ASSURANT®

Caribbean American Life Assurance Company
Caribbean American Property Insurance Company

CREDIT CARD PROTECTION PLAN FORM | **FOR CRITICAL ILLNESS 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 retain copies of all documentation submitted to us for review.

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FOR CRITICAL ILLNESS CLAIMS

- Complete and sign Sections 1 and 3.
- Attach a copy of credit card statement with closing date immediately following the diagnosis of the illness and copy of a photo identification.
- Have your physician complete Section 2.
- If you would like to authorize a third-party to manage the claim for you, you should fill the "Verbal Information Disclosure" included in Section 3. This authorization will allow them to discuss your claim with any Assurant representative should you be unavailable.

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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

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SECTION 1: INSURED'S INFORMATION

THIS SECTION IS REQUIRED TO EVALUATE YOUR CLAIM. Please complete the form in legible font.

FINANCIAL INSTITUTION'S NAME	CREDIT CARD NUMBER

INSURED'S FULL NAME	DATE OF BIRTH				AGE
		MONTH	DAY	YEAR	

PHYSICAL ADDRESS	
MAILING ADDRESS	

FULL SOCIAL SECURITY NUMBER		LICENSE NUMBER	

MOBILE NUMBER	SECONDARY NUMBER	ALTERNATE NUMBER

DO YOU AUTHORIZE US TO SEND YOU EMAILS?	☐ YES ☐ NO
EMAIL	

WE AND OTHERS ACTING ON OUR BEHALF MAY USE THE INFORMATION WE GATHER TO OPERATE OUR PRODUCT AND OUR SERVICE. FOR EXAMPLE, WE MAY USE THE INFORMATION WE COLLECT OR RECEIVE TO TRY AND CONTACT YOU THROUGH EMAIL TO PROVIDE SUPPORT AND ASSISTANCE DURING THE CLAIM PROCESS, AS PERMITTED BY LAW.

HAVE YOU HAD ANY CLAIMS UNDER THIS PRODUCT NUMBER PREVIOUSLY?	☐ YES ☐ NO

IF YOU ANSWERED YES, INCLUDE THE CLAIM NUMBERS

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SECTION 2: PHYSICIAN'S DECLARATION

This is meant to be filled by a licensed physician free of any fees to the company. If you would like to submit a medical certificate that contains the same information that the form requires, the certificate must be on a physician's stationary or prescription paper, must be dated and signed, and must include the medical license number.

PATIENT'S FULL NAME	GENDER	HEIGHT	WEIGHT	AGE

PATIENT'S ADDRESS	PATIENT'S CONTACT NUMBER

WHEN DID THE PATIENT VISIT YOU FOR A CONSULT? _____ MONTH _____ DAY _____ YEAR

WHICH OF THESE DID THE PATIENT SUFFERED? ☐ HEART ATTACK ☐ STROKE ☐ CANCER ☐ BYPASS SURGERY

DIAGNOSIS CODE		WHEN WAS THE PATIENT DIAGNOSED?
ICD-10:	DSM V:	_____ MONTH _____ DAY _____ YEAR

IF YOU ANSWERED BYPASS SURGERY, PLEASE INDICATE THE DATE OF THE SURGERY _____ MONTH _____ DAY _____ YEAR

DIAGNOSIS

HAS THE PATIENT SUFFERED FROM THE SAME OR A SIMILAR CONDITION BEFORE? ☐ YES ☐ NO

PROVIDE TREATMENT DATES FOR THE SIMILAR CONDITION _____ MONTH _____ DAY _____ YEAR

IF YOU ANSWERED YES, PLEASE EXPLAIN THE CONDITION

GIVE ALL DATES OF TREATMENT SINCE ONSET OF CONDITION

TYPE OF TREATMENT

HAS THE PATIENT BEEN HOSPITALIZED? ☐ YES ☐ NO

FROM _____ MONTH _____ DAY _____ YEAR

UNTIL _____ MONTH _____ DAY _____ YEAR

HOSPITAL'S NAME

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SECTION 2: PHYSICIAN'S DECLARATION (CONTINUED)

WHAT ARE THE NAMES AND ADDRESSES OF OTHER DOCTORS THAT HAVE TREATED YOU FOR THIS CONDITIONS?

PROGNOSIS / COMMENTS. PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL (IF NEEDED, ATTACH ADDITIONAL SHEET)

LICENSED PHYSICIAN'S INFORMATION

NAME	SPECIALTY	LICENSE NUMBER

ADDRESS

CONTACT NUMBER	FAX	EMAIL

"I hereby certify that the information provided here is based on a probable medical reason, that it is true and trustworthy to the best of my knowledge and understanding."

PHYSICIAN'S 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 provided reasonable and relevant information with regards to the critical illness claim form that the insured is 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 the insured's claim. Furthermore, I certify I have read and completed in all its parts the section of the form that applies to me, 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.

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SECTION 3: AUTHORIZATION

Please 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 effective 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.

VERBAL INFORMATION DISCLOSURE

It is important for us to safeguard the privacy of our customers and protect private and confidential information. We also understand that, on occasion, a claimant may want to authorize third parties to speak with Assurant on their behalf. Please complete this authorization section so others can discuss details of your claim. Without this authorization we cannot talk to anyone except the claimant.

I authorize Assurant to speak with , who is my , about my claim.

RESPONSIBILITY FOR FRAUDULENT INFORMATION

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.

INSURED'S SIGNATURE

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 critical illness 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.