

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.
- 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.
- For faster processing, we recommend you file your claim online at cardbenefits.assurant.com

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.

TOTAL DISABILITY CONTINUING CLAIMS

This form must be completed if your loss will continue beyond the last payment date.

- Complete and sign Section 1.
- Have your family physician complete Section 2.

PLEASE RETURN YOUR FORM AND/OR SUPPORTING DOCUMENTATION IN ONE OF THE FOLLOWING WAYS:



Upload your documents for faster processing.

Online: cardbenefits.assurant.com



Alternatively, you can mail the documents.

Mail: Assurant, Financial Claims,
P.O. Box 7000 Kingston, ON K7L 5V3

We recommend that you retain copies of all documentation submitted to us for review.

All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

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Please visit cardbenefits.assurant.com



SECTION 1

FOR FASTER CLAIM PROCESSING: Please complete form, save file and upload to cardbenefits.assurant.com

CLAIMANT'S INFORMATION

MUST BE COMPLETED IN FULL

Total Disability

CLAIMANT'S NAME				CLAIM NUMBER			
<input type="checkbox"/> CHECK HERE IF YOU ARE FILING A CLAIM FOR MORE THAN ONE ACCOUNT							
PLEASE LIST ALL ACCOUNT NUMBERS							
ADDRESS <input type="checkbox"/> CHECK HERE IF ADDRESS HAS CHANGED							
STREET			CITY		PROVINCE	POSTAL CODE	
CREDITOR NAME (GROUP POLICYHOLDER)							
PREFERRED METHOD OF COMMUNICATION <input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL			EMAIL ADDRESS (IF AVAILABLE)				
DESCRIBE YOUR CURRENT ACTIVITIES OR ANY CHANGES IN YOUR CONDITION							
HAVE YOU RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> NO		IF YES, WHAT DATE MM DD YYYY		# OF HOURS/WEEK		ARE YOU RECEIVING WCB OR OTHER DISABILITY BENEFITS? <input type="checkbox"/> WCB <input type="checkbox"/> NO <input type="checkbox"/> OTHER, SPECIFY: _____	
<p>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 the above noted insurer(s), American Bankers Life Assurance Company of Florida and/or American Bankers Insurance Company of Florida hereinafter collectively referred to as "Assurant", or its authorized representative as requested. I understand that in executing this authorization, I waive the right for such information to be privileged.</p> <p>A photocopy of this authorization shall be considered as effective and valid as the original.</p> <p>This authorization shall remain valid for the duration of the claim.</p> <p>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.</p> <p><input type="checkbox"/> By checking this box, I acknowledge that the above statement is true as of _____</p>							
CLAIMANT'S SIGNATURE				TELEPHONE NUMBER ()		DATE MM DD YYYY	

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																			
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 <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER _____								DID PATIENT HAVE SURGERY SINCE LAST REPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO							
IF SO, DESCRIBE SURGERY												SURGERY DATE MM DD YYYY							
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK/NORMAL ACTIVITIES OF DAILY LIVING MM DD YYYY								IF NO, DATE PATIENT WAS RELEASED FROM YOUR CARE MM DD YYYY							
LIST PATIENT'S FULL LIMITATIONS																			
PROGNOSIS														HAS PATIENT PROGRESSED? <input type="checkbox"/> YES <input type="checkbox"/> NO					
GIVE EXACT DATES OF TOTAL DISABILITY		FROM MM DD YYYY			TO MM DD YYYY			<input type="checkbox"/> PATIENT'S OCCUPATION <input type="checkbox"/> ANY OCCUPATION <input type="checkbox"/> NORMAL ACTIVITIES OF DAILY LIVING											
GIVE DATES OF PARTIAL DISABILITY (ABLE TO PERFORM SOME DUTIES)		FROM MM DD YYYY			TO MM DD YYYY			<input type="checkbox"/> PATIENT'S OCCUPATION <input type="checkbox"/> ANY OCCUPATION <input type="checkbox"/> NORMAL ACTIVITIES OF DAILY LIVING						# OF HOURS/WEEK					
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT?				<input type="checkbox"/> PERMANENTLY DISABLED <input type="checkbox"/> TEMPORARILY DISABLED <input type="checkbox"/> NON-DISABLED				IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED? <input type="checkbox"/> 1 MONTH <input type="checkbox"/> 2 MONTHS <input type="checkbox"/> 3 MONTHS <input type="checkbox"/> OTHER: <input type="checkbox"/> 4 MONTHS <input type="checkbox"/> 5 MONTHS <input type="checkbox"/> 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																			