ASSURANT®

American Bankers Insurance Company of Florida
American Bankers Life Assurance Company of Florida

LIFE CLAIM FORM

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.
- If required, use a separate sheet of paper to include the name and account numbers of multiple accounts also covered by Assurant.
- You are responsible for continuing to make your minimum monthly payments until a decision is made by us on any claim submitted under the Certificate.

Complete sections for your claim 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.

1

- ☐ Complete Sections 1, 2 & 3 (including signature where applicable).
- ☐ **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.

2

- ☐ Please provide the death certificate, funeral director's statement or Coroner's report.
- ☐ Have a physician complete Section 4.
- ☐ Complete the enclosed Estate Form (Section 5) or include a copy from the page of the Will indicating the executor of the Estate.

3

SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

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.

Once your claim has been submitted, please allow 15 business days for processing. All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

WE'RE HERE TO HELP!
Please visit cardbenefits.assurant.com

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American Bankers Life Assurance Company of Florida

Financial Claims, 1945 King Street East, Suite 100,
Hamilton, Ontario L8K 1W2 | Telephone: 1-800-361-5344

PLEASE PRINT

SECTION 1

CLAIMANT INFORMATION

PLEASE COMPLETE FOR ALL CLAIMS BEING SUBMITTED

CREDITOR NAME				ACCOUNT NUMBER	
NAME OF CLAIMANT					
LAST NAME	FIRST NAME, MIDDLE INITIAL			DATE OF BIRTH MM DD YYYY	AGE
PREFERRED METHOD OF CONTACT ☐ MAIL ☐ EMAIL	EMAIL ADDRESS				
ADDRESS					
STREET	CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER ( )	
NAME OF PRIMARY (FIRST NAME ON BILLING STATEMENT)					
LAST NAME	FIRST NAME, MIDDLE INITIAL			RELATIONSHIP TO CLAIMANT	

SECTION 2

AUTHORIZATION

PLEASE CERTIFY THAT THE INFORMATION GIVEN HERE IS TRUE AND CORRECT.

Assurant may collect, use, and share personal information provided by you to Assurant, and obtained from others with your consent, or as required or permitted by law. Assurant may use the information to serve you as a customer and communicate with you. Assurant may process and store your personal information outside your province in another country, which may be subject to access by government authorities under applicable laws of that country. You may obtain a copy of Assurant's privacy policy by calling 1-888-778-8023 or from their website: www.assurant.ca/privacy-policy. If you have any questions or concerns regarding the privacy policy, the purposes and means for which your information is being collected, your rights, your options for refusing or withdrawing your consent to the use of your personal information, you may call Assurant at the number listed above.

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) in regard to the claim, their 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, their 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

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 his or her 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

PLEASE PRINT

CREDITOR INFORMATION

TO BE COMPLETED BY THE CREDITOR/LIENHOLDER

NAME OF CREDITOR/LIENHOLDER	○ LOAN ○ LEASE	LOAN ACCOUNT NUMBER	CERTIFICATE NUMBER

CREDITOR ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE

PAYMENT INFORMATION - REQUIRED FOR ALL CLAIM TYPES

EFFECTIVE DATE OF LOAN	1ST PAYMENT DATE	WHEN IS YOUR NEXT SCHEDULED PAYMENT DUE?	EXPIRY DATE OF LOAN
MM DD YYYY	MM DD YYYY	MM DD YYYY	MM DD YYYY

FREQUENCY OF PAYMENT	PAYMENT AMOUNT	PAYMENT DUE DATE	ANNUAL INTEREST RATE
○ MONTHLY ○ SEMI-MONTHLY ○ BI-WEEKLY ○ WEEKLY	$	MM DD YYYY	%

PAYMENT INFORMATION - REQUIRED FOR LIFE CLAIM ONLY

ORIGINAL AMOUNT OF LOAN	TOTAL AMOUNT PAID TO DATE OF DEATH	GROSS BALANCE DUE AT DATE OF DEATH	NET BALANCE DUE AT DATE OF DEATH
$	$	$	$

CONTACT INFORMATION

REPRESENTATIVE NAME	CONTACT TELEPHONE NUMBER	FAX NUMBER
	( )	( )

REPRESENTATIVE SIGNATURE

IF INFORMATION IS INCOMPLETE OR INCORRECT WE MAY REQUEST ADDITIONAL INFORMATION IN ORDER TO PROCESS YOUR CLAIM.

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SECTION 4

PLEASE PRINT

LIFE CLAIM

TO BE COMPLETED BY LICENSED PHYSICIAN WITHOUT EXPENSE TO THE INSURANCE COMPANY

INFORMATION OF DECEASED

LAST NAME			FIRST NAME, MIDDLE INITIAL		
DATE OF BIRTH MM	DD	YYYY	DATE OF DEATH MM	DD	YYYY
PLACE OF DEATH					

IF HOSPITAL OR INSTITUTION, GIVE NAME AND ADDRESS

NAME OF HOSPITAL OR INSTITUTION			DATE ADMITTED MM	DD	YYYY
STREET	CITY		PROVINCE	POSTAL CODE	

HOW LONG DID YOU KNOW THE PATIENT? FROM MM	DD	YYYY	TO MM	DD	YYYY	CAUSE OF DEATH	IMMEDIATE CAUSE	UNDERLYING CAUSE	DATE OF DIAGNOSIS MM	DD	YYYY

PLEASE PROVIDE THE DECEASED'S LAST 3 YEARS OF MEDICAL HISTORY

IS DEATH DUE TO: ACCIDENT? ☐ YES ☐ NO HOMICIDE? ☐ YES ☐ NO SUICIDE? ☐ YES ☐ NO DRUGS & ALCOHOL? ☐ YES ☐ NO

BRIEFLY DESCRIBE CIRCUMSTANCES SURROUNDING DEATH

WAS AUTOPSY PERFORMED? ☐ YES ☐ NO	IF YES, PLEASE SUMMARIZE RESULTS AND ATTACH REPORTS
WAS AN INQUEST HELD? ☐ YES ☐ NO	IF YES, BY WHOM AND WHAT WERE THE FINDINGS?

TO YOUR KNOWLEDGE, DID THE DECEASED RECEIVE MEDICAL TREATMENT DURING THE LAST 3 YEARS FROM ANY OTHER PHYSICIAN/HOSPITAL FOR THE CAUSE OF DEATH LISTED ABOVE?
☐ YES ☐ NO *IF YES, PLEASE FURNISH THE FOLLOWING*

NAME OF PHYSICIAN OR HOSPITAL

STREET	CITY	PROVINCE	POSTAL CODE

ILLNESS/INJURY	DATES TREATED MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY

LICENSED PHYSICIAN INFORMATION

NAME (PLEASE PRINT)		PHYSICIAN'S ADDRESS STAMP
SPECIALTY	MEDICAL ID #	
ADDRESS		
TELEPHONE NUMBER	FAX NUMBER	
SIGNATURE	DATE MM DD YYYY	

"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."

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SECTION 4.A

PLEASE PRINT

PHYSICIAN NOTE SHEET

SECTION 5

PLEASE PRINT

ESTATE FORM

In an effort to protect the privacy of our customer, we respectfully request the following information when completing a Life claim:

CREDITOR NAME	CLAIM NUMBER	ACCOUNT NUMBER

☐ **WILL INCLUDED**

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

Relationship to the customer: _____

☐ **NO WILL**

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

Relationship to the customer: _____

☐ **FAMILY MEMBER REQUEST**

I hereby declare that I, _____ **, am requesting the information in the capacity of[spouse / child / grandchild] of the deceased.**

Relationship to the customer: _____

CAUSE OF DEATH

CLAIMANT'S AUTHORIZATION

I certify that the above information is true and correct.

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

CLAIMANT'S SIGNATURE	DATE MM	DD	YYYY
WITNESS' SIGNATURE	DATE MM	DD	YYYY

Please include this document when returning your claim forms.

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