AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA
AMERICAN BANKERS LIFE ASSURANCE COMPANY OF FLORIDA
Financial Claims, P.O. Box 7000, Kingston, Ontario K7L 5V3
Telephone: 1-800-361-5344
Fax: 1-800-645-9405

CONTINUING DISABILITY CLAIM FORM

A: CLAIMANT'S INFORMATION (Must be completed in full) PLEASE PRINT

NAME AND ADDRESS ☐ CHECK HERE IF ADDRESS HAS CHANGED	CLAIM NUMBER	ACCOUNT NUMBER
	NAME OF FINANCIAL INSTITUTION	
	NAME OF EMPLOYER	
CLAIMANT'S INTERNET ADDRESS (IF AVAILABLE)	TELEPHONE NUMBER (EMPLOYER) ( )	EXTENSION

DESCRIBE YOUR CURRENT ACTIVITIES OR ANY CHANGES IN YOUR CONDITION

HAVE YOU RETURNED TO WORK SINCE YOU BECAME DISABLED?	IF YES, WHAT DATE M D Y / /	# OF HOURS / WEEK	ARE YOU RECEIVING WCB OR OTHER DISABILITY BENEFITS
☐ YES ☐ NO ☐ FULL-TIME ☐ PART-TIME			☐ WCB ☐ NO ☐ OTHER (specify) _____

ARE YOU RECEIVING CPP / QPP ☐ YES ☐ NO	**IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR ACCEPTANCE LETTER OR VERIFICATION THAT YOU ARE RECEIVING CPP / QPP.**

I certify that the information given here is true and correct. I AUTHORIZE any employer, physician, hospital, insurer, law enforcement agency, fire department or other organization, or person having any records, data or information concerning this claim to furnish such records, data or information to ASSURANT SOLUTIONS or its authorized representative as requested. 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.

This authorization shall remain valid for the duration of the claim.

CLAIMANT'S SIGNATURE X	TELEPHONE NUMBER ( )	DATE M D Y / /

B : PHYSICIAN'S STATEMENT (to be furnished without expense to the Insurance company) PLEASE PRINT

PATIENT'S FULL NAME:	PATIENT'S STREET ADDRESS, APT#, CITY/PROVINCE/POSTAL CODE	AGE

OBJECTIVE DIAGNOSIS / FINDINGS:	DIAGNOSTICS CODE(S) ☐ ICD-9 _____ ☐ CPT _____ ☐ DSM III _____

DATES OF TREATMENT FOR THE LAST 6 MONTHS	DATE OF NEXT VISIT M D Y / /	FREQUENCY OF VISITS ☐ MONTHLY ☐ WEEKLY ☐ OTHER _____

DID PATIENT HAVE SURGERY SINCE LAST REPORT? ☐ YES ☐ NO	IF SO, DESCRIBE SURGERY.	SURGERY DATE M D Y / /

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO	IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK. M D Y / /	IF NO, DATE PATIENT WAS RELEASED FROM YOUR CARE. M D Y / /

LIST PATIENTS FULL LIMITATIONS.	PROGNOSIS :	HAS PATIENT PROGRESSED? ☐ YES ☐ NO

GIVE EXACT DATES OF TOTAL DISABILITY (INABILITY TO WORK) M D Y M D Y FROM / / TO / / ☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION	GIVE DATES OF PARTIAL DISABILITY (ABLE TO PERFORM SOME DUTIES) M D Y M D Y FROM / / TO / / ____ NO. OF HOURS/ WEEK ☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT? ☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled	IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED. ☐ 1 Mo. ☐ 2 - 3 Mo. ☐ 3 - 6 Mo. ☐ > 6Mo. ☐ Other _____	LIFE EXPECTANCY OF LESS THAN 12 MONTHS? ☐ YES ☐ NO

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

PHYSICIAN'S NAME (PLEASE PRINT)	STREET ADDRESS/CITY/PROVINCE/POSTAL CODE

PHYSICIAN'S SIGNATURE X	DATE M D Y / /	MEDICAL ID NUMBER	TELEPHONE NUMBER ( )	FAX NUMBER ( )

FORM MUST BE SIGNED OR STAMPED BY DOCTOR'S OFFICE