ASSURANT®

Caribbean American Life Assurance Company
Caribbean American Property Insurance Company

CREDIT CARD PROTECTION PLAN FORM | **FOR CONTINUED UNEMPLOYMENT COVERAGE CLAIMS**

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WE ARE HERE TO SERVE!

Please take note of the following information on how to submit a claim to Assurant.

- You are responsible for continuing to make your monthly payments until a decision is made by us on any claim submitted.
- If required, use a separate sheet of paper to include the name and account numbers of any account also covered by Assurant.
- To avoid any delays with your claim, review the forms to make sure you've included all documentation required and have duly signed all forms.
- We recommend that you save copies of all documentation submitted to us for review.

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FOR CONTINUED UNEMPLOYMENT CLAIMS

- Complete and sign the form.
- Include copy of a photo identification.
- While unemployed, you should update your information every month using the **Continued Unemployment** claims form found in our self-service portal: pr.assurantcustomerportal.com.

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SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION BY:

Mail
350 Carlos Chardón Ave.
Torre Chardón Suite 1101
San Juan, PR 00918

Email:
reclamaciones@assurant.com

Online by visiting:
claimspr.assurant.com

Once your claim has been received, please allow 15 business days for processing.
All benefit payments are paid directly to the creditor.

NEED HELP?

Visit claimspr.assurant.com
24 hours a day, 7 days a week or
call our toll-free number 1-800-981-8888
We're available Monday through Friday from 8:00 am to 5:00 pm

ASSURANT®

INSURED'S INFORMATION

THIS SECTION IS REQUIRED TO EVALUATE YOUR CLAIM. Please print.			
INSURED'S FULL NAME			
CLAIM NUMBER		SOCIAL SECURITY NUMBER	
NAME OF FINANCIAL INSTITUTION		CREDIT CARD NUMBER	
HAS YOUR ADDRESS CHANGED? ☐ YES ☐ NO	IF YOU ANSWERED "YES", WHAT'S YOUR NEW ADDRESS?		
HAVE YOU RETURNED TO WORK SINCE BEING UNEMPLOYED? ☐ YES ☐ NO	IF YOU ANSWERED "YES", WHAT TYPE OF JOB IS IT? ☐ FULL TIME ☐ PART-TIME	IF YOU ANSWERED "YES", WHEN DID YOU START?	MONTH _____ DAY _____ YEAR _____
ARE YOU BEEN RECEIVING UNEMPLOYMENT BENEFITS? ☐ YES ☐ NO			

IF YOU ANSWERED "YES", ATTACH A COPY OF YOUR STATE UNEMPLOYMENT CHECKS OR REGISTRATION CARD; AND A COPY OF YOUR UNEMPLOYMENT ELIGIBILITY. THE CHECKS OR REGISTRATION CARD SHOULD SHOW APPROXIMATELY THE SAME DATES CLAIMED.

INCLUDE EVIDENCE OF YOUR EFFORTS TO SEEK EMPLOYMENT AND CHECK THE BOX FOR THE TYPE OF EVIDENCE YOU ARE INCLUDING.

☐ COPY OF RESUMES SIGNED BY THE COMPANY RECEIVING IT, OR FAX TRANSMISSION CONFIRMATION.
☐ EMAIL CORRESPONDENCE SEEKING EMPLOYMENT.
☐ EMPLOYMENT APPLICATIONS SUBMITTED THROUGH SPECIALTY WEB PAGES SUCH AS MONSTER OR INDEED.
☐ OTHER: _____

I certify that all the information provided here is correct and reliable. **I AUTHORIZE** any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., insurance or reinsuring Company, insurer, law enforcement agency, fire department, or other organization, or person having any records, data or information concerning this claim to furnish such record, data or information to Caribbean American Life Assurance Company/Caribbean American Property Insurance Company or its authorized representative(s) as requested. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as affective and valid as the original. I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above. This authorization shall remain valid for 6 months after the date of the signature.

ANY PERSON who knowingly and with the intention to commit fraud provides false information in an insurance application, or submits, helps or causes the submission of a fraudulent insurance claim for the payment of a loss or any other benefit, or submits more than one claim for the same damage or loss, will incur in a felony and, upon conviction thereof, shall be punished, for each violation, with a fine not less than five thousand ($5,000) dollars, nor greater than ten thousand ($10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances are present, the fixed penalty established could be increased up to a maximum of five (5) years; if attenuating circumstances are present, the penalty could be reduced to a minimum of two (2) years.

SIGNATURE	MONTH _____ DAY _____ YEAR _____

If you are unable to provide an original signature, please read and complete the following section to confirm your consent:

I declare I have received reasonable and relevant information with regards to the unemployment claim form that I am about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process my claim. Furthermore, I certify I have read and completed the form and all its parts, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.

☐ In witness whereof, I sign this declaration by checking the box here provided.