ASSURANT®

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

TOTAL DISABILITY 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.
- 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,
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, and will be shown on your monthly billing statement.

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Financial Claims, 1945 King Street East, Suite 100,
Hamilton, Ontario L8K 1W2 | Telephone: 1-800-361-5344

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

SECTION 1
CLAIMANT'S INFORMATION
MUST BE COMPLETED IN FULL

Total Disability

CLAIMANT'S NAME	CLAIM NUMBER

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

PLEASE LIST ALL ACCOUNT NUMBERS

ADDRESS ☐ **CHECK HERE IF ADDRESS HAS CHANGED**

STREET	CITY	PROVINCE	POSTAL CODE

CREDITOR NAME (GROUP POLICYHOLDER)

PREFERRED METHOD OF COMMUNICATION	EMAIL ADDRESS (IF AVAILABLE)
☐ MAIL ☐ EMAIL	

DESCRIBE YOUR CURRENT ACTIVITIES OR ANY CHANGES IN YOUR CONDITION

HAVE YOU RETURNED TO WORK?	IF YES, WHAT DATE	# OF HOURS/WEEK	ARE YOU RECEIVING WCB OR OTHER DISABILITY BENEFITS?
☐ YES ☐ FULL-TIME ☐ PART-TIME ☐ NO	MM DD YYYY		☐ WCB ☐ NO ☐ OTHER, SPECIFY: ____________

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.

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.

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'S SIGNATURE	TELEPHONE NUMBER	DATE MM DD YYYY
	( )	

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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

#	MM	DD	YYYY	#	MM	DD	YYYY	#	MM	DD	YYYY	#	MM	DD	YYYY	#	MM	DD	YYYY
1				2				3				4				5			
6				7				8				9				10			

DATE OF NEXT VISIT (MM DD YYYY)

FREQUENCY OF VISITS ☐ WEEKLY ☐ MONTHLY ☐ OTHER ______________

DID PATIENT HAVE SURGERY SINCE LAST REPORT? ☐ YES ☐ NO

IF SO, DESCRIBE SURGERY

SURGERY DATE (MM DD YYYY)

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK/NORMAL ACTIVIITIES 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? ☐ YES ☐ NO

GIVE EXACT DATES OF TOTAL DISABILITY — FROM (MM DD YYYY) TO (MM DD YYYY)
☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION
☐ NORMAL ACTIVITIES OF DAILY LIVING

GIVE DATES OF PARTIAL DISABILITY (ABLE TO PERFORM SOME DUTIES) — FROM (MM DD YYYY) TO (MM DD YYYY)
☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION
☐ NORMAL ACTIVITIES OF DAILY LIVING
OF HOURS/WEEK

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT?
☐ PERMANENTLY DISABLED
☐ TEMPORARILY DISABLED
☐ NON-DISABLED

IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED?
☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS ☐ OTHER: ______________
☐ 4 MONTHS ☐ 5 MONTHS ☐ 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

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