	र			
WHICH OF THESE DID THE PATIENT SUFFER?	ER 🗆 BYPASS S	URGERY					
WHEN DID THE PATIENT VISIT YOU FOR A CONSULT? MONTH DAY YEAR							
DIAGNOSIS							
DIAGNOSIS CODE WHEN WAS THE PATIENT							
ICD-11: DSM V: DIAGNOSED?		H DAY	(	YEAR			
IF YOU ANSWERED BYPASS SURGERY, PLEASE INDICATE THE DATE OF THE SURGERY MONTH DAY YEA	R						
HAS THE PATIENT SUFFERED FROM THE I YES DATES FOR THE SIMILAR SAME OR A SIMILAR CONDITION BEFORE?	4Y YE	AR					
IF YOU ANSWERED YES, PLEASE EXPLAIN THE CONDITION							
PLEASE PROVIDE ALL THE TREATMENT DATES FROM THE BEGININNG OF THE CONDITION							
TYPE OF TREATMENT							
HAS THE PATIENT BEEN HOSPITALIZED? INO FROM NONTH DAY YEAR	NTIL —	ONTH [		YEAR			
HOSPITAL'S NAME							



WHAT ARE THE NAMES AND ADDRESSES OF OTHER DOCTORS THAT HAVE TREATED YOU FOR THIS CONDITION?						
PROGNOSIS / COMMENTS (PLEASE PROVIDE ANY	ADDITIONAL DETAILS, <sup>-</sup>	THAT, TO YOUR UNDERS	STING, ARE I	RELEVANT)	1	
LICENSED PHYSICIAN'S INFORMATION						
NAME		SPECIALTY		LICENSE	NUMBER	
ADDRESS						
CONTACT NUMBER	FAX		EMAIL			
"I hereby certify that the information provide my knowledge and understanding."	d before is based on a	a probable medical rea	son, that it	is true an	d trustworth	y to the best of
PHYSICIAN'S SIGNATURE						
			мо	NTH	DAY	YEAR
If you are unable to provide an original signatu	re, please read and c	omplete the following	section to a	confirm yo	our consent:	
I declare I have provided reasonable and relevant information with regards to the critical illness claim form that I am about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process my claim. Furthermore, I certify I have read and completed the form and all its parts, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the						

 $\hfill\square$  In witness whereof, I sign this declaration by checking the box here provided.

information.



### **SECTION 4: AUTHORIZATION**

Please certify that all the information provided here is correct and reliable.

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., insurance or reinsuring Company, insurer, law enforcement agency, fire department, or other organization, or person having any records, data or information concerning this claim to furnish such record, data or information to Caribbean American Life Assurance Company/Caribbean American Property Insurance Company or its authorized representative(s) as requested. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original. I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above. This authorization shall remain valid for 6 months after the date of the signature.

## VERBAL INFORMATION DISCLOSURE

It is important for us to safeguard the privacy of our customers and protect private and confidential information. We also understand that, on occasion, a claimant may want to authorize third parties to speak with Assurant on their behalf. Please complete this authorization section so others can discuss details of your claim. Without this authorization we cannot talk to anyone except the claimant.

, who is my

I authorize Assurant to speak with

## RESPONSIBILITY FOR FRAUDULENT INFORMATION

, about my claim.

ANY PERSON who knowingly and with the intention to commit fraud provides false information in an insurance application, or submits, helps or causes the submission of a fraudulent insurance claim for the payment of a loss or any other benefit, or submits more than one claim for the same damage or loss, will incur in a felony and, upon conviction thereof, shall be punished, for each violation, with a fine not less than five thousand (\$5,000) dollars, nor greater than ten thousand (\$10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances are present, the fixed penalty established could be increased up to a maximum of five (5) years; if attenuating circumstances are present, the penalty could be reduced to a minimum of two (2) years.

"I hereby certify that the above information is based on reasonable and that it is true and correct to the best of my knowledge and belief."

	INSURED'S SIGNATURE				
SIGNATURE					
	MONTH	DAY	YEAR		

If you are unable to provide an original signature, please read and complete the following section to confirm your consent:

I declare I have received reasonable and relevant information with regards to the critical illness claim form that I am about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process my claim. Furthermore, I certify I have read and completed the form and all its parts, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.

 $\Box$  In witness whereof, I sign this declaration by checking the box here provided.