

**AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA  
 AMERICAN BANKERS LIFE ASSURANCE COMPANY OF FLORIDA  
 Financial Claims, P.O. Box 7000, Kingston, Ontario K7L 5V3  
 Telephone: 1-800-361-5344  
 Fax: 1-800-645-9405**

**CONTINUING DISABILITY CLAIM FORM**

<b>A: CLAIMANT'S INFORMATION (Must be completed in full)</b>				<b>PLEASE PRINT</b>	
NAME AND ADDRESS <input type="checkbox"/> CHECK HERE IF ADDRESS HAS CHANGED		CLAIM NUMBER		ACCOUNT NUMBER	
		NAME OF FINANCIAL INSTITUTION			
		NAME OF EMPLOYER			
CLAIMANT'S INTERNET ADDRESS (IF AVAILABLE)		TELEPHONE NUMBER (EMPLOYER) (      )		EXTENSION	
DESCRIBE YOUR CURRENT ACTIVITIES OR ANY CHANGES IN YOUR CONDITION					
HAVE YOU RETURNED TO WORK SINCE YOU BECAME DISABLED?		IF YES, WHAT DATE	# OF HOURS / WEEK	ARE YOU RECEIVING WCB OR OTHER DISABILITY BENEFITS	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME		M / D / Y		<input type="checkbox"/> WCB <input type="checkbox"/> NO <input type="checkbox"/> OTHER (specify) _____	
ARE YOU RECEIVING CPP / QPP		IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR ACCEPTANCE LETTER OR VERIFICATION THAT YOU ARE RECEIVING CPP / QPP.			
<input type="checkbox"/> YES <input type="checkbox"/> NO					
<p>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 ASSURANT SOLUTIONS or its authorized representative as requested. I understand that in executing this authorization, I waive the right for such information to be privileged.</p> <p>A photocopy of this authorization shall be considered as effective and valid as the original.</p> <p>This authorization shall remain valid for the duration of the claim.</p>					
CLAIMANT'S SIGNATURE			TELEPHONE NUMBER		DATE
X			(      )		M / D / Y
<b>B : PHYSICIAN'S STATEMENT (to be furnished without expense to the Insurance company)</b>				<b>PLEASE PRINT</b>	
PATIENT'S FULL NAME:		PATIENT'S STREET ADDRESS, APT#, CITY/PROVINCE/POSTAL CODE			AGE
OBJECTIVE DIAGNOSIS / FINDINGS:				DIAGNOSTICS CODE(S)	
				<input type="checkbox"/> ICD-9 _____ <input type="checkbox"/> CPT _____ <input type="checkbox"/> DSM III	
DATES OF TREATMENT FOR THE LAST 6 MONTHS			DATE OF NEXT VISIT	FREQUENCY OF VISITS	
			M / D / Y	<input type="checkbox"/> MONTHLY <input type="checkbox"/> WEEKLY <input type="checkbox"/> OTHER _____	
DID PATIENT HAVE SURGERY SINCE LAST REPORT?		IF SO, DESCRIBE SURGERY.			SURGERY DATE
<input type="checkbox"/> YES <input type="checkbox"/> NO					M / D / Y
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?		IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK.		IF NO, DATE PATIENT WAS RELEASED FROM YOUR CARE.	
<input type="checkbox"/> YES <input type="checkbox"/> NO		M / D / Y		M / D / Y	
LIST PATIENTS FULL LIMITATIONS.			PROGNOSIS :		HAS PATIENT PROGRESSED?
					<input type="checkbox"/> YES <input type="checkbox"/> NO
GIVE EXACT DATES OF TOTAL DISABILITY (INABILITY TO WORK)			GIVE DATES OF PARTIAL DISABILITY (ABLE TO PERFORM SOME DUTIES)		
FROM M / D / Y TO M / D / Y <input type="checkbox"/> HIS/HER OCCUPATION <input type="checkbox"/> ANY OCCUPATION			FROM M / D / Y TO M / D / Y NO. OF HOURS/ WEEK <input type="checkbox"/> HIS/HER OCCUPATION <input type="checkbox"/> ANY OCCUPATION		
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT?		IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED.			LIFE EXPECTANCY OF LESS THAN 12 MONTHS?
<input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Non-Disabled		<input type="checkbox"/> 1 Mo. <input type="checkbox"/> 2 - 3 Mo. <input type="checkbox"/> 3 - 6 Mo. <input type="checkbox"/> > 6Mo. <input type="checkbox"/> Other _____			<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE</b>					
PHYSICIAN'S NAME (PLEASE PRINT)			STREET ADDRESS/CITY/PROVINCE/POSTAL CODE		
PHYSICIAN'S SIGNATURE			DATE	MEDICAL ID NUMBER	TELEPHONE NUMBER
X			M / D / Y	(      )	(      )

**FORM MUST BE SIGNED OR STAMPED BY DOCTOR'S OFFICE**