ASSURANT® | American Bankers Insurance Company of Florida

INVOLUNTARY UNEMPLOYMENT/JOB LOSS CONTINUING 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.
- 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.

INVOLUNTARY UNEMPLOYMENT/JOB LOSS CONTINUING CLAIMS

This form must be submitted every 30 days to be considered for continued benefits if your loss will continue beyond the last payment date.

☐ Complete and sign Section 1.

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.

WE'RE HERE TO HELP!

Please visit cardbenefits.assurant.com

ASSURANT®
American Bankers
Insurance Company of Florida

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

SECTION 1

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

CLAIMANT'S INFORMATION

MUST BE COMPLETED IN FULL

Involuntary Unemployment/Job Loss

CLAIMANT'S NAME	CLAIM NUMBER

☐ **CHECK HERE IF YOU ARE FILING A CLAIM FOR MORE THAN ONE ACCOUNT**

PLEASE LIST ALL ACCOUNT NUMBERS

ADDRESS ☐ **CHECK HERE IF ADDRESS HAS CHANGED**

STREET	CITY	PROVINCE	POSTAL CODE

CREDITOR NAME (GROUP POLICYHOLDER)

PREFERRED METHOD OF COMMUNICATION	EMAIL ADDRESS (IF AVAILABLE)
☐ MAIL ☐ EMAIL	

HAVE YOU RETURNED TO WORK SINCE YOU BECAME UNEMPLOYED?	IF YES, WHAT DATE? MM / DD / YYYY	# OF HOURS/WEEK YOU NOW WORK	ARE YOU RECEIVING EMPLOYMENT INSURANCE BENEFITS?	ARE YOU RECEIVING INCOME/ WAGES FROM AN EMPLOYER?
☐ YES ☐ FULL-TIME ☐ PART-TIME ☐ NO			☐ YES ☐ NO	☐ YES ☐ NO

IF YOU HAVE NOT RETURNED TO WORK, WHY NOT?

ARE YOU CURRENTLY ON STRIKE?	ARE YOU RECEIVING STRIKE PAY BENEFITS?
☐ YES ☐ NO	☐ YES ☐ NO

I certify that the information given here is true and correct. I AUTHORIZE any employer, physician, hospital, insurer, law enforcement agency, fire department or other organization, or person having any records, data or information concerning this claim to furnish such records, data or information to the above noted insurer(s), American Bankers Insurance Company of Florida hereinafter referred to as "Assurant", or its authorized representative as requested. 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.

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

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'S SIGNATURE	TELEPHONE NUMBER	DATE MM / DD / YYYY
	( )	

FORM MUST BE SIGNED AND DATED