ASSURANT®

Caribbean American Life Assurance Company
Caribbean American Property Insurance Company

CREDIT CARD PROTECTION PLAN FORM | **FOR INITIAL 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 INITIAL DISABILITY CLAIMS

- Complete and sign Sections 1 and 4.
- Attach a copy of the credit card statement with closing date immediately following the start date of the disability and copy of a valid photo ID.
- Have your physician complete Section 2.
- Have your employer complete Section 3. If you are self-employed you must complete the "Self-employed Questionnaire" and include copy of your most recent tax forms, Form 480 or evidence of filing for bankruptcy.
- If the condition has been evaluated and approved by the Social Security Administration, include copy of the notification of approval of benefits.
- If your case is under the care of the "Corporación del Fondo del Seguro del Estado" (CFSE) or the "Administración de Compensaciones por Accidentes de Automoviles" (ACAA) you should submit the following information:
  - For CFSE: "CFSE Certificado médico del Fondo", Form 1021, Copy of your appointment card and Form 395.
  - For ACAA: Medical evaluation report
- If you would like to authorize a third-party to manage the claim for you, you should fill the "Verbal Information Disclosure" included in Section 4. This authorization will allow them to discuss your claim with any Assurant representative should you be unavailable.

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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 print.

NAME OF FINANCIAL INSTITUTION	CREDIT CARD NUMBER

NAME OF INSURED	DATE OF BIRTH	AGE
	MONTH _____ DAY _____ YEAR _____	

PHYSICAL ADDRESS	
MAILING ADDRESS	

FULL SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER	

MOBILE NUMBER	SECONDARY NUMBER	ALTERNATE NUMBER

DO YOU AUTHORIZE US TO SEND YOU EMAILS?	☐ YES ☐ NO
EMAIL	

WE AND OTHERS ACTING ON OUR BEHALF MAY USE THE INFORMATION WE GATHER TO OPERATE OUR PRODUCT AND OUR SERVICE. FOR EXAMPLE, WE MAY USE THE INFORMATION WE COLLECT OR RECEIVE TO TRY AND CONTACT YOU THROUGH EMAIL TO PROVIDE SUPPORT AND ASSISTANCE DURING THE CLAIM PROCESS, AS PERMITTED BY LAW.

HAVE YOU HAD ANY CLAIMS UNDER THIS PRODUCT NUMBER PREVIOUSLY?	☐ YES ☐ NO
IF YES, LIST THE CLAIM NUMBERS	

HEALTH INSURANCE INFORMATION

DO YOU HAVE HEALTH INSURANCE?	INSURANCE PROVIDER	NAME OF THE MAIN INSURED
☐ YES ☐ NO		

SINCE WHEN HAVE YOU BEEN INSURED BY THIS PLAN?		POLICY NUMBER	PHONE NUMBER
	MONTH _____ DAY _____ YEAR _____		

WHAT ARE THE NAMES AND ADDRESSES OF OTHER DOCTORS THAT HAVE TREATED YOUR CONDITION? (USE ADDITIONAL PAPER IF NECESSARY)

WHEN DID YOU START TREATMENT FOR THIS CONDITION? INCLUDE ALL DATES YOU WERE TREATED FOR THIS CONDITION.

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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 FULL NAME	GENDER	HEIGHT	WEIGHT	AGE

PATIENT ADDRESS	PATIENT CONTACT NUMBER

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	IF ACCIDENT, PLEASE DESCRIBE CIRCUMSTANCES
MONTH _____ DAY _____ YEAR _____	

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

DIAGNOSIS

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

IF YES, DESCRIBE ANY OTHER DISEASE, ILLNESS OR SECONDARY CONDITION AFFECTING PRESENT CONDITION (IF NEEDED, ATTACH ADDITIONAL SHEET)

GIVE DATES OF TREATMENT FOR SIMILAR CONDITION

MONTH / DAY / YEAR MONTH / DAY / YEAR MONTH / DAY / YEAR

IS CONDITION DUE TO PREGNANCY?	ESTIMATED DELIVERY DATE
☐ YES ☐ NO	MONTH _____ DAY _____ YEAR _____

IF YES, PLEASE DESCRIBE COMPLICATIONS

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SECTION 2: PHYSICIAN'S DECLARATION (CONTINUED)

DATES OF TREATMENT FOR CURRENT DISABILITY

LAST VISIT	_____ MONTH	_____ DAY	_____ YEAR	**NEXT VISIT**	_____ MONTH	_____ DAY	_____ YEAR

FREQUENCY OF VISITS ☐ WEEKLY ☐ MONTHLY ☐ OTHER, SPECIFY: _____

GIVE ALL DATES OF TREATMENT SINCE ONSET OF CONDITION

NATURE OF TREATMENTS

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	**THROUGH**	_____ MONTH	_____ DAY	_____ YEAR

DATES OF PARTIAL DISABILITY (ABLE TO WORK UNDER TREATMENT)

FROM	_____ MONTH	_____ DAY	_____ YEAR	**THROUGH**	_____ MONTH	_____ DAY	_____ YEAR

WHEN WILL PATIENT RECOVER SUFFICIENTLY TO RETURN TO WORK?	_____ MONTH _____ DAY _____ YEAR	IN YOUR OPINION, IS THE PATIENT TOTAL AND PERMANENTLY INCAPACITATED? ☐ YES ☐ NO

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

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SECTION 2: PHYSICIAN'S DECLARATION (CONTINUED)

LICENSED PHYSICIAN'S INFORMATION		
NAME	SPECIALTY	LICENSE NUMBER
ADDRESS		
CONTACT NUMBER	FAX	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:

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

To be completed 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							
DATE HIRED	MONTH	DAY	YEAR	LAST DAY WORKED	MONTH	DAY	YEAR
REASON FOR THE INTERRUPTION OF EMPLOYMENT							
TYPE OF EMPLOYMENT	☐ FULL TIME ☐ PART-TIME ☐ SEASONAL ☐ TEMPORARY			NUMBER OF HOURS WORKED PER WEEK			
EMPLOYEE'S OCCUPATION				BRIEF DESCRIPTION OF DUTIES			
DATE RETURNED TO WORK	MONTH	DAY	YEAR	HAS THE EMPLOYEE RESUMED ALL DUTIES? ☐ YES ☐ NO			IF YES, HOW MANY HOURS ARE THEY WORKING PER WEEK?
IF NO, WHAT DUTIES ARE THEY UNABLE TO CARRY OUT?				ADDITIONAL COMMENTS			

EMPLOYER'S INFORMATION

COMPANY NAME	CONTACT NUMBER	FAX NUMBER
COMPANY ADDRESS		
COMPLETED BY NAME (PLEASE PRINT)		
TITLE	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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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

LAST DAY WORKED	_____ MONTH	_____ DAY	_____ YEAR	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 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.

VERBAL INFORMATION DISCLOSURE

It is important for us to safeguard the privacy of our customers and protect private and confidential information. We also understand that, on occasion, a claimant may want to authorize third parties to speak with Assurant on their behalf. Please complete this authorization section so others can discuss details of your claim. Without this authorization we cannot talk to anyone except the claimant.

I authorize Assurant to speak with , who is my , about my claim.

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.