

WE'RE HERE TO HELP! Please note the following important information regarding filing a claim with Assurant.

- It is important that you complete all required sections and include documentation to avoid delays in processing your claim.
- You are responsible for continuing to make your regular scheduled payments until a decision is made by us on any claim submitted under the Certificate.
- For faster processing, we recommend you file your claim online at cardbenefits.assurant.com

Complete sections for your claim type as identified below

Review the checklist to make sure that you have provided all required documentation and have completed, signed and obtained signatures for all required sections in full.

TOTAL DISABILITY CLAIMS

Please submit your claim form after 30 consecutive days of total disability.

- Complete and sign Section 1 & 2.
Note: If you wish to authorize a family member or friend to speak on your behalf, please complete the 'Verbal Release of Information', part of Section 2. This authorization will allow them to discuss your claim with a representative of Assurant if you are not available.
- Have your family physician complete Section 3.
- Have your current employer complete Section 4 (if applicable). If you are unable to have Section 4 completed, please complete the form yourself and provide a copy of your record of employment.
- If you are self-employed, AND your coverage includes disability benefits for self-employed individuals, please complete Section 5.

DISEMBLEMENT CLAIMS

Please submit your claim any time after date of surgery.

- Complete and sign Section 1 & 2.
Note: If you wish to authorize a family member or friend to speak on your behalf, please complete the 'Verbal Release of Information', part of Section 2. This authorization will allow them to discuss your claim with a representative of Assurant if you are not available.
- Have your family physician complete Section 3.
- ** You do not need to complete Section 4 or 5.

HOSPITALIZATION CLAIMS

- Complete and sign Section 1 & 2.
Note: If you wish to authorize a family member or friend to speak on your behalf, please complete the 'Verbal Release of Information', part of Section 2. This authorization will allow them to discuss your claim with a representative of Assurant if you are not available.
- Please provide an admission and discharge summary (please ensure admission date is captured).
- Have your physician complete Section 3.
- ** You do not need to complete Section 4 or 5.

PLEASE RETURN YOUR FORM AND/OR SUPPORTING DOCUMENTATION IN ONE OF THE FOLLOWING WAYS:



Upload your documents for faster processing.
Online: cardbenefits.assurant.com



Alternatively, you can mail the documents.
Mail: Assurant, Financial Claims,
1945 King Street East, Suite 100,
Hamilton, Ontario L8K 1W2

We recommend that you retain copies of all documentation submitted to us for review.
All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

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SECTION 1

FOR FASTER CLAIM PROCESSING: Please complete form, save file and upload to cardbenefits.assurant.com

PRIMARY CARDHOLDER INFORMATION

Please complete for all claims being submitted Total Disability/
Dismemberment/Hospitalization

CREDITOR NAME (GROUP POLICYHOLDER)					
<input type="checkbox"/> CHECK HERE IF YOU ARE FILING A CLAIM FOR MORE THAN ONE ACCOUNT					
PLEASE LIST ALL ACCOUNT NUMBERS					
NAME OF PRIMARY CARDHOLDER					
LAST NAME		FIRST NAME, MIDDLE INITIAL		DATE OF BIRTH MM DD YYYY	AGE
PREFERRED METHOD OF CONTACT <input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL		EMAIL ADDRESS			
ADDRESS					
STREET		CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER ()
NAME OF CLAIMANT					
LAST NAME		FIRST NAME, MIDDLE INITIAL		DATE OF BIRTH MM DD YYYY	
RELATIONSHIP TO PRIMARY CARDHOLDER		HAVE YOU RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT DATE DID YOU RETURN TO WORK? MM DD YYYY	

SECTION 2

AUTHORIZATION AND CLAIMS ASSISTANCE

Please certify that the information given here is true and correct.

I AUTHORIZE any current or former employer, worker's compensation body, physician, hospital, clinic, insurance company, law enforcement agency, fire department, or other entity or person, including the group policyholder, that has any personal, financial or medical records or knowledge in regard to the claimant/deceased, to release and provide full details (including furnishing copies) of all available personal, financial and medical information records and knowledge, including prior medical history, toxicological or pathological findings which they may possess to the above noted insurer(s) American Bankers Life Assurance Company of Florida and/or American Bankers Insurance Company of Florida hereinafter collectively referred to as "Assurant", in regard to the claim, its authorized administrator, its re-insurer, or their respective agents.

The information is to be used in the evaluation of an insurance claim and for the purposes relating to such claim. This consent shall be valid during the continuation of such claim.

I also authorize the insurer, its authorized administrator, its re-insurers, the group policyholder and their respective agents to exchange and or transmit information concerning this claim to the organization listed above as necessary to evaluate this claim.

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.

I confirm and understand that the information provided is true and accurate to the best of my knowledge. This claim shall be void if, whether before or after the loss, I concealed or misrepresented any facts, or if any documents submitted have concealed or misrepresented any fact or circumstance concerning this claim.

By checking this box, I acknowledge that the above statement is true as of _____

CLAIMANT SIGNATURE	DATE MM DD YYYY
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VERBAL RELEASE OF INFORMATION

Customer privacy and the protection of private and confidential information is important to us. We do understand that in some cases, a claimant may wish to have someone speak to Assurant on their behalf. Please complete this authorization section if you wish to have another individual discuss the details of your claim. Without this authorization we are unable to speak to anyone other than the claimant.

I give my authorization to Assurant to speak to _____,
who is my _____, with regard to my claim.

By checking this box, I acknowledge that the above statement is true as of _____

CLAIMANT SIGNATURE	DATE MM DD YYYY
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SECTION 3

TOTAL DISABILITY / DISMEMBERMENT / HOSPITALIZATION CLAIMS

To be completed by Licensed Physician without expense to the Insurance Company

PATIENT'S FULL NAME													
LAST NAME			FIRST NAME, MIDDLE INITIAL				HEIGHT	WEIGHT	AGE	BLOOD PRESSURE			
STREET			CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER ()							
WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?		MM	DD	YYYY	IF ACCIDENT, PLEASE DESCRIBE CIRCUMSTANCES			WAS THE CLAIMANT OPERATING A MOTOR VEHICLE?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY DIAGNOSIS							DATE OF DIAGNOSIS		MM	DD	YYYY		
DESCRIBE ANY OTHER DISEASE, INFIRMITY OR SECONDARY CONDITION AFFECTING PRESENT CONDITION: (ATTACH ADDITIONAL SHEET)													
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?		<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE				GIVE DATE OF TREATMENT FOR SIMILAR CONDITION		MM	DD	YYYY		
IS THE PATIENT IN A TREATMENT CENTRE?		<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT IS THE NAME OF THE TREATMENT CENTRE?										
IS CONDITION DUE TO PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE COMPLICATIONS				ESTIMATED DATE OF DELIVERY		MM	DD	YYYY		
DATES OF TREATMENT FOR CURRENT ILLNESS					FREQUENCY OF VISITS								
FIRST VISIT			MM	DD	YYYY	LAST VISIT			MM	DD	YYYY		
					<input type="checkbox"/> WEEKLY <input type="checkbox"/> OTHER, SPECIFY: <input type="checkbox"/> MONTHLY								
GIVE ALL DATES OF TREATMENT, SINCE ONSET OF CONDITION							NATURE OF TREATMENTS						
MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY					
HAS PATIENT BEEN HOSPITALIZED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	FROM		MM	DD	YYYY	THROUGH		MM	DD	YYYY	
NAME OF HOSPITAL													
DID PATIENT HAVE SURGERY?		<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE DATE PERFORMED		MM	DD	YYYY	DESCRIBE SURGERY					
GIVE NAMES, ADDRESSES & TELEPHONE NUMBERS OF OTHER TREATING PHYSICIANS FOR THIS CONDITION: (ATTACH ADDITIONAL SHEET)													
GIVE EXACT DATES OF TOTAL DISABILITY		FROM			MM	DD	YYYY	THROUGH			MM	DD	YYYY
		<input type="checkbox"/> PATIENT'S OCCUPATION <input type="checkbox"/> ANY OCCUPATION <input type="checkbox"/> NORMAL ACTIVITIES OF DAILY LIVING											
GIVE DATES OF PARTIAL DISABILITY		FROM			MM	DD	YYYY	THROUGH			MM	DD	YYYY
		<input type="checkbox"/> PATIENT'S OCCUPATION <input type="checkbox"/> ANY OCCUPATION <input type="checkbox"/> NORMAL ACTIVITIES OF DAILY LIVING											
WHEN WILL THE PATIENT SUFFICIENTLY RETURN TO WORK OR NORMAL ACTIVITIES OF DAILY LIVING?				MM	DD	YYYY	<input type="checkbox"/> 1 MONTH <input type="checkbox"/> 2 MONTHS <input type="checkbox"/> 3 MONTHS <input type="checkbox"/> PERMANENT DISABILITY <input type="checkbox"/> 4 MONTHS <input type="checkbox"/> 5 MONTHS <input type="checkbox"/> 6 MONTHS <input type="checkbox"/> OTHER: _____			LIFE EXPECTANCY OF LESS THAN 12 MONTHS?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
LICENSED PHYSICIAN INFORMATION													
NAME (PLEASE PRINT)								PHYSICIAN'S ADDRESS STAMP					
SPECIALTY					MEDICAL ID #								
ADDRESS													
PHONE NUMBER					FAX NUMBER								
SIGNATURE					DATE						MM	DD	YYYY

PROGNOSIS / COMMENTS (PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL - ATTACH ADDITIONAL SHEET)

"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."

SECTION 4

EMPLOYER'S STATEMENT

Please complete if a Record of Employment is not available.

To be completed by Employer without expense to the Insurance Company.

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:

EMPLOYEE'S INFORMATION				
EMPLOYEE'S NAME				
LAST NAME		FIRST NAME, MIDDLE INITIAL		DATE HIRED MM DD YYYY
NUMBER OF HOURS WORKED PER WEEK	EMPLOYEE'S JOB TITLE			
TYPE OF EMPLOYMENT <input type="checkbox"/> PERMANENT <input type="checkbox"/> SEASONAL <input type="checkbox"/> TEMPORARY <input type="checkbox"/> CONTRACT <input type="checkbox"/> SELF-EMPLOYED (Complete the Self-Employment Affidavit)		IF SEASONAL EMPLOYMENT, PLEASE PROVIDE DATES OF REGULAR SEASONAL EMPLOYMENT	FROM MM DD YYYY	TO MM DD YYYY
DATE OF JOB LOSS NOTICE PROVIDED MM DD YYYY	LAST DAY WORKED MM DD YYYY	DATE RETURNED TO WORK MM DD YYYY	DID EMPLOYEE RECEIVE SEVERANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE SEVERANCE ENDS MM DD YYYY
REASON FOR INTERRUPTION OF EMPLOYMENT				
HAS EMPLOYEE RESUMED FULL DUTIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PROVIDE NUMBER OF HOURS WORKED PER WEEK			
ADDITIONAL COMMENTS				
COMPANY INFORMATION				
NAME OF COMPANY			CONTACT TELEPHONE NUMBER ()	
ADDRESS				
STREET		CITY	PROVINCE	POSTAL CODE
COMPLETED BY				
TITLE				
LAST NAME		FIRST NAME, MIDDLE INITIAL		
EMAIL ADDRESS FOR COMPANY REPRESENTATIVE		SIGNATURE	DATE MM DD YYYY	

SECTION 5

FOR FASTER CLAIM PROCESSING: Please complete form, save file and upload to cardbenefits.assurant.com

SELF-EMPLOYMENT AFFIDAVIT

Not all coverages include benefits for loss of self-employment income, please review your coverage before completing this section

CREDITOR NAME (GROUP POLICYHOLDER)		ACCOUNT NUMBER		DATE LAST WORKED MM DD YYYY	
CLAIMANT'S NAME					
LAST NAME			FIRST NAME, MIDDLE INITIAL		
ADDRESS					
STREET		CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER ()
HOME TELEPHONE NUMBER ()		EMAIL ADDRESS (IF AVAILABLE)			
ARE YOU STILL OFF WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, DATE YOU RETURNED TO WORK MM DD YYYY	NUMBER OF HOURS WORKED PER WEEK	EXPECTED RETURN TO WORK DATE MM DD YYYY	MY OCCUPATION IS	
WHAT PERCENTAGE OF YOUR TIME WAS SPENT AT EACH OF THE FOLLOWING:	SUPERVISORY / ADMINISTRATIVE %	MANUAL WORK %	WHAT DATE DID YOUR BUSINESS START? MM DD YYYY	WHAT DATE DID YOUR BUSINESS CLOSE? MM DD YYYY	
REASON FOR CLOSURE: <input type="checkbox"/> BANKRUPTCY <input type="checkbox"/> FINANCIAL REASONS <input type="checkbox"/> SEASONAL <input type="checkbox"/> LACK OF WORK <input type="checkbox"/> INJURY/ILLNESS <input type="checkbox"/> OTHER _____					
BUSINESS INFORMATION					
WAS BUSINESS INCORPORATED OR REGISTERED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHAT DATE WAS BUSINESS INCORPORATED OR REGISTERED? MM DD YYYY	BUSINESS NAME			MY BUSINESS IS OPERATED FROM MY RESIDENCE <input type="checkbox"/> YES <input type="checkbox"/> NO
STREET		CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER ()
BUSINESS TELEPHONE NUMBER ()	FAX NUMBER ()	BUSINESS LICENSE NUMBER		GST NUMBER	
CLAIMANT'S AUTHORIZATION					
I certify that the above information is true and correct. I authorize any Employer, Physician, Hospital, Insurer or other organization, or person having my records, data or information concerning this claim, to furnish such record, data or information to Assurant or authorized representative if requested. I understand that in executing this authorization, I waive the right for such information to be privileged.					
<input type="checkbox"/> By checking this box, I acknowledge that the above statement is true as of _____					
CLAIMANT'S SIGNATURE				DATE MM DD YYYY	
Subscribed and sworn before me, a Notary Public or Commissioner of Oaths for the Country of _____, Signature: _____ Province of _____ this date _____ of _____, 20_____.				NOTARY PUBLIC OR COMMISSIONER OF OATHS LEGAL SEAL STAMP	

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