AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA 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

CONTINUING DISABILITY CLAIM FORM

A: CLAIMANT'S INFORMATION	(Must be	completed	in full)					PLEASE PRINT	
NAME AND ADDRESS CHECK HERE IF ADDRESS HAS CHANGED							COUNT NUMBER		
				NAME OF FINANCIAL	. INSTITUTIO	<u> </u>			
				NAME OF EMPLOYER					
CLAIMANT'S INTERNET ADDRESS (IF AVAILABLE)		Т	TELEPHONE NUMBER (EMPLOYER)			E	XTENSION		
DESCRIBE YOUR CURRENT ACTIVITIES OR ANY CHANGES IN YOUR CONDITION			()					
DESCRIBE FOUR CORRENT ACTIVITIES OR ART CHARGES IN TO	OK CONDITION								
		IF YES, WHAT DATE	# OF HO	HOURS / WEEK ARE YOU RECEIVING WCB OR OTHER DISABILITY BENEFITS			BILITY BENEFITS		
☐ YES ☐ NO ☐ FULL-TIME ☐ PART-TIME		/ /	/ITU A CODY	DPY OF YOUR ACCEPTANCE LETTE			NO DOTHER (specify)		
☐ YES ☐ NO	RECEIVING C	CPP / QPP.							
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 ASSURANT SOLUTIONS or its authorized									
representative as requested. I under									
be privileged.	istanu tna	t iii executiiiş	g tills aut	nonzation,	i waive	the ris	gric for Suci	i iiiioiiiiatioii 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.									
CLAIMANT'S SIGNATURE					TELEPHONE	NUMBER	D	ATE M D Y	
X					()			/ /	
B: PHYSICIAN'S STATEMENT (to be furnished without expense to the Insurance company) PLEASE PRINT									
PATIENT'S FULL NAME: PATIENT'S STREET ADDRESS, APT#, CITY/PROVINCE/POSTAL CODE AGE									
	711.2111 9 9 111.221	Γ ADDRESS, APT#, CITY				P	ILLAGE		
OBJECTIVE DIAGNOSIS / FINDINGS:		Γ ADDRESS, APT#, CIT`				TICS CODE			
OBJECTIVE DIAGNOSIS / FINDINGS:		Γ ADDRESS, APT#, CIT\			DIAGNOS	TICS CODE		AGE	
OBJECTIVE DIAGNOSIS / FINDINGS: DATES OF TREATMENT FOR THE LAST 6 MONTHS		F ADDRESS, APT#, CIT	Y/PROVINCE/PO	OSTAL CODE DATE OF NEXT VISIT	DIAGNOS	TICS CODE	S)	AGE	
DATES OF TREATMENT FOR THE LAST 6 MONTHS			Y/PROVINCE/PO	OSTAL CODE	DIAGNOS □ ICD-	TICS CODE	S) CPT //ISITS WEEKLY		
DATES OF TREATMENT FOR THE LAST 6 MONTHS DID PATIENT HAVE SURGERY SINCE LAST REPORT?	IF SO, DESCRIB		Y/PROVINCE/PO	OSTAL CODE DATE OF NEXT VISIT	DIAGNOS □ ICD-	TICS CODE	S)	AGE DSM III OTHER Y DATE	
DATES OF TREATMENT FOR THE LAST 6 MONTHS	IF SO, DESCRIB	SE SURGERY. ES, ESTIMATE THE DAT	Y/PROVINCE/PC	DATE OF NEXT VISIT M D Y / /	DIAGNOS CD- FREQ	TICS CODE 9 JENCY OF V AONTHLY	S) CPT //SITS WEEKLY SURGER M NO, DATE PATIENT	AGE DSM III OTHER Y DATE D Y / / WAS RELEASED FROM YOUR	
DATES OF TREATMENT FOR THE LAST 6 MONTHS DID PATIENT HAVE SURGERY SINCE LAST REPORT? YES NO IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?	IF SO, DESCRIB	SE SURGERY.	Y/PROVINCE/PC	DATE OF NEXT VISIT M D Y / /	DIAGNOS CD- FREQ	TICS CODE	S) CPT //SITS WEEKLY SURGER M NO, DATE PATIENT	AGE DSM III OTHER Y DATE D Y ////	
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DATES OF TREATMENT FOR THE LAST 6 MONTHS DID PATIENT HAVE SURGERY SINCE LAST REPORT? YES NO IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES NO LIST PATIENTS FULL LIMITATIONS. GIVE EXACT DATES OF TOTAL DISABILITY (INABILITY TO WORK M D Y M D Y FROM / / TO / /	IF SO, DESCRIB IF YE HIS/HER C ANY OCCU	SE SURGERY. ES, ESTIMATE THE DAT M / CCCUPATION JPATION	TE THE PATIENT / PROGNOSIS: GIVE DATES OF M FROM / SABLED, HOW M	DATE OF NEXT VISIT M D Y / / CAN RETURN TO W PARTIAL DISABILIT D Y / I	DIAGNOS ICD- FREQ WORK. Y (ABLE TO F	TICS CODE: 9 JENCY OF V MONTHLY IF I CA	S) CPT SURGER O, DATE PATIENT PI HAS PATIENT PI YES ME DUTIES) NO. OF HOURS/ WEEK	AGE DSM III DOTHER Y DATE D Y / / WAS RELEASED FROM YOUR D Y ROGRESSED? NO HIS/HER OCCUPATION ANY OCCUPATION PECTANCY OF LESS THAN 12	
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FORM MUST BE SIGNED OR STAMPED BY DOCTOR'S OFFICE