ASSURANT®

American Bankers Insurance Company of Florida

American Bankers Life Assurance Company of Florida

DISABILITY / DISMEMBERMENT 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 payments on your account 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

FOR ALL CLAIMS:

☐ Complete and sign Section 1 & 2.

☐ NOTE: If you wish to authorize a family member or friend to speak on your behalf, please complete the 'Verbal Release of Information', part of Section 2. This authorization will allow them to discuss your claim with a representative of Assurant if you are not available.

2

FOR DISABILITY / DISMEMBERMENT CLAIMS

☐ Have your family physician complete Section 3.

☐ For Disability claims, have your current employer complete Section 4 or if self-employed, complete the Self-Employment Affidavit.

3

MAIL OR FAX THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

- **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

PLEASE PRINT

SECTION 1
CLAIMANT INFORMATION

Please complete for all claims being submitted

CREDITOR NAME:	ACCOUNT NUMBER:

NAME OF CLAIMANT:

LAST NAME	FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH: ____ / ____ / ____ MM / DD / YY	AGE:

PREFERRED METHOD OF CONTACT ☐ Mail ☐ Email	EMAIL ADDRESS:

ADDRESS:

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER: ( )

NAME OF PRIMARY CARDHOLDER: (FIRST NAME ON BILLING STATEMENT)

LAST NAME	FIRST NAME, MIDDLE INITIAL	RELATIONSHIP TO CLAIMANT:

HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, WHAT DATE DID YOU RETURN TO WORK? ____ / ____ / ____ MM / DD / YY

SECTION 2
AUTHORIZATION

Please certify that the information given here is true and correct.

I AUTHORIZE any current or former employer, worker's compensation body, physician, hospital, clinic, insurance company, law enforcement agency, fire department, or other entity or person, including the group policyholder, that has any personal, financial or medical records or knowledge in regard to the claimant/deceased, to release and provide full details (including furnishing copies) of all available personal, financial and medical information records and knowledge, including prior medical history, toxicological or pathological findings which they may possess to the above noted insurer(s) in regard to the claim, its authorized administrator (ASSURANT), its re-insurer, or their respective agents.

The information is to be used in the evaluation of an insurance claim and for the purposes relating to such claim. This consent shall be valid during the continuation of such claim.

I also authorize the insurer, its authorized administrator, its re-insurers, the group policyholder and their respective agents to exchange and or transmit information concerning this claim to the organization listed above as necessary to evaluate this claim.

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.

CLAIMANT SIGNATURE:	DATE: ____ / ____ / ____ MM / DD / YY

VERBAL RELEASE OF INFORMATION

Customer privacy and the protection of private and confidential information is important to us. We do understand that in some cases, a claimant may wish to have someone speak to Assurant on his or her behalf. Please complete this authorization section if you wish to have another individual discuss the details of your claim. Without this authorization we are unable to speak to anyone other than the claimant.

I give my authorization to Assurant to speak to _____,

who is my _____ , with regard to my claim.

CLAIMANT SIGNATURE:	DATE: ____ / ____ / ____ MM / DD / YY

SECTION 3

PLEASE PRINT

DISABILITY / DISMEMBERMENT CLAIMS

To be completed by Licensed Physician without expense to the Insurance Company

PATIENT'S FULL NAME:						
LAST NAME	FIRST NAME, MIDDLE INITIAL	HEIGHT	WEIGHT	AGE	BLOOD PRESSURE	
STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER: ( )		

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	____ / ____ / ____ MM / DD / YY	IF ACCIDENT, PLEASE DESCRIBE CIRCUMSTANCES:	WAS THE CLAIMANT OPERATING A MOTOR VEHICLE?	☐ YES ☐ NO
PRIMARY DIAGNOSIS:			DATE OF DIAGNOSIS: ____ / ____ / ____ MM / DD / YY	

DESCRIBE ANY OTHER DISEASE, INFIRMITY OR SECONDARY CONDITION AFFECTING PRESENT CONDITION: (ATTACH ADDITIONAL SHEET)

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?	☐ YES ☐ NO	IF YES, PLEASE DESCRIBE:	GIVE DATE OF TREATMENT FOR SIMILAR CONDITION:	____ / ____ / ____ MM / DD / YY
IS CONDITION DUE TO PREGNANCY?	☐ YES ☐ NO	IF YES, PLEASE DESCRIBE COMPLICATIONS:	ESTIMATED DATE OF DELIVERY:	____ / ____ / ____ MM / DD / YY

DATES OF TREATMENT FOR CURRENT ILLNESS: **FIRST VISIT:** ____ / ____ / ____ MM / DD / YY **LAST VISIT:** ____ / ____ / ____ MM / DD / YY	FREQUENCY OF VISITS: ☐ WEEKLY ☐ MONTHLY ☐ OTHER, SPECIFY:
GIVE ALL DATES OF TREATMENT, SINCE ONSET OF CONDITION: ____ / ____ / ____ MM / DD / YY ____ / ____ / ____ MM / DD / YY ____ / ____ / ____ MM / DD / YY	NATURE OF TREATMENTS:

HAS PATIENT BEEN HOSPITALIZED?	☐ YES ☐ NO	**FROM:** ____ / ____ / ____ MM / DD / YY **THROUGH:** ____ / ____ / ____ MM / DD / YY	NAME OF HOSPITAL:
DID PATIENT HAVE SURGERY?	☐ YES ☐ NO	**IF YES, GIVE DATE PERFORMED:** ____ / ____ / ____ MM / DD / YY	DESCRIBE SURGERY:

GIVE NAMES, ADDRESSES & TELEPHONE NUMBERS OF OTHER TREATING PHYSICIANS FOR THIS CONDITION: (ATTACH ADDITIONAL SHEET)

GIVE EXACT DATES OF INABILITY TO WORK:	**FROM:** ____ / ____ / ____ MM / DD / YY **THROUGH:** ____ / ____ / ____ MM / DD / YY	☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION
GIVE DATES OF PARTIAL INABILITY TO WORK:	**FROM:** ____ / ____ / ____ MM / DD / YY **THROUGH:** ____ / ____ / ____ MM / DD / YY	☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION

WHEN WILL PATIENT RECOVER SUFFICIENTLY TO RETURN TO WORK?	____ / ____ / ____ MM / DD / YY	☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS ☐ 4 MONTHS ☐ 5 MONTHS ☐ 6 MONTHS ☐ PERMANENT DISABILITY ☐ OTHER: _____	LIFE EXPECTANCY OF LESS THAN 12 MONTHS?	☐ YES ☐ NO

LICENSED PHYSICIAN INFORMATION:

NAME (PLEASE PRINT):		PHYSICIAN'S ADDRESS STAMP:
SPECIALTY:		
MEDICAL ID #:		
ADDRESS:		
PHONE NUMBER:		
FAX NUMBER:		
TODAY'S DATE:		
SIGNATURE:		

PROGNOSIS / COMMENTS (PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL - ATTACH ADDITIONAL SHEET)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

SECTION 4

PLEASE PRINT

EMPLOYER'S STATEMENT

To be completed by Employer without expense to the Insurance Company

I am the employer of the named Insured, and for the purpose of furnishing information to the named Insurance Company to induce payment of claim of said employee, do certify as follows:

EMPLOYEE'S INFORMATION

EMPLOYEE'S NAME:

LAST NAME:	FIRST NAME, MIDDLE INITIAL:	DATE HIRED: ____ / ____ / ____ MM / DD / YY	NUMBER OF HOURS WORKED PER WEEK:

EMPLOYEE'S JOB TITLE:

TYPE OF EMPLOYMENT:

☐ PERMANENT ☐ SEASONAL ☐ TEMPORARY ☐ CONTRACT
☐ SELF-EMPLOYED (Complete the Self-Employment Affidavit)

IF SEASONAL EMPLOYMENT, PLEASE PROVIDE DATES OF REGULAR SEASONAL EMPLOYMENT:

FROM: ____ / ____ / ____ MM / DD / YY TO: ____ / ____ / ____ MM / DD / YY

BRIEF DESCRIPTION OF DUTIES:	DATE OF JOB LOSS NOTICE PROVIDED: ____ / ____ / ____ MM / DD / YY	LAST DAY WORKED: ____ / ____ / ____ MM / DD / YY	DATE RETURNED TO WORK: ____ / ____ / ____ MM / DD / YY

REASON FOR INTERRUPTION OF EMPLOYMENT:

DID EMPLOYEE RECEIVE SEVERANCE? ☐ YES ☐ NO

DATE SEVERANCE ENDS: ____ / ____ / ____ MM / DD / YY

HAS EMPLOYEE RESUMED FULL DUTIES? ☐ YES ☐ NO

IF YES, PROVIDE NUMBER OF HOURS WORKED PER WEEK:

IF NO, WHAT DUTIES ARE THEY ABLE TO PERFORM?

ADDITIONAL COMMENTS:

COMPANY INFORMATION

NAME OF COMPANY:

CONTACT TELEPHONE NUMBER: ( )

ADDRESS:

STREET	CITY	PROVINCE	POSTAL CODE	FAX NUMBER: ( )

COMPLETED BY: TITLE:

LAST NAME	FIRST NAME, MIDDLE INITIAL

EMAIL ADDRESS FOR COMPANY REPRESENTATIVE	SIGNATURE	DATE: ____ / ____ / ____ MM / DD / YY

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Fax: 1-800-645-9405

PLEASE PRINT

SELF-EMPLOYMENT AFFIDAVIT

CREDITOR NAME:	ACCOUNT NUMBER:	DATE LAST WORKED: ____ / ____ / ____ MM / DD / YY

CLAIMANT'S NAME

LAST NAME:	FIRST NAME, MIDDLE INITIAL:

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER: ( )

HOME TELEPHONE NUMBER: ( )	E-MAIL ADDRESS (IF AVAILABLE):

ARE YOU STILL OFF WORK? ☐ YES ☐ NO	IF NO, DATE YOU RETURNED TO WORK: ____ / ____ / ____ MM / DD / YY	NUMBER OF HOURS WORKED PER WEEK:	EXPECTED RETURN TO WORK DATE: ____ / ____ / ____ MM / DD / YY

WHAT PERCENTAGE OF YOUR TIME WAS SPENT AT EACH OF THE FOLLOWING: SUPERVISORY / ADMINISTRATIVE _____% MANUAL WORK _____%

MY OCCUPATION IS:	WHAT DATE DID YOUR BUSINESS START: ____ / ____ / ____ MM / DD / YY	WHAT DATE DID YOUR BUSINESS CLOSE: ____ / ____ / ____ MM / DD / YY

REASON FOR CLOSURE: ☐ BANKRUPTCY ☐ FINANCIAL REASONS ☐ SEASONAL ☐ LACK OF WORK ☐ INJURY/ILLNESS ☐ OTHER _____

BUSINESS INFORMATION

WAS BUSINESS INCORPORATED OR REGISTERED: ☐ YES ☐ NO	WHAT DATE WAS BUSINESS INCORPORATED OR REGISTERED: ____ / ____ / ____ MM / DD / YY

BUSINESS NAME:	MY BUSINESS IS OPERATED FROM MY RESIDENCE: ☐ YES ☐ NO

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER: ( )

BUSINESS TELEPHONE NUMBER: ( )	FAX NUMBER: ( )
BUSINESS LICENSE NUMBER:	GST NUMBER:

CLAIMANT'S AUTHORIZATION

I certify that the above information is true and correct. I authorize any Employer, Physician, Hospital, Insurer or other organization, or person having my records, data or information concerning this claim, to furnish such record, data or information to Assurant or authorized representative if requested. I understand that in executing this authorization, I waive the right for such information to be privileged.

CLAIMANT'S SIGNATURE:	DATE: ____ / ____ / ____ MM / DD / YY

Subscribed and sworn before me, a Notary Public or Commissioner of Oaths for the Country of_____,

Signature:_____.

Province of _____this date _____ of _____, 20_____.

NOTARY PUBLIC OR COMMISSIONER OF OATHS LEGAL SEAL STAMP.

A COPY OF THIS FORM WILL NOT BE ACCEPTED.

PLEASE PRINT

CREDITOR INFORMATION

Please complete for all claims being submitted

NAME OF CREDITOR / LIENHOLDER			ACCOUNT NUMBER / CERTIFICATE NUMBER:
BRANCH ADDRESS:			
STREET	CITY	PROVINCE	POSTAL CODE

EFFECTIVE DATE OF LOAN	1ST PAYMENT DATE	WHEN IS YOUR NEXT SCHEDULED PAYMENT DUE?	EXPIRY DATE OF LOAN
____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY

PAYMENT INFORMATION		
FREQUENCY OF PAYMENT	PAYMENT AMOUNT	MONTHLY PAYMENT DUE DATE
☐ MONTHLY ☐ SEMI-MONTHLY ☐ BI-WEEKLY ☐ WEEKLY	$	____ / ____ / ____ MM / DD / YY

CONTACT INFORMATION			
BRANCH REPRESENTATIVE NAME:	EMAIL ADDRESS:	CONTACT TELEPHONE NUMBER:	FAX #
		( )	( )