

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.

LIFE 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.
- Have a physician complete Section 3.
- Complete Section 4 (Estate Form) or include a copy of the page of the will indicating the executor of the estate.
Note: Please ensure the witness signature is completed. The witness must be at least 18 years of age.
- Attach a copy of the death certificate.

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.

WE'RE HERE TO HELP!
 Please visit cardbenefits.assurant.com



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

Life

CREDITOR NAME (GROUP POLICYHOLDER)				
<input type="checkbox"/> 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
PREFERRED METHOD OF CONTACT <input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL		EMAIL ADDRESS		
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
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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

LIFE CLAIMS

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

FULL NAME OF DECEASED															
LAST NAME						FIRST NAME, MIDDLE INITIAL									
DATE OF BIRTH MM DD YYYY			DATE OF DEATH MM DD YYYY			PLACE OF DEATH									
IF HOSPITAL OR INSTITUTION, GIVE NAME AND ADDRESS															
NAME OF HOSPITAL OR INSTITUTION								DATE ADMITTED MM DD YYYY							
STREET					CITY			PROVINCE		POSTAL CODE					
HOW LONG DID YOU KNOW THE PATIENT? FROM MM DD YYYY TO MM DD YYYY				CAUSE OF DEATH		IMMEDIATE CAUSE			UNDERLYING CAUSE						
DATE OF DIAGNOSIS MM DD YYYY															
DATES OF MEDICAL TREATMENT, EXAMINATION OR ADVICE RELATED TO THE CAUSE OF DEATH DURING THE LAST 3 YEARS MM DD YYYY MM DD YYYY MM DD YYYY															
IS DEATH DUE TO: ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO HOMICIDE? <input type="checkbox"/> YES <input type="checkbox"/> NO SUICIDE? <input type="checkbox"/> YES <input type="checkbox"/> NO DRUGS & ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO															
BRIEFLY DESCRIBE CIRCUMSTANCES SURROUNDING DEATH								WAS THE CLAIMANT OPERATING A MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO							
WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, PLEASE SUMMARIZE RESULTS AND ATTACH REPORTS												
TO YOUR KNOWLEDGE, DID THE DECEASED RECEIVE MEDICAL TREATMENT DURING THE LAST 3 YEARS FROM ANY OTHER PHYSICIAN OR HOSPITAL FOR THE CAUSE OF DEATH LISTED ABOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE FURNISH THE FOLLOWING															
NAME OF PHYSICIAN OR HOSPITAL															
LICENSED PHYSICIAN INFORMATION															
NAME (PLEASE PRINT)								PHYSICIAN'S ADDRESS STAMP							
SPECIALTY				MEDICAL ID #											
ADDRESS															
PHONE NUMBER					FAX NUMBER										
SIGNATURE						DATE MM DD YYYY									
<p align="center">PROGNOSIS / COMMENTS (PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL - ATTACH ADDITIONAL SHEET)</p> <p align="center">"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."</p>															

SECTION 4

ESTATE FORM

In an effort to protect the privacy of our customer, we respectfully request the following information when completing a Life claim:

CREDITOR NAME (GROUP POLICYHOLDER)	CLAIM NUMBER	ACCOUNT NUMBER
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WILL INCLUDED

I hereby declare that _____ is the person acting in the capacity of Executor of the Estate of _____.

Relationship to the customer: _____.

NO WILL

I hereby declare that _____ is the person acting in the capacity of Executor of the Estate of _____.

Relationship to the customer: _____.

FAMILY MEMBER REQUEST

I hereby declare that I, _____, am requesting the information in the capacity of [spouse / child / grandchild] of the deceased.

Relationship to the customer: _____.

CAUSE OF DEATH

CLAIMANT'S AUTHORIZATION

I certify that the above information is true and correct.

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

CLAIMANT'S SIGNATURE	DATE MM DD YYYY
WITNESS' SIGNATURE	DATE MM DD YYYY

Please include this document when returning your claim forms.