ASSURANT®

American Bankers Insurance Company of Florida
American Bankers Life Assurance Company of Florida

CRITICAL ILLNESS 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.
- 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 claims.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.

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 CRITICAL ILLNESS CLAIMS

☐ For Critical Illness, please submit your claim as soon as possible.

☐ Have your family physician complete Section 3.

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

Upload your documents for faster processing.
Online: login at claims.assurant.com

Visit your easyfinancial branch

Call (855) 996-3279

Mail: Assurant, Financial Claims,
1945 King Street East, Suite 100, Hamilton, Ontario L8K 1W2

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

All benefit payments are paid directly to your creditor.

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Please visit claims.assurant.com

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Financial Claims, 1945 King Street East, Suite 100,
Hamilton, Ontario L8K 1W2 | Telephone: 1-800-663-9822

SECTION 1

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

CLAIMANT INFORMATION

Please complete for all claims being submitted

Critical Illness

☐ **CHECK HERE IF YOU ARE FILING A CLAIM FOR MORE THAN ONE LOAN/ACCOUNT**

PLEASE LIST ALL LOAN/ACCOUNT NUMBERS (You can find this information on your loan/account documents)

NAME OF PRIMARY DEBTOR/CO-DEBTOR (FIRST NAME ON PROMISSORY NOTE)

LAST NAME	FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH MM DD YYYY	AGE

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

NAME OF CLAIMANT

LAST NAME	FIRST NAME, MIDDLE INITIAL	EMAIL ADDRESS	RELATIONSHIP TO PRIMARY DEBTOR/CO-DEBTOR

SECTION 2

AUTHORIZATION AND CLAIMS ASSISTANCE

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) American Bankers Life Assurance Company of Florida and/or American Bankers Insurance Company of Florida hereinafter collectively referred to as "Assurant", in regard to the claim, its authorized administrator, 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.

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.

☐ By checking this box, I acknowledge that the above statement is true as of _____

CLAIMANT SIGNATURE	DATE MM DD YYYY

Assurant understands that easyfinancial employees and/or third parties acting on behalf of easyfinancial, may play an important role in assisting you with the claim process (e.g., filing your claim form, submitting other required claim documents and discussing your claim status). In order to protect your privacy, we require your explicit consent to discuss your claim with easyfinancial employees and/or third parties acting on behalf of easyfinancial. Your consent is specific to this claim only and you have the right to withdraw your consent at any time. You may choose to submit your claim information directly to Assurant as noted on this claim form.

I give permission to Assurant to share my claim status and claim details with easyfinancial employees and/or third parties acting on behalf of easyfinancial assisting me with my claim. I am aware and acknowledge that my claim status and claim details may include **sensitive personal information (medical and otherwise)**.

CLAIMANT SIGNATURE	DATE MM DD YYYY

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 their behalf. Please complete this authorization section if you wish to have another individual, other than an organization or representative of an organization, 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.

☐ By checking this box, I acknowledge that the above statement is true as of _____

CLAIMANT SIGNATURE	DATE MM DD YYYY

SECTION 3

Financial Claims, 1945 King Street East, Suite 100, Hamilton, Ontario L8K 1W2 | Telephone: 1-800-663-9822

CRITICAL ILLNESS 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? MM DD YYYY	PRIMARY DIAGNOSIS	IS PRIMARY DIAGNOSIS CONSIDERED LIFE THREATENING? ☐ YES ☐ NO	DATE OF DIAGNOSIS MM DD YYYY

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 YYYY

DATES OF TREATMENT FOR CURRENT ILLNESS MM DD YYYY		FREQUENCY OF VISITS ☐ WEEKLY ☐ OTHER, SPECIFY: ☐ MONTHLY
FIRST VISIT	LAST VISIT	

GIVE ALL DATES OF TREATMENT, SINCE ONSET OF CONDITION MM DD YYYY MM DD YYYY MM DD YYYY	NATURE OF TREATMENTS

HAS PATIENT BEEN HOSPITALIZED? ☐ YES ☐ NO	FROM MM DD YYYY	THROUGH MM DD YYYY	NAME OF HOSPITAL

DID PATIENT HAVE SURGERY? ☐ YES ☐ NO	IF YES, GIVE DATE PERFORMED MM DD YYYY	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 YYYY	THROUGH MM DD YYYY	☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION
GIVE DATES OF PARTIAL INABILITY TO WORK	FROM MM DD YYYY	THROUGH MM DD YYYY	☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION

WHEN WILL PATIENT RECOVER SUFFICIENTLY TO RETURN TO WORK? MM DD YYYY	☐ 1 MONTH ☐ 2-3 MONTHS ☐ 3-6 MONTHS ☐ >6 MONTHS ☐ PERMANENT DISABILITY ☐ OTHER: _____

LICENSED PHYSICIAN INFORMATION

NAME (PLEASE PRINT)	PHYSICIAN'S ADDRESS STAMP

SPECIALTY	MEDICAL ID #

ADDRESS

PHONE NUMBER	FAX NUMBER

SIGNATURE	DATE MM DD YYYY

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."