ASSURANT®

Caribbean American Life Assurance Company
Caribbean American Property Insurance Company

CREDIT CARD PROTECTION PLAN FORM | **FOR CONTINUED DISABILITY COVERAGE CLAIMS**

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WE ARE HERE TO SERVE!

Please take note of the following information on how to submit a claim to Assurant.

- You are responsible for continuing to make your monthly payments until a decision is made by us on any claim submitted.
- If required, use a separate sheet of paper to include the name and account numbers of any account also covered by Assurant.
- To avoid any delays with your claim, review the forms to make sure you've included all documentation required and have duly signed all forms.
- We recommend that you retain copies of all documentation submitted to us for review.

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FOR CONTINUED DISABILITY CLAIMS

- Complete and sign Sections 1 & 4.
- Provide copy of a photo identification.
- Have your physician complete Section 2.
- Have your employer complete Section 3.

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SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION BY:

Mail
350 Carlos Chardón Ave.
Torre Chardón Suite 1101
San Juan, PR 00918

Email:
reclamaciones@assurant.com

Online by visiting:
claimspr.assurant.com

Once your claim has been received, please allow 15 business days for processing.
All benefit payments are paid directly to the creditor.

NEED HELP?

Visit claimspr.assurant.com
24 hours a day, 7 days a week or
Call our toll-free number 1-800-981-8888
We're available Monday through Friday from 8:00 am to 5:00 pm

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SECTION 1: INSURED'S INFORMATION

THIS SECTION IS REQUIRED TO EVALUATE YOUR CLAIM. Please complete the form in legible font.			
NAME OF INSURED			
CLAIM NUMBER		FULL SOCIAL SECURITY NUMBER	
NAME OF FINANCIAL INSTITUTION		CREDIT CARD NUMBER	
HAS YOUR ADDRESS CHANGED? ☐ YES ☐ NO	IF YES, PROVIDE YOUR NEW ADDRESS		

SELF-EMPLOYED QUESTIONNAIRE

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

INSURED'S INFORMATION

NAME OF INSURED	CREDIT CARD NUMBER

HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE RETURNED TO WORK?	MONTH	DAY	YEAR

BUSINESS INFORMATION

BUSINESS NAME	STARTING DATE OF THIS BUSINESS	MONTH	DAY	YEAR

BUSINESS ADDRESS		
WORK NUMBER	FAX	EMAIL

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SECTION 2: PHYSICIAN'S DECLARATION

To be completed by Licensed Physician.
Alternatively, you may submit a medical certificate containing the same information requested in the form. The certificate must use the physician's letterhead, be dated and signed, and include their medical license number.

PATIENT'S FULL NAME	PATIENT'S CONTACT NUMBER

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	_____ MONTH	_____ DAY	_____ YEAR

DIAGNOSIS CODE		WHEN WAS THE PATIENT DIAGNOSED?	_____ MONTH	_____ DAY	_____ YEAR
ICD-10:	DSM V:				

DIAGNOSIS

PLEASE PROVIDE ALL THE TREATMENT DATES FROM THE LAST VISIT	NEXT TREATMENT DATE

WHAT ARE THE NAMES AND ADDRESSES OF OTHER DOCTORS TREATING THE PATIENT FOR THE SAME CONDITION?

DATES OF TOTAL DISABILITY (UNABLE TO WORK)

FROM	_____ MONTH	_____ DAY	_____ YEAR	**UNTIL**	_____ MONTH	_____ DAY	_____ YEAR

DATES OF PARTIAL DISABILITY (ABLE TO WORK UNDER TREATMENT)

FROM	_____ MONTH	_____ DAY	_____ YEAR	**UNTIL**	_____ MONTH	_____ DAY	_____ YEAR

IF THE PATIENT IS STILL UNDER YOUR CARE, WHEN DO YOU ESTIMATE THE PATIENT CAN RETURN TO THEIR JOB?	_____ MONTH	_____ DAY	_____ YEAR
IF NOT, WHEN WILL PATIENT RECOVER SUFFICIENTLY TO RETURN TO WORK?	_____ MONTH	_____ DAY	_____ YEAR

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SECTION 2: PHYSICIAN'S DECLARATION (CONTINUED)

PROGNOSIS / COMMENTS (PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL (IF NEEDED, ATTACH ADDITIONAL SHEET)

IN YOUR EXPERT OPINION, HOW WOULD YOU CLASSIFY THE PATIENT?
☐ TOTALLY AND PERMANENTLY DISABLED ☐ PARTIALLY DISABLED ☐ NOT DISABLED

IF THE PATIENT IS PARTIALLY DISABLED, HOW LONG DO YOU THINK THE PATIENT WILL REMAIN DISABLED?
☐ 1-2 MONTHS ☐ 3 MONTHS ☐ 6 MONTHS ☐ LONGER THAN 9 MONTHS ☐ UNDETERMINED

LICENSED PHYSICIAN'S INFORMATION

NAME	SPECIALTY	LICENSE NUMBER

ADDRESS

CONTACT NUMBER	FAX NUMBER	EMAIL

"I hereby certify that the information provided here is based on a probable medical reason, that it is true and trustworthy to the best of my knowledge and understanding."

PHYSICIAN'S SIGNATURE	_____ MONTH	_____ DAY	_____ YEAR

If you are unable to provide an original signature, please read and complete the following section to confirm your consent:

I declare I have provided reasonable and relevant information with regards to the disability claim form that the insured is about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process the insured's claim. Furthermore, I certify I have read and completed in all its parts the section of the form that applies to me, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.

☐ In witness whereof, I sign this declaration by checking the box here provided.

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SECTION 3: EMPLOYER'S DECLARATION

This is meant to be filled by the employer free of any fees to the company.
"I am the employer of the named insured and, in order to provide information to the company that provides the payment of the claim of said insured, certify the following:"

EMPLOYEE'S INFORMATION

EMPLOYEE'S NAME	

HAS THE EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO	WHAT DAY DID THE EMPLOYEE RETURN TO WORK?	MONTH	DAY	YEAR

HAS THE EMPLOYEE RESUMED ALL OF THEIR RESPONSIBILITIES? ☐ YES ☐ NO	IF YOU ANSWERED NO, WHAT ASSIGNMENTS WERE THEY ARE ABLE TO DO?

ADDITIONAL COMMENTS

EMPLOYER'S INFORMATION

COMPANY NAME	CONTACT NUMBER	FAX NUMBER

COMPANY ADDRESS

COMPLETED BY NAME (IN LEGIBLE LETTERING)

POSITION	EMAIL

SIGNATURE	MONTH	DAY	YEAR

If you are unable to provide an original signature, please read and complete the following section to confirm your consent:

I declare I have provided reasonable and relevant information with regards to the disability claim form that the insured is about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process the insured's claim. Furthermore, I certify I have read and completed in all its parts the section of the form that applies to me, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.

☐ In witness whereof, I sign this declaration by checking the box here provided.

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SECTION 4: AUTHORIZATION

Please certify that all the information provided here is correct and reliable.

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., insurance or reinsuring Company, insurer, law enforcement agency, fire department, or other organization, or person having any records, data or information concerning this claim to furnish such record, data or information to Caribbean American Life Assurance Company/Caribbean American Property Insurance Company or its authorized representative(s) as requested. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original. I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above. This authorization shall remain valid for 6 months after the date of the signature.

RESPONSIBILITY FOR FRAUDULENT INFORMATION

ANY PERSON who knowingly and with the intention to commit fraud provides false information in an insurance application, or submits, helps or causes the submission of a fraudulent insurance claim for the payment of a loss or any other benefit, or submits more than one claim for the same damage or loss, will incur in a felony and, upon conviction thereof, shall be punished, for each violation, with a fine not less than five thousand ($5,000) dollars, nor greater than ten thousand ($10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances are present, the fixed penalty established could be increased up to a maximum of five (5) years; if attenuating circumstances are present, the penalty could be reduced to a minimum of two (2) years.

INSURED'S SIGNATURE

SIGNATURE	MONTH	DAY	YEAR

If you are unable to provide an original signature, please read and complete the following section to confirm your consent:

I declare I have received reasonable and relevant information with regards to the disability claim form that I am about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process my claim. Furthermore, I certify I have read and completed the form and all its parts, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.

☐ In witness whereof, I sign this declaration by checking the box here provided.