

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 payments on your account until a decision is made by us on any claim submitted under the Certificate.

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.

1

FOR ALL 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.

2

FOR UNEMPLOYMENT CLAIMS

- For Unemployment, please submit your claim form after the number of consecutive days of Unemployment outlined in your Certificate of Insurance.
- Have your former employer complete Section 3.
- If unable to have Employer's Statement completed, please complete the form yourself, provide a copy of your Record of Employment and provide last 2 consecutive pay stubs.
- If you are self-employed, AND your coverage includes benefits for loss of self-employment income, please complete the section titled "Self Employment Affidavit"

3

SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

Upload your documents for faster processing.

Online: cardbenefits.assurant.com

Alternatively, you can mail the documents.

Mail: Assurant, Financial Claims,
P.O. Box 7000 Kingston, ON K7L 5V3

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.

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SECTION 1

PLEASE COMPLETE FORM, SAVE FILE AND UPLOAD TO CARDBENEFITS.ASSURANT.COM

PRIMARY CARDHOLDER INFORMATION Please complete for all claims being submitted

CREDITOR NAME		ACCOUNT NUMBER				
NAME OF PRIMARY CARDHOLDER						
LAST NAME		FIRST NAME, MIDDLE INITIAL		DATE OF BIRTH		AGE
				MM	DD	YYYY
PREFERRED METHOD OF CONTACT		EMAIL ADDRESS				
<input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL						
ADDRESS						
STREET		CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER ()	
NAME OF CLAIMANT						
LAST NAME		FIRST NAME, MIDDLE INITIAL		DATE OF BIRTH		RELATIONSHIP TO PRIMARY CARDHOLDER
				MM	DD	YYYY
DO YOU QUALIFY TO RECEIVE UNEMPLOYMENT BENEFITS FROM SERVICE CANADA?		HAVE YOU RETURNED TO WORK?		IF YES, WHAT DATE DID YOU RETURN TO WORK?		ARE YOU RECEIVING INCOME/WAGES FROM AN EMPLOYER?
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
				MM	DD	YYYY

SECTION 2

AUTHORIZATION 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) in regard to the claim, its authorized administrator (ASSURANT), 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

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

SECTION 3

PLEASE COMPLETE FORM, SAVE FILE AND UPLOAD TO CARDBENEFITS.ASSURANT.COM

EMPLOYER'S STATEMENT

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		TO				
						MM	DD	YYYY	MM	DD	YYYY	
BRIEF DESCRIPTION OF DUTIES												
DATE OF JOB LOSS NOTICE PROVIDED		LAST DAY WORKED		DATE RETURNED TO WORK		DID EMPLOYEE RECEIVE SEVERANCE?		DATE SEVERANCE ENDS				
MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM	DD	YYYY
REASON FOR INTERRUPTION OF EMPLOYMENT												
HAS EMPLOYEE RESUMED FULL DUTIES?		IF YES, PROVIDE NUMBER OF HOURS WORKED PER WEEK		IF NO, WHAT DUTIES ARE THEY ABLE TO PERFORM?								
<input type="checkbox"/> YES <input type="checkbox"/> NO												
ADDITIONAL COMMENTS												
COMPANY INFORMATION												
NAME OF COMPANY							CONTACT TELEPHONE NUMBER					
							()					
ADDRESS												
STREET				CITY		PROVINCE	POSTAL CODE	FAX NUMBER				
								()				
COMPLETED BY												
TITLE												
LAST NAME					FIRST NAME, MIDDLE INITIAL							
EMAIL ADDRESS FOR COMPANY REPRESENTATIVE					SIGNATURE			DATE				
								MM	DD	YYYY		

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SECTION 4

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			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			
A COPY OF THIS FORM WILL NOT BE ACCEPTED.										

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