ASSURANT®

American Bankers
Life Assurance Company of Florida

CRITICAL / TERMINAL 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 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.

CRITICAL/TERMINAL ILLNESS CLAIMS

*Please submit your claim any time **after** date of diagnosis and/or applicable waiting period*.*

**Refer to your Certificate of Insurance*

☐ 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 ofAssurant if you are not available.

☐ Have your family physician complete Section 3.

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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Financial Claims, P.O. Box 7000, Kingston, Ontario K7L 5V3
Telephone: 1-800-361-5344

SECTION 1

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

PRIMARY CARDHOLDER INFORMATION

Please complete for all claims being submitted

Critical/Terminal Illness

CREDITOR NAME (GROUP POLICYHOLDER)

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

PLEASE LIST ALL ACCOUNT NUMBERS

NAME OF PRIMARY CARDHOLDER

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

PREFERRED METHOD OF CONTACT	EMAIL ADDRESS
☐ MAIL ☐ EMAIL	

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

NAME OF CLAIMANT

LAST NAME	FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH MM DD YYYY	RELATIONSHIP TO PRIMARY CARDHOLDER

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 hereinafter 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

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 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

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SECTION 3

CRITICAL / TERMINAL 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	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	FIRST VISIT (MM DD YYYY)	LAST VISIT (MM DD YYYY)	FREQUENCY OF VISITS
			☐ WEEKLY ☐ OTHER, SPECIFY: ☐ MONTHLY

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 TOTAL DISABILITY	FROM (MM DD YYYY)	THROUGH (MM DD YYYY)	☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION ☐ NORMAL ACTIVITIES OF DAILY LIVING

GIVE DATES OF PARTIAL DISABILITY	FROM (MM DD YYYY)	THROUGH (MM DD YYYY)	☐ PATIENT'S OCCUPATION ☐ ANY OCCUPATION ☐ NORMAL ACTIVITIES OF DAILY LIVING

WHEN WILL THE PATIENT SUFFICIENTLY RETURN TO WORK OR NORMAL ACTIVITIES OF DAILY LIVING? (MM DD YYYY)	☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS ☐ PERMANENT DISABILITY ☐ 4 MONTHS ☐ 5 MONTHS ☐ 6 MONTHS ☐ 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	
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."