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

LIFE INSURANCE CLAIM FORM for Group Life Insurance

PHYSICIAN'S STATEMENT — PLEASE PRINT OR TYPE

FULL NAME OF DECEASED (PLEASE PRINT) LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF DEATH M D Y / /
PLACE OF DEATH			DATE OF BIRTH M D Y / /
IF HOSPITAL OR INSTITUTION, GIVE NAME AND ADDRESS		DATE ADMITTED M D Y / /	HOW LONG DID YOU KNOW THE PATIENT? PERIOD FROM M D Y / / PERIOD TO M D Y / /

CAUSE OF DEATH

IMMEDIATE CAUSE	UNDERLYING CAUSE

DATES OF MEDICAL TREATMENT, EXAMINATION OR ADVICE RELATED TO THE CAUSE OF DEATH DURING THE LAST 3 YEARS

IS DEATH DUE TO

ACCIDENT? ☐ YES ☐ NO HOMICIDE? ☐ YES ☐ NO SUICIDE? ☐ YES ☐ NO

BRIEFLY DESCRIBE CIRCUMSTANCES SURROUNDING DEATH

WAS AN AUTOPSY PERFORMED?

☐ YES ☐ NO *(IF YES, PLEASE SUMMARIZE RESULTS AND ATTACH REPORT)*

WAS AN INQUEST HELD?

☐ YES ☐ NO *(IF YES, BY WHOM AND WHAT WERE THE FINDINGS?)*

TO YOUR KNOWLEDGE, DID THE DECEASED RECEIVE TREATMENT DURING THE LAST 3 YEARS FROM ANY OTHER PHYSICIAN OR HOSPITAL, FOR THE CAUSE OF DEATH LISTED ABOVE?

☐ YES ☐ NO *IF YES, PLEASE FURNISH THE FOLLOWING:*

NAME OF PHYSICIAN OR HOSPITAL	ADDRESS	DATES TREATED	ILLNESS/INJURY

"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	DATE M D Y	SPECIALTY	MEDICAL ID#	TELEPHONE NO.	FAX NO.
X	/ /			( )	( )

Any charges for the completion of this form is the responsibility of the Next of Kin.

CREDITOR'S STATEMENT — PLEASE PRINT OR TYPE

IN ORDER TO PROCESS THIS CLAIM, WE WILL REQUIRE THE FOLLOWING:
- COMPLETION OF THIS FORM
- COPY OF CONDITIONAL SALES AGREEMENT
- ACCOUNT RECORD INDICATING PAYMENTS MADE ON THE LOAN FROM ITS INCEPTION

FULL NAME OF DECEASED (PLEASE PRINT)	ADDRESS				
CITY	PROVINCE	POSTAL CODE	DATE OF DEATH M D Y / /	☐ LOAN or ☐ LEASE	

INSURED LOAN INFORMATION

DATE OF LOAN M D Y / /	ACCOUNT/LOAN #
ORIGINAL AMOUNT OF LOAN	PAYMENT SCHEDULE _____ MONTHS AT $ _____
TOTAL AMOUNT PAID TO DATE OF DEATH	GROSS BALANCE DUE AT DATE OF DEATH
GROSS BALANCE DUE LESS UNEARNED INTEREST	NET BALANCE DUE AT DATE OF DEATH
FINANCIAL INSTITUTION	ADDRESS

CITY	PROVINCE	POSTAL CODE	NAME OF CONTACT PERSON & TITLE AT FINANCIAL INSTITUTION

TELEPHONE NO.	FAX NO.
( )	( )

DATE M D Y / /	SIGNATURE	PLEASE PRINT NAME
	X	

11B28101NAA
2004D14

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 Y / /	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 _____

AUTHORIZATION TO 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)

_____
SIGNATURE OF NEXT OF KIN

_____
RELATIONSHIP TO DECEASED/INSURED

M D Y / /

_____
DATE

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.

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.
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 ☐

I hereby declare that _____ is the person acting in the capacity of Executor of the Estate of _____

Relationship to the customer: _____

I hereby declare that the information provided is true and correct.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

Please include this document when returning your claim form.