ASSURANT®

American Bankers Life Assurance Company of Florida
1-877-273-1736

MDA SERVICES LTD

DISABILITY/DISMEMBERMENT 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.
- 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 your minimum monthly payments until a decision is made by us on any claim submitted under the Certificate.

Complete sections for your claim 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 Sections 1 & 2 (including signature where applicable).

☐ **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.

☐ Complete Section 3.

2

FOR DISABILITY/DISMEMBERMENT CLAIMS

☐ Please verify your employment at the time you originally enrolled in the Certificate of Insurance. To do this, please have the employer you were working for at the time complete Section 4, Employer's Statement.

☐ If unable to have Employer's Statement completed, please include a letter explaining the reason with a copy of your Record of Employment.

☐ Have your family physician complete Section 5.

☐ If self-employed, complete the Self-Employment Affidavit.

3

MAIL OR FAX THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION TO:

MDA Services Ltd. Suite 220, 9440 49 Street NW Edmonton, Alberta T6B 2M9 Fax 1-780-469-5433

We recommend that you retain copies of all documentation submitted to us for review.

You may check the status of your claim by visiting our website: https://cardbenefits.assurant.com/

Upon receipt, allow 15 business days for processing. All benefit payments are paid directly to your creditor and will be shown on your monthly billing statement.

11O27101NBJ 2024L02

MDA Services Ltd.
Suite 220, 9440 49 Street NW
Edmonton, Alberta T6B 2M9
Telephone:1-800-661-6926 | Fax: 1-780-469-5433

American Bankers Life Assurance Company of Florida
Financial Claims
1945 King Street East, Suite 100
Hamilton, Ontario L8K 1W2
Telephone: 1-877-273-1736

PLEASE PRINT

SECTION 1

CLAIMANT INFORMATION

Please complete for all claims being submitted

INSURED'S INFORMATION				
LAST NAME	FIRST NAME, MIDDLE INITIAL		DATE OF BIRTH MM / DD / YY	AGE
STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER ( )
HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, WHAT DATE DID YOU RETURN TO WORK? MM / DD / YY			

FAMILY PHYSICIAN INFORMATION				
FAMILY PHYSICIAN NAME	STREET	CITY	PROVINCE	POSTAL CODE
	CONTACT TELEPHONE NUMBER ( )	EXT	FAX NUMBER ( )	

NAME OF CLAIMANT (IF DIFFERENT THAN INSURED)		
LAST NAME	FIRST NAME, MIDDLE INITIAL	RELATIONSHIP TO INSURED

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 (MDA SERVICES LTD.), 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.

CLAIMANT SIGNATURE	DATE
x	MM / DD / YY

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 be able to 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.

CLAIMANT SIGNATURE	DATE:
x	MM / DD / YY

SECTION 3

PLEASE PRINT

CREDITOR INFORMATION

CREDITOR / LIENHOLDER	☐ LOAN ☐ LEASE	LOAN ACCOUNT NUMBER	CERTIFICATE NUMBER

BRANCH ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE

PAYMENT INFORMATION

EFFECTIVE DATE OF LOAN	1ST PAYMENT DATE	WHEN IS YOUR NEXT SCHEDULED PAYMENT DUE?
____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY

FREQUENCY OF PAYMENT	PAYMENT AMOUNT	MONTHLY PAYMENT DUE DATE
☐ MONTHLY ☐ SEMI-MONTHLY ☐ BI-WEEKLY ☐ WEEKLY	$	____ / ____ / ____ MM / DD / YY

CONTACT INFORMATION

BRANCH REPRESENTATIVE NAME	CONTACT TELEPHONE NUMBER	FAX #
	( )	

IF INFORMATION IS INCOMPLETE OR INCORRECT WE MAY REQUEST ADDITIONAL INFORMATION IN ORDER TO PROCESS YOUR CLAIM.

SECTION 4

PLEASE PRINT

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

LAST NAME	FIRST NAME	DATE HIRED	NUMBER OF HOURS WORKED PER WEEK:
		____ / ____ / ____ MM / DD / YY	

EMPLOYEE'S JOB TITLE	TYPE OF EMPLOYMENT
	☐ PERMANENT ☐ SEASONAL ☐ TEMPORARY ☐ CONTRACT ☐ SELF-EMPLOYED (Complete the Self-Employment Affidavit)

IF SEASONAL EMPLOYMENT, PLEASE PROVIDE DATES OF REGULAR SEASONAL EMPLOYMENT	LAST DAY WORKED	HAS EMPLOYEE RETURNED TO WORK?
FROM ____ / ____ / ____ MM / DD / YY **TO** ____ / ____ / ____ MM / DD / YY	____ / ____ / ____ MM / DD / YY	☐ YES ☐ NO

BRIEF DESCRIPTION OF DUTIES	HAS EMPLOYEE RESUMED FULL DUTIES?	IF YES, PROVIDE NUMBER OF HOURS WORKED PER WEEK AND DATE RETURNED RESUMING FULL DUTIES
	☐ YES ☐ NO	____ / ____ / ____ MM / DD / YY ____ HRS/WEEK

REASON FOR INTERRUPTION OF EMPLOYMENT	IF NO, PROVIDE DATE EMPLOYEE RETURNED PARTIALLY AND WHAT DUTIES ARE THEY ABLE TO PERFORM?
	____ / ____ / ____ MM / DD / YY

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

SIGNATURE	DATE
x	____ / ____ / ____ MM / DD / YY

SECTION 5

PLEASE PRINT

DISABILITY CLAIM

To be completed by licensed physician without expense to the insurance company

PATIENT'S INFORMATION

LAST NAME	FIRST NAME, MIDDLE INITIAL	HEIGHT	WEIGHT	AGE	BLOOD PRESSURE

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER
				( )

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	IF ACCIDENT, PLEASE DESCRIBE CIRCUMSTANCES
____ / ____ / ____ MM / DD / YY	

DISABILITY CAUSED BY	PRIMARY DIAGNOSIS	DATE OF DIAGNOSIS
☐ ACCIDENT ☐ ILLNESS		____ / ____ / ____ MM / DD / YY

DESCRIBE ANY OTHER DISEASE, INFIRMITY OR SECONDARY CONDITION AFFECTING PRESENT CONDITION (PLEASE SEE ADDITIONAL PHYSICIAN NOTE SHEET, ATTACHED)

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?	☐ YES ☐ NO	IF YES, PLEASE DESCRIBE	GIVE DATES OF TREATMENT FOR SIMILAR CONDITION	____ / ____ / ____ MM / DD / YY
IS CONDITION DUE TO PREGNANCY?	☐ YES ☐ NO	IF YES, PLEASE DESCRIBE COMPLICATIONS	ESTIMATED DATE OF DELIVERY	____ / ____ / ____ MM / DD / YY

DATES OF TREATMENT FOR CURRENT DISABILITY	FREQUENCY OF VISITS
FIRST VISIT ____ / ____ / ____ MM / DD / YY **LAST VISIT** ____ / ____ / ____ MM / DD / YY	☐ WEEKLY ☐ MONTHLY ☐ OTHER, SPECIFY
GIVE ALL DATES OF TREATMENT, SINCE ONSET OF CONDITION	NATURE OF TREATMENTS
____ / ____ / ____ MM / DD / YY ____ / ____ / ____ MM / DD / YY ____ / ____ / ____ MM / DD / YY	

HAS PATIENT BEEN HOSPITALIZED?	☐ YES ☐ NO	**FROM** ____ / ____ / ____ MM / DD / YY **THROUGH** ____ / ____ / ____ MM / DD / YY	NAME OF HOSPITAL	CITY
DID PATIENT HAVE SURGERY?	☐ YES ☐ NO	**IF YES, GIVE DATE PERFORMED** ____ / ____ / ____ MM / DD / YY	DESCRIBE SURGERY	

GIVEN NAMES, ADDRESSES & TELEPHONE NUMBERS OF OTHER TREATING PHYSICIANS FOR THIS CONDITION (PLEASE SEE ADDITIONAL PHYSICIAN NOTE SHEET, ATTACHED)

GIVE EXACT DATES OF TOTAL DISABILITY (INABILITY TO WORK)	**FROM** ____ / ____ / ____ MM / DD / YY **THROUGH** ____ / ____ / ____ MM / DD / YY	☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION
GIVE DATES OF PARTIAL DISABILITY	**FROM:** ____ / ____ / ____ MM / DD / YY **THROUGH** ____ / ____ / ____ MM / DD / YY	☐ HIS/HER OCCUPATION ☐ ANY OCCUPATION

WHEN WILL PATIENT RECOVER SUFFICIENTLY TO RETURN TO WORK?	____ / ____ / ____ MM / DD / YY	☐ 1 MONTH ☐ 2-3 MONTHS ☐ 3-6 MONTHS ☐ >6 MONTHS ☐ PERMANENT DISABILITY ☐ OTHER: _____ LIFE EXPECTANCY OF LESS THAN 12 MONTHS? ☐ YES ☐ NO

LICENSED PHYSICIAN INFORMATION

NAME (PLEASE PRINT)		PHYSICIAN'S ADDRESS STAMP
SPECIALTY		
MEDICAL ID #		
ADDRESS		
PHONE NUMBER	( )	
FAX NUMBER	( )	
TODAY'S DATE		
SIGNATURE	x	

PROGNOSIS / COMMENTS (PLEASE PROVIDE FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL - ATTACH ADDITIONAL SHEET)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

SECTION 5

PLEASE PRINT

PHYSICIAN NOTE SHEET