ASSURANT®

American Bankers Insurance Company of Florida

American Bankers Life Assurance Company of Florida

INVOLUNTARY UNEMPLOYMENT CONTINUING 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 your regular scheduled payments 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

☐ Complete and sign Section 1.

2

WHEN TO RETURN FORMS AND SUPPORTING DOCUMENTATION

The Continuing Claim Form must be completed if your loss will continue beyond the last payment date.

3

RETURNING YOUR FORMS:

Please return your form and all supporting documentation in one of the following ways:

- **Mail:** Assurant, Financial Claims, P.O. Box 7000, Kingston, ON, K7L 5V3
- **Fax:** 1-800-645-9405

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-fee: 1-800-361-5344 or Fax: 1-800-645-9405

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Telephone: 1-800-361-5344
Fax: 1-800-645-9405

SECTION 1

PLEASE PRINT

CLAIMANT'S INFORMATION

MUST BE COMPLETED IN FULL

CLAIMANT'S NAME	CLAIM NUMBER	ACCOUNT NUMBER

ADDRESS ☐ CHECK HERE IF ADDRESS HAS CHANGED

CREDITOR NAME

EMAIL ADDRESS (IF AVAILABLE)	WHAT IS THE PREFERRED METHOD OF COMMUNICATION?
	☐ Email ☐ Mail

DESCRIBE YOUR CURRENT ACTIVITIES

HAVE YOU RETURNED TO WORK SINCE YOU BECAME UNEMPLOYED?	IF YES, WHAT DATE	# OF HOURS / WEEK YOU NOW WORK	ARE YOU RECEIVING UNEMPLOYMENT BENEFITS?
☐ YES ☐ NO ☐ FULL-TIME ☐ PART-TIME	____ / ____ / ____ MM / DD / YY		☐ YES ☐ NO

IF YOU HAVE NOT RETURNED TO WORK, WHY NOT?

ARE YOU CURRENTLY ON STRIKE?	ARE YOU RECEIVING STRIKE PAY BENEFITS?
☐ YES ☐ NO	☐ YES ☐ NO

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 or its authorized representative as requested. 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.

This authorization shall remain valid for the duration of the claim.

CLAIMANT'S SIGNATURE	TELEPHONE NUMBER:	DATE
X	( )	____ / ____ / ____ MM / DD / YY

FORM MUST BE SIGNED AND DATED