IMPORTANT NOTICE:

PLEASE READ CAREFULLY BEFORE COMPLETING CLAIM FORM

- **Failure to complete all required sections and/or provide the requested documentation will delay processing your claim.**
- **If applicable, use a separate sheet of paper to include the name and account numbers of multiple accounts also covered by Assurant Solutions.**
- **Please note any current and future payments due will continue to be your responsibility while your claim is being considered.**
- **Once the form has been received in our office, please allow approximately 10 business days to process your claim.**

INSTRUCTIONS FOR COMPLETING CLAIM FORM

FOR ALL CLAIMS

- **Complete the Finance company or Creditor statement including the Financial Institution who holds the loan or lease and the loan/lease number (For example: GMAC - Loan # 333444556).**

FOR DISABILITY CLAIMS

- **For Disability claims, please verify your employment at the time you originally enrolled in the Certificate of Insurance. To do this, please have the employer you were working for at that time complete the Employer's Certificate. If self-employed, request and complete the self-employment affidavit and questionnaire. If unable to have Employer's Statement completed, please include a letter explaining the reason with a copy of your Record of Employment.**
- **Complete and sign the Insured's Statement for Accident or Sickness Claim.**
- **Have your family physician complete the Physician's Statement.**

FOR LIFE CLAIMS

- **Have your family physician complete the Physician's Statement.**
- **Complete the Next of Kin's Statement.**
- **Complete the enclosed estate authorization form or include a copy from the page of the Will indicating the executor of the Estate.**
- **Attach an original death certificate.**

Mail or fax the completed forms and all supporting documentation to:

Assurant Solutions, Financial Claims
P O Box 7000 Kingston, ON K7L 5V3
Fax - 1 800 645-9405

We recommend that you retain copies of all documentation submitted to us for review.

You May Check The Status Of Your Claim By Visiting Our Website:

www.benefitactivations.ca

MDA SERVICES LTD.
MDA Services Ltd.
#220 9440 49 St NW
Edmonton, AB T6B 2M9
Phone: 780-440-9399
Fax: 780-469-5433
Toll Free: 1-800-661-6926

ASSURANT Solutions

American Bankers Life Assurance Company of Florida
an Assurant Solutions™ company
P.O. Box 7000, Kingston, Ontario K7L 5V3
Telephone 1-877-273-1736

CERTIFICATE OF ATTENDING PHYSICIAN

BOTH SIDES OF THIS CLAIM FORM MUST BE FULLY COMPLETED. UNANSWERED QUESTIONS MAY DELAY PROCESSING.

A. PHYSICIAN'S STATEMENT

(ANY CHARGE FOR THE COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE PATIENT)

PLEASE PRINT OR TYPE

PATIENT'S FULL NAME — LAST NAME — FIRST NAME — MIDDLE INITIAL | HEIGHT | WEIGHT | AGE | BLOOD PRESSURE

STREET - ADDRESS | CITY | PROVINCE | POSTAL CODE

DISABILITY CAUSED BY ☐ ACCIDENT ☐ SICKNESS | PRIMARY DIAGNOSIS / OBJECTIVE FINDINGS

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? M / D / Y | IF ACCIDENT, PLEASE DESCRIBE CIRCUMSTANCES

DESCRIBE ANY OTHER DISEASE, INFIRMITY OR SECONDARY CONDITION AFFECTING PRESENT CONDITION

GIVE DATES BELOW OF ALL OTHER MEDICAL TREATMENT, IF ANY, FOR THE PRIMARY DIAGNOSIS ABOVE OR OTHER RELATED CONDITIONS DURING THE PAST 2 YEARS:

IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO | IF YES, DESCRIBE COMPLICATIONS | ESTIMATED DATE OF DELIVERY M / D / Y

DATES OF TREATMENT FOR CURRENT DISABILITY
FIRST VISIT M / D / Y — LAST VISIT M / D / Y

FREQUENCY OF VISITS ☐ WEEKLY ☐ MONTHLY ☐ OTHER (SPECIFY) _____

GIVE ALL DATES OF TREATMENT SINCE ONSET OF CONDITION (M/D/Y) | NATURE OF TREATMENTS

HAS PATIENT BEEN HOSPITALIZED?
☐ YES ☐ NO FROM M / D / Y THROUGH M / D / Y

NAME AND CITY OF HOSPITAL

WILL/DID PATIENT HAVE SURGERY? ☐ YES ☐ NO | IF YES, DATE PERFORMED/SCHEDULED M / D / Y | DESCRIBE SURGERY

PHYSICAL IMPAIRMENTS (*AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work. * No restrictions. (0-10%)
- ☐ Class 2 - Medium manual activity. * (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work. * (35-55%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical / administrative (sedentary*) activity. (60-70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)

REMARKS:

MENTAL IMPAIRMENTS (IF APPLICABLE)

(a) Please define "stress" as it applies to this claimant _____

(b) What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
- ☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
- ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- ☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

REMARKS:

GIVE NAMES, ADDRESSES & TELEPHONE NUMBERS OF OTHER TREATING PHYSICIANS FOR THIS CONDITION (ATTACH ADDITIONAL SHEET IF NECESSARY)

GIVE EXACT DATES OF TOTAL DISABILITY (INABILITY TO WORK) ☐ HIS / HER OCCUPATION ☐ ANY OCCUPATION
FROM M / D / Y TO M / D / Y

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

WHEN WILL PATIENT RECOVER SUFFICIENTLY TO RETURN TO WORK? M / D / Y ☐ 1 MONTH ☐ 2-3 MONTHS ☐ OTHER _____

PROGNOSIS / COMMENTS (PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL)

"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."

ATTENDING PHYSICIAN'S NAME (PLEASE PRINT) | ADDRESS | CITY | PROVINCE | POSTAL CODE

ATTENDING PHYSICIAN'S SIGNATURE
X
DATE M / D / Y | SPECIALTY | MEDICAL ID# | TELEPHONE NO. ( ) | FAX NO. ( )

B. FINANCE COMPANY NAME & ADDRESS

PLEASE PRINT OR TYPE

FINANCIAL INSTITUTION | ADDRESS | CITY | PROVINCE | POSTAL CODE

LOAN NUMBER | REFINANCE OF PREVIOUS LOAN? ☐ YES ☐ NO | IF YES, PREVIOUS LOAN NO.(S) | INSURED MONTHLY PAYMENT | CERTIFICATE NUMBER

CERTIFICATE EFFECTIVE DATE M / D / Y | REPRESENTATIVE (PLEASE PRINT) | TELEPHONE NO. ( ) | FAX NO. ( ) | DATE M / D / Y

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2004J20
 Printed in Canada

NOTICE TO INSURED

BY FURNISHING FORMS AND INVESTIGATING THE CLAIM THE COMPANY DOES NOT ADMIT THAT THERE IS ANY INSURANCE IN FORCE AND DOES NOT WAIVE ANY OF ITS RIGHTS OR DEFENCES

C. INSURED'S STATEMENT FOR ACCIDENT OR SICKNESS CLAIM — PLEASE PRINT OR TYPE

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH M D Y / /	CERTIFICATE #

STREET - ADDRESS	CITY	PROVINCE	POSTAL CODE	TELEPHONE NO.
				( )

WERE YOU EMPLOYED WHEN DISABILITY BEGAN?	IF NO, WHEN DID UNEMPLOYMENT BEGIN? GIVE EXACT DATE AND REASON
☐ YES ☐ NO	M D Y / /

CURRENT EMPLOYER (IF UNEMPLOYED WHEN DISABILITY BEGAN, INDICATE LAST EMPLOYER) NAME OF COMPANY	ADDRESS	TELEPHONE NO.
		( )

WHAT IS YOUR USUAL OCCUPATION?	DESCRIBE YOUR USUAL JOB DUTIES?

DISABILITY CAUSED BY	DATE ACCIDENT HAPPENED OR DATE SICKNESS BEGAN	DESCRIBE YOUR SICKNESS OR THE CIRCUMSTANCES OF YOUR ACCIDENT
☐ ACCIDENT ☐ SICKNESS	M D Y / /	

ON WHAT DATE WERE YOU FIRST TREATED BY A PHYSICIAN FOR THIS INJURY OR SICKNESS M D Y / /	NAME AND ADDRESS OF FAMILY PHYSICIAN	TELEPHONE NO. OF FAMILY PHYSICIAN
		( )

LIST ALL DOCTORS, CLINICS AND HOSPITALS WHICH TREATED YOU IN THE PAST FIVE YEARS, FOR ANY INJURY, ILLNESS OR GENERAL CHECK-UPS (ATTACH ADDITIONAL SHEETS IF NECESSARY)

NAME	ADDRESS (CITY & PROVINCE)	TELEPHONE NO.	REASON FOR TREATMENT

ARE YOU NOW RECEIVING OR HAVE YOU APPLIED FOR UNEMPLOYMENT BENEFITS	WORKER'S COMPENSATION	OTHER DISABILITY BENEFITS	DESCRIBE	DATE OF ENTITLEMENT M D Y / /
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO		

FIRST DATE YOU DID NOT WORK BECAUSE OF THIS INJURY OR SICKNESS M D Y / /	WHAT DATES WERE YOU TOTALLY DISABLED? M D Y M D Y FROM / / TO / /	DATE YOU WERE FIRST ABLE TO DO ANY PART OF YOUR WORK DUTIES, SUPERVISORY OR OTHERWISE M D Y / /

DESCRIBE DUTIES AND NUMBER OF HOURS YOU ARE NOW ABLE TO WORK	DATE YOU RESUMED YOUR REGULAR DUTIES M D Y / /

I authorize any physician, medical practitioner, who has examined or treated me; any hospital, clinic or medical or medically related facility where I have been confined, treated or examined; the Medical Information Bureau Inc., or any other individual or organization which has provided me with health care services or having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me to release information concerning my medical history, mental or physical condition, or treatment which may be requested by American Bankers Life Assurance Company of Florida, an Assurant Solutions™ company, or their duly authorized representatives for the purpose of determining eligibility for benefits requested.

I also authorize any employer, creditor, consumer reporting agency, law enforcement agency, fire department, insurer, reinsurer or other organization or person having any non-medical records or information concerning me to release the information to American Bankers Life Assurance Company of Florida, an Assurant Solutions™ company, or their authorized representatives for the purpose of determining eligibility for the benefits requested.

I authorize the above parties to exchange and share information amongst themselves and any other parties as necessary in order to investigate and assess my claim. This information may be released by telephone to expedite the processing of my claim.

I understand that a photocopy of the authorization shall be as the original. I know that I, or my authorized representative, may receive a copy of this authorization if I request it.

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

DATE
M D Y
____ / ____ / ____

INSURED'S SIGNATURE
X _____

PROTECTING YOUR PERSONAL INFORMATION

We keep personal information in confidential files at our offices or in the offices of an organization authorized by us. We limit access to information in files to our staff or persons authorized by us who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to investigate and assess your claim. If you have any questions pertaining to your personal information, please call us at 1-888-778-8023.

D. EMPLOYER'S CERTIFICATE *(MUST BE FULLY COMPLETED)* — PLEASE PRINT OR TYPE

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:

NAME OF EMPLOYEE	DATE OF HIRE M D Y / /	☐ FULL-TIME ☐ PART-TIME ☐ TEMPORARY ☐ SEASONAL	AVERAGE NO. OF HOURS WORKED / WEEK

REASON FOR LOSS OF EMPLOYMENT	WHAT WAS LAST DATE WORKED? M D Y / /	HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO	IF YES, ON WHAT DATE DID EMPLOYEE RESUME PARTIAL DUTIES? M D Y / /

ON WHAT DATE DID EMPLOYEE RESUME FULL DUTIES? M D Y / /	IF PARTIALLY DISABLED, WHAT DUTIES WAS EMPLOYEE ABLE TO PERFORM?

NAME OF COMPANY	TELEPHONE NO.	FAX NO.
	( )	( )

ADDRESS	CITY	PROVINCE	POSTAL CODE

REPRESENTATIVE'S NAME (PRINT)	POSITION	REPRESENTATIVE'S SIGNATURE	DATE M D Y / /
		X	