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



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

LIFE INSURANCE CLAIM FORM for Group Life Insurance

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NEXT OF KIN'S STATEMENT	PLEASE PRINT OR TYPE						
FULL LEGAL NAME OF DECEASED (PLEASE PRINT)	INSURANCE CERTIFICATE NUMBER DATE OF BIRTH M D Y						
LAST ADDRESS OF DECEASED	NAME & ADDRESS OF FAMILY PHYSICIAN						
DATE FIRST COMPLAINED OF, OR GAVE OTHER INDICATIONS OF, LAST ILLNESS OR INJURY?							
M D / /	DATE FIRST CONSULTED A PHYSICIAN M D Y / /						
NAME & ADDRESS OF FIRST PHYSICIAN CONSULTED?							
DID THE DECEASED, TO YOUR KNOWLEDGE, RECEIVE TREATMENT DURING THE LAST 3 YEARS FROM ANY OTHER PHYSICIAN OR HOSPITAL?							
	☐ YES ☐ NO						
IF YES, PLEASE PROVIDE NAME, ADDRESS, NATURE OF ILLNESS AND DATES IF POSSIBLE							
NAME OF PERSON SIGNING THE FORM	ADDRESS						
HOME TELEPHONE NO.	WORK TELEPHONE NO.						
RELATIONSHIP TO INSURED	,						
SPOUSE SON/DAUGHTER EXECUTOR LEGAL COUNSEL OTHER (PLEASE SPECIFY)							
"I certify that the information contained in this application is true, correct and complete to the best of my knowledge and belief." M D Y							
/ / / DATE SIGNATURE OF NEXT OF KIN	PRINT NAME CLEARLY						
	TOTAL SECURE						
	OBTAIN INFORMATION						
I authorize any physician, medical practitioner, who has examined or treated the deceased; any hospital, clinic or medical or medically related facility where the deceased has been confined, treated or examined; the Medical Information Bureau Inc., or any other individual or organization which has provided the deceased with health care services to release information concerning the deceased's 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 its duly authorized representative 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 the deceased to release the information to American Bankers Life Assurance Company of Florida, an Assurant Solutions™ company, or its authorized representative 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.							
NAME OF DECEASED/INSURED (PLEASE PRINT NAME) PRO	TECTING YOUR PERSONAL INFORMATION						
SIGNATURE OF NEXT OF KIN Staff of to wh inform	eep personal information in confidential files at our offices or in the offices organization authorized by us. We limit access to information in files to our or persons authorized by us who require it to perform their duties, to persons from you have granted access, and to persons authorized by law. We use the mation to investigate and assess your claim. If you have any questions						
RELATIONSHIP TO DECEASED/INSURED pertaining to your personal information, please call us at 1-888-778-8023 M D Y / / DATE							

COMPLETION INSTRUCTIONS FOR THE NEXT OF KIN

All of the following properly completed forms are essential for the prompt processing of this life insurance claim:

- 1. Next of Kin's statement (you complete)
- 2. Physician's statement (have doctor complete)
- **3. Creditor's statement** (the finance company completes)
 A copy of the conditional sales contract and payment history is also needed to accompany the creditor's statement.
 - An original Death Cartificate or original Funeral Directors Statement must be submitted along with the claims
- 4. An original **Death Certificate** or original **Funeral Directors Statement** must be submitted along with the claim.
- 5. Please ensure "Authorization for Information" statement is signed.
- 6. If cause of death is due to an accident please provide a copy of a police report or the name of the investigating detachment.

Please ensure that the attached forms are completed in full and all details listed on the forms are provided. Incomplete forms will delay claim processing and our service to you.

We remind you that it remains the estate's responsibility to continue to make the payments to the Financial Institution until the claim is accepted and approved for payment by us. We recommend that you contact the Financial Institution to ensure that they are aware of these circumstances pending claim settlement.

PROMPT REPORTING OF THE CLAIM IS IMPORTANT

Note: The initial expense required for providing the above information is the responsibility of the Next of Kin.

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

In an effort to protect the privacy of our customers, we respectfully request the following information when completing a Life claim: a copy of the customer's Will including the name(s) of the executor of the estate. In the event that there is no Will, please provide us with the following information declaring the person assuming the responsibility of executor of the estate.

Will included	
No Will	
hereby declare thatthe capacity of Executor of the Estate of	
Relationship to the customer:	
hereby declare that the information provided	d is true and correct.
Signed:	Date:
Witnessed:	Date:

Please include this document when returning your claim form.