ASSURANT®

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

LOAN 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.
- If required, use a separate sheet of paper to include the name and account numbers of multiple accounts also covered by Assurant.
- You are responsible for continuing to make your minimum monthly payments until a decision is made by us on any claim submitted under the Certificate.

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 Sections 1 & 2 (including signature where applicable).

☐ 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 DISABILITY / CRITICAL ILLNESS / DISMEMBERMENT CLAIMS

☐ Have your family physician complete Section 6.

☐ For Disability, have your current employer complete Section 4 or if self-employed, complete the Self-Employment Affidavit.

FOR UNEMPLOYMENT CLAIMS

☐ For Unemployment, please submit your claim form after 30 consecutive days of Unemployment.

☐ Have your former employer complete Section 4.

☐ If unable to have Employer's Statement completed, please include a letter explaining the reason with a copy of your Record of Employment.

☐ Attach all copies of the Employment Insurance benefit payment statements as verification of unemployment verifying the dates paid to current.

FOR LIFE CLAIMS

☐ Please provide the death certificate, attending physician statement, funeral director's statement or Coroner's report.

☐ Complete the enclosed Estate Form or include a copy from the page of the Will indicating the executor of the Estate.

☐ Have a physician complete Section 5.

3

SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

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.

Once your claim has been submitted, please allow 15 business days for processing. All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

ASSURANT®

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

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

PLEASE PRINT

SECTION 1

CLAIMANT INFORMATION Please complete for all claims being submitted

CREDITOR NAME	ACCOUNT NUMBER

NAME OF CLAIMANT

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 PRIMARY CARDHOLDER (FIRST NAME ON BILLING STATEMENT)

LAST NAME	FIRST NAME, MIDDLE INITIAL	RELATIONSHIP TO CLAIMANT

SECTION 2

AUTHORIZATION Please certify that the information given here is true and correct.

Assurant may collect, use, and share personal information provided by you to Assurant, and obtained from others with your consent, or as required or permitted by law. Assurant may use the information to serve you as a customer and communicate with you. Assurant may process and store your personal information outside your province in another country, which may be subject to access by government authorities under applicable laws of that country. You may obtain a copy of Assurant's privacy policy by calling 1-888-778-8023 or from their website: www.assurant.ca/privacy-policy. If you have any questions or concerns regarding the privacy policy, the purposes and means for which your information is being collected, your rights, your options for refusing or withdrawing your consent to the use of your personal information, you may call Assurant at the number listed above.

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) in regard to the claim, their 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, their 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 his or her 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

SECTION 3

PLEASE PRINT

CREDITOR INFORMATION

To be completed by the creditor/lienholder

NAME OF CREDITOR/LIENHOLDER	☐ LOAN ☐ LEASE	LOAN ACCOUNT NUMBER	CERTIFICATE NUMBER

BRANCH ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE

PAYMENT INFORMATION - REQUIRED FOR ALL CLAIM TYPES

EFFECTIVE DATE OF LOAN			1ST PAYMENT DATE			WHEN IS YOUR NEXT SCHEDULED PAYMENT DUE?			EXPIRY DATE OF LOAN		
MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY

FREQUENCY OF PAYMENT	PAYMENT AMOUNT	MONTHLY PAYMENT DUE DATE			ANNUAL INTEREST RATE
☐ MONTHLY ☐ SEMI-MONTHLY ☐ BI-WEEKLY ☐ WEEKLY	$	MM	DD	YYYY	%

PAYMENT INFORMATION - REQUIRED FOR LIFE CLAIM ONLY

ORIGINAL AMOUNT OF LOAN	TOTAL AMOUNT PAID TO DATE OF DEATH	GROSS BALANCE DUE AT DATE OF DEATH	NET BALANCE DUE AT DATE OF DEATH
$	$	$	$

CONTACT INFORMATION

BRANCH REPRESENTATIVE NAME	CONTACT TELEPHONE NUMBER	FAX NUMBER
	( )	( )

BRANCH REPRESENTATIVE SIGNATURE

IF INFORMATION IS INCOMPLETE OR INCORRECT WE MAY REQUEST ADDITIONAL INFORMATION IN ORDER TO PROCESS YOUR CLAIM.

SECTION 4

PLEASE PRINT

EMPLOYER'S STATEMENT

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

LAST NAME	FIRST NAME	DATE HIRED (MM DD YYYY)

NUMBER OF HOURS WORKED PER WEEK	EMPLOYEE'S JOB TITLE	TYPE OF EMPLOYMENT
		☐ PERMANENT ☐ SEASONAL ☐ TEMPORARY ☐ CONTRACT ☐ SELF-EMPLOYED (Complete the Self-Employment Affidavit)

IF SEASONAL EMPLOYMENT, PLEASE PROVIDE DATES OF REGULAR SEASONAL EMPLOYMENT	LAST DAY WORKED (MM DD YYYY)	HAS EMPLOYEE RETURNED TO WORK?
FROM MM DD YYYY TO MM DD YYYY	MM DD YYYY	☐ YES ☐ NO

BRIEF DESCRIPTION OF DUTIES

REASON FOR INTERRUPTION OF EMPLOYMENT

HAS EMPLOYEE RESUMED FULL DUTIES?	IF YES, PROVIDE NUMBER OF HOURS WORKED PER WEEK AND DATE RETURNED RESUMING FULL DUTIES
☐ YES ☐ NO	HRS/WEEK MM DD YYYY

IF NO, PROVIDE DATE EMPLOYEE RETURNED PARTIALLY AND WHAT DUTIES ARE THEY ABLE TO PERFORM? (MM DD YYYY)	

DID EMPLOYEE RECEIVE SEVERANCE?	DATE SEVERANCE ENDS (MM DD YYYY)	ADDITIONAL COMMENTS
☐ YES ☐ NO		

COMPANY INFORMATION

NAME OF COMPANY	CONTACT TELEPHONE NUMBER
	( )

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	FAX NUMBER
				( )

COMPLETED BY

TITLE

LAST NAME	FIRST NAME

EMAIL ADDRESS FOR COMPANY REPRESENTATIVE	SIGNATURE	DATE (MM DD YYYY)

SECTION 5

PLEASE PRINT

LIFE CLAIM

To be completed by licensed physician without expense to the insurance company

INFORMATION 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)

PLEASE PROVIDE THE DECEASED'S LAST 3 YEARS OF MEDICAL HISTORY

IS DEATH DUE TO: ACCIDENT? ☐ YES ☐ NO HOMICIDE? ☐ YES ☐ NO SUICIDE? ☐ YES ☐ NO DRUGS & ALCOHOL? ☐ YES ☐ NO

BRIEFLY DESCRIBE CIRCUMSTANCES SURROUNDING DEATH

WAS AUTOPSY PERFORMED? ☐ YES ☐ NO	IF YES, PLEASE SUMMARIZE RESULTS AND ATTACH REPORTS
WAS AN INQUEST HELD? ☐ YES ☐ NO	IF YES, BY WHOM AND WHAT WERE THE FINDINGS?

TO YOUR KNOWLEDGE, DID THE DECEASED RECEIVE MEDICAL TREATMENT DURING THE LAST 3 YEARS FROM ANY OTHER PHYSICIAN/HOSPITAL FOR THE CAUSE OF DEATH LISTED ABOVE?

☐ YES ☐ NO *IF YES, PLEASE FURNISH THE FOLLOWING*

NAME OF PHYSICIAN OR HOSPITAL

STREET	CITY	PROVINCE	POSTAL CODE

ILLNESS/INJURY	DATES TREATED (MM / DD / YYYY)	(MM / DD / YYYY)	(MM / DD / YYYY)	(MM / DD / YYYY)

LICENSED PHYSICIAN INFORMATION

NAME (PLEASE PRINT)	PHYSICIAN'S ADDRESS STAMP

SPECIALTY	MEDICAL ID #

ADDRESS

PHONE NUMBER	FAX NUMBER

SIGNATURE	DATE (MM / DD / YYYY)

"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."

SECTION 6

PLEASE PRINT

DISABILITY/CRITICAL ILLNESS CLAIM

To be completed by licensed physician without expense to the insurance company

PATIENT'S INFORMATION

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

DISABILITY CAUSED BY ☐ ACCIDENT ☐ ILLNESS	PRIMARY DIAGNOSIS	DATE OF DIAGNOSIS MM DD YYYY

DESCRIBE ANY OTHER DISEASE, INFIRMITY OR SECONDARY CONDITION AFFECTING PRESENT CONDITION (PLEASE SEE ADDITIONAL PHYSICIAN NOTE SHEET, ATTACHED)

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 CONDITION DUE TO PREGNANCY?	☐ YES ☐ NO	IF YES, PLEASE DESCRIBE COMPLICATIONS	ESTIMATED DATE OF DELIVERY MM DD YYYY

DATES OF TREATMENT FOR CURRENT DISABILITY	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	NATURE OF TREATMENTS
MM DD YYYY MM DD YYYY MM DD YYYY	

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

DID PATIENT HAVE SURGERY?	☐ YES ☐ NO	IF YES, GIVE DATE PERFORMED MM DD YYYY	DESCRIBE SURGERY

GIVEN NAMES, ADDRESSES & TELEPHONE NUMBERS OF OTHER TREATING PHYSICIANS FOR THIS CONDITION (PLEASE SEE ADDITIONAL PHYSICIAN NOTE SHEET, ATTACHED)

GIVE EXACT DATES OF TOTAL DISABILITY (INABILITY TO WORK)	FROM MM DD YYYY	THROUGH MM DD YYYY	☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION

GIVE DATES OF PARTIAL DISABILITY	FROM MM DD YYYY	THROUGH MM DD YYYY	☐ HIS/HER 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: _____	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."

SECTION 7
ESTATE FORM

PLEASE PRINT

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

CREDITOR NAME	CLAIM NUMBER	ACCOUNT NUMBER

☐ 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.

SECTION 8

PLEASE PRINT

SELF-EMPLOYMENT AFFIDAVIT

CREDITOR NAME	ACCOUNT NUMBER	DATE LAST WORKED MM DD YYYY

CLAIMANT'S INFORMATION

LAST NAME	FIRST NAME, MIDDLE INITIAL

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

HOME TELEPHONE NUMBER	EMAIL ADDRESS (IF AVAILABLE)
( )	

BUSINESS INFORMATION

WAS BUSINESS INCORPORATED OR REGISTERED?	WHAT DATE WAS BUSINESS INCORPORATED OR REGISTERED? MM DD YYYY	BUSINESS NAME	MY BUSINESS IS OPERATED FROM MY RESIDENCE
☐ YES ☐ NO			☐ YES ☐ NO

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

BUSINESS TELEPHONE NUMBER	FAX NUMBER	BUSINESS LICENSE NUMBER	GST NUMBER
( )	( )		

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

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 _____

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

A COPY OF THIS FORM WILL NOT BE ACCEPTED.

SECTION 9

PLEASE PRINT

PHYSICIAN NOTE SHEET