ASSURANT®

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

TOTAL DISABILITY/DISMEMBERMENT/ HOSPITALIZATION 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 CLAIMS

*Please submit your claim form **after** 30 consecutive days of total disability.*

- ☐ 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.
- ☐ Have your family physician complete Section 3.
- ☐ Have your current employer complete Section 4 (if applicable). If you are unable to have Section 4 completed, please complete the form yourself and provide a copy of your record of employment.
- ☐ If you are self-employed, AND your coverage includes disability benefits for self-employed individuals, please complete Section 5.

DISMEMBERMENT CLAIMS

Please submit your claim any time after date of surgery.

- ☐ 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.
- ☐ Have your family physician complete Section 3.

** You do not need to complete Section 4 or 5.

HOSPITALIZATION 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.
- ☐ Please provide an admission and discharge summary (please ensure admission date is captured).
- ☐ Have your physician complete Section 3.

** You do not need to complete Section 4 or 5.

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

Total Disability/ Dismemberment/Hospitalization

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

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

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

TOTAL 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 YYYY	IF ACCIDENT, PLEASE DESCRIBE CIRCUMSTANCES	WAS THE CLAIMANT OPERATING A MOTOR VEHICLE? ☐ YES ☐ NO

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
IS THE PATIENT IN A TREATMENT CENTRE?	☐ YES ☐ NO	IF YES, WHAT IS THE NAME OF THE TREATMENT CENTRE?	
IS CONDITION DUE TO PREGNANCY?	☐ YES ☐ NO	IF YES, PLEASE DESCRIBE COMPLICATIONS	ESTIMATED DATE OF DELIVERY MM DD YYYY

DATES OF TREATMENT FOR CURRENT ILLNESS		FREQUENCY OF VISITS
FIRST VISIT MM DD YYYY	LAST VISIT MM DD YYYY	☐ 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."

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SECTION 4

EMPLOYER'S STATEMENT

Please complete if a Record of Employment is not available.
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 YYYY

NUMBER OF HOURS WORKED PER WEEK	EMPLOYEE'S JOB TITLE

TYPE OF EMPLOYMENT	IF SEASONAL EMPLOYMENT, PLEASE PROVIDE DATES OF REGULAR SEASONAL EMPLOYMENT	FROM MM DD YYYY	TO MM DD YYYY
☐ PERMANENT ☐ SEASONAL ☐ TEMPORARY ☐ CONTRACT ☐ SELF-EMPLOYED (Complete the Self-Employment Affidavit)			

DATE OF JOB LOSS NOTICE PROVIDED MM DD YYYY	LAST DAY WORKED MM DD YYYY	DATE RETURNED TO WORK MM DD YYYY	DID EMPLOYEE RECEIVE SEVERANCE? ☐ YES ☐ NO	DATE SEVERANCE ENDS MM DD YYYY

REASON FOR INTERRUPTION OF EMPLOYMENT

HAS EMPLOYEE RESUMED FULL DUTIES? ☐ YES ☐ NO	IF YES, PROVIDE NUMBER OF HOURS WORKED PER WEEK

ADDITIONAL COMMENTS

COMPANY INFORMATION

NAME OF COMPANY	CONTACT TELEPHONE NUMBER ( )

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE

COMPLETED BY

TITLE

LAST NAME	FIRST NAME, MIDDLE INITIAL

EMAIL ADDRESS FOR COMPANY REPRESENTATIVE	SIGNATURE	DATE MM DD YYYY

SECTION 5

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

SELF-EMPLOYMENT AFFIDAVIT

Not all coverages include benefits for loss of self-employment income, please review your coverage before completing this section

CREDITOR NAME (GROUP POLICYHOLDER)	ACCOUNT NUMBER	DATE LAST WORKED MM DD YYYY

CLAIMANT'S NAME

LAST NAME	FIRST NAME, MIDDLE INITIAL

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

HOME TELEPHONE NUMBER	EMAIL ADDRESS (IF AVAILABLE)
( )	

ARE YOU STILL OFF WORK? ☐ YES ☐ NO	IF NO, DATE YOU RETURNED TO WORK MM DD YYYY	NUMBER OF HOURS WORKED PER WEEK	EXPECTED RETURN TO WORK DATE MM DD YYYY	MY OCCUPATION IS

WHAT PERCENTAGE OF YOUR TIME WAS SPENT AT EACH OF THE FOLLOWING:	SUPERVISORY / ADMINISTRATIVE %	MANUAL WORK %	WHAT DATE DID YOUR BUSINESS START? MM DD YYYY	WHAT DATE DID YOUR BUSINESS CLOSE? MM DD YYYY

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 YYYY	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.

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

CLAIMANT'S SIGNATURE:	DATE MM DD YYYY

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

WE'RE HERE TO HELP!

Please visit cardbenefits.assurant.com