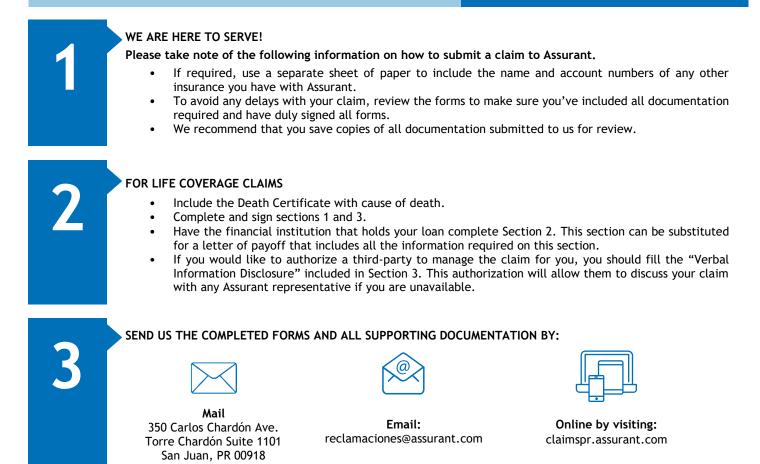


PERSONAL LOANS PROTECTION PLAN FORM

## FOR LIFE COVERAGE CLAIMS



Once your claim has been received, please allow 15 business days for processing. All benefit payments are paid directly to the creditor.



**NEED HELP?** 

Visit claimspr.assurant.com 24 hours a day, 7 days a week or call our toll-free number 1-800-981-8888 We're available Monday through Friday from 8:00 am to 5:00 pm





SECTION 1:	INSURED'S IN	FORMATIO

THIS SECTION IS REQUIRED TO EVALUATE YOUR CLAIM. Please complete the form in legible font.										
NAME OF FINANCIAL INSTITUTION		LOAN NUMBER								
NAME OF INSURED				DATE			_			AGE
				OF BIRTH		MONTH	DA	Y	YEAR	
PHYSICAL ADDRESS										
MAILING ADDRESS										
FULL SOCIAL SECURITY NUMBER										
WHAT ARE THE NAMES AND ADDRESSES OF OTHER DOCTORS THAT TREATED THE INSURED IN THE PAST (USE ADDITIONAL PAPER IF NECESSARY)										
DOCTOR'S NAME						PHONE NU	JMBER			
PHYSICAL ADDRESS										
TREATMENT DATE				DIAGNOSIS						
DOCTOR'S NAME					PH	IONE NUMBE	R			
PHYSICAL ADDRESS					-					
TREATMENT DATE				DIAGNOSIS						
COMPLAINT NUMBER FOR THE POLICE REPORT, IF IT APPLIES;										

				CLAIMANT'S INFORMATION
CLAIMANT'S FULL NAME			FULL SO	CIAL SECURITY NUMBER
CLAIMANT'S ADDRESS		RELATIONSHIP WITH THE INSURED		
MOBILE NUMBER	SECONDARY NUMBER			ALTERNATE NUMBER
DO YOU AUTHORIZE US TO SEND YOU EMAILS?	□ YES □ NO			
EMAIL ADDRESS				
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.				



SECTION 2: CREDITOR'S DECLARATION

To be completed by financial institution. Please attach a copy of the certificate if its available.							
NAME OF THE FINANCIAL INSTITUTION	NAME OF THE BRANCH	OF THE BRANCH 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 OCCURREED							
UNEARNED INTEREST AT THE DATE EVENT OCCURRED			\$				
MONTHLY PAYMENTS			\$				
PRE-PAID PAYMENTS			\$				
AMOUNT CLAIMED TO THE COMPANY			\$	\$			
OVERDUE PAYMENTS			\$				
"I certify that all the information provided here is correct and reliable."							
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 life 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: 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.

I authorize Assurant to speak with	, who is my	, about my claim.		

## RESPONSIBILITY FOR FRAUDULENT INFORMATION

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.

	CLAIMANT'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 life 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.

□ In witness whereof, I sign this declaration by checking the box here provided.