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

MDA SERVICES LTD

LIFE 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.

☐ Creditor/Lienholder to complete and sign Section 3.

☐ Attach account record indicating payments made on the loan from its inception.

2

FOR LIFE CLAIMS

☐ Attach a copy of the death certificate or funeral director's statement.

☐ Have a physician complete Section 4.

☐ Complete the enclosed Estate Form or include a copy from the page of the Will indicating the executor of the Estate.

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.

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®Assurant is a registered trademark of Assurant, Inc.
ABLAC uses and shares personal information provided to it by you and obtained from others with your consent. It may use the information to establish and serve you as a customer or when required or permitted by law. Your information may be processed and stored in another country and may be subject to access by government authorities under applicable laws of that country.

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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

SECTION 1

PLEASE PRINT

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 ( )	

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

NEXT OF KIN		
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.

NEXT OF KIN 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.

NEXT OF KIN SIGNATURE	DATE:
x	___ / ___ / ___ MM / DD / YY

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SECTION 3

PLEASE PRINT

CREDITOR INFORMATION

To be completed by the Creditor / Lienholder

FULL NAME OF DECEASED			DATE OF DEATH MM / DD / YY
STREET	CITY	PROVINCE	POSTAL CODE
CREDITOR / LIENHOLDER	☐ LOAN ☐ LEASE	LOAN ACCOUNT NUMBER	CERTIFICATE NUMBER
BRANCH ADDRESS			
STREET	CITY	PROVINCE	POSTAL CODE
PAYMENT INFORMATION			
EFFECTIVE DATE OF LOAN MM / DD / YY	1ST PAYMENT DATE MM / DD / YY	WHEN IS THE NEXT SCHEDULED PAYMENT DUE? MM / DD / YY	EXPIRY DATE OF LOAN MM / DD / YY
FREQUENCY OF PAYMENT ☐ MONTHLY ☐ SEMI-MONTHLY ☐ BI-WEEKLY ☐ WEEKLY	PAYMENT AMOUNT $	MONTHLY PAYMENT DUE DATE MM / DD / YY	ANNUAL INTEREST RATE ____________ %
ORIGINAL AMOUNT OF LOAN $	TOTAL AMOUNT PAID TO DATE OF DEATH $	GROSS BALANCE DUE AT DATE OF DEATH $	NET BALANCE DUE AT DATE OF DEATH $
CONTACT INFORMATION			
BRANCH REPRESENTATIVE NAME		CONTACT TELEPHONE NUMBER ( )	FAX #
BRANCH REPRESENTATIVE SIGNATURE x			

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

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SECTION 4

PLEASE PRINT

LIFE CLAIM

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

INFORMATION OF DECEASED			
LAST NAME		FIRST NAME, MIDDLE INITIAL	
DATE OF BIRTH ___ / ___ / ___ (MM / DD / YY)	DATE OF DEATH ___ / ___ / ___ (MM / DD / YY)	PLACE OF DEATH	
IF HOSPITAL OR INSTITUTION, GIVE NAME AND ADDRESS:			
NAME OF HOSPITAL OR INSTITUTION			DATE ADMITTED ___ / ___ / ___ (MM / DD / YY)
STREET	CITY	PROVINCE	POSTAL CODE
HOW LONG DID YOU KNOW THE PATIENT? **FROM** ___ / ___ / ___ (MM / DD / YY) **TO** ___ / ___ / ___ (MM / DD / YY)			

CAUSE OF DEATH	IMMEDIATE CAUSE	UNDERLYING CAUSE	DATE OF DIAGNOSIS ___ / ___ / ___ (MM / DD / YY)
DATES OF MEDICAL TREATMENT, EXAMINATION OR ADVICE RELATED TO THE CAUSE OF DEATH DURING THE LAST 3 YEARS	___ / ___ / ___ (MM / DD / YY)	___ / ___ / ___ (MM / DD / YY)	___ / ___ / ___ (MM / DD / YY)
IS DEATH DUE TO	ACCIDENT? ☐ YES ☐ NO HOMICIDE? ☐ YES ☐ NO	SUICIDE? ☐ YES ☐ NO	DRUGS & ALCOHOL? ☐ YES ☐ NO
BRIEFLY DESCRIBE CIRCUMSTANCES SURROUNDING DEATH			
WAS AUTOPSY PERFORMED?	☐ YES ☐ NO	IF YES, PLEASE SUMMARIZE RESULTS AND ATTACH REPORTS	
WAS AN INQUEST HELD?	☐ YES ☐ NO	IF YES, BY WHOM AND WHAT WERE THE FINDINGS?	

TO YOUR KNOWLEDGE, DID THE DECEASED RECEIVE MEDICAL TREATMENT DURING THE LAST 3 YEARS FROM ANY OTHER PHYSICIAN OR HOSPITAL FOR THE CAUSE OF DEATH LISTED ABOVE?

☐ YES ☐ NO ***IF YES, PLEASE FURNISH THE FOLLOWING:***

NAME OF PHYSICIAN OR HOSPITAL:			
ADDRESS			
STREET	CITY	PROVINCE	POSTAL CODE
ILLNESS / INJURY			

DATES TREATED					
	___ / ___ / ___ (MM / DD / YY)	___ / ___ / ___ (MM / DD / YY)	___ / ___ / ___ (MM / DD / YY)	___ / ___ / ___ (MM / DD / YY)	___ / ___ / ___ (MM / DD / YY)

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

"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."

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Hamilton, Ontario L8K 1W2
Telephone: 1-877-273-1736

ESTATE FORM

PLEASE PRINT

In an effort to protect the privacy of our customer, we respectfully request the following information when completing a Life claim.

CREDITOR / LIENHOLDER NAME	CERTIFICATE NUMBER

☐ WILL INCLUDED

I hereby declare that ______________________________ is the person acting in the capacity of Executor of the Estate of

______________________________.

Relationship to the insured: ______________________________.

☐ NO WILL

I hereby declare that ______________________________ is the person acting in the capacity of Executor of the Estate of

______________________________.

Relationship to the insured: ______________________________.

☐ FAMILY MEMBER REQUEST

I hereby declare that I, ______________________________, am requesting the information in the capacity of
[spouse / child / grandchild / sibling] of the deceased.

Relationship to the insured: ______________________________.

CAUSE OF DEATH

NEXT OF KIN'S AUTHORIZATION

I certify that the above information is true and correct.

☐ By checking this box, I acknowledge that the above statement is true as of ____________________

NEXT OF KIN'S SIGNATURE	DATE		
	MM	DD	YYYY
WITNESS' SIGNATURE	**DATE**		
	MM	DD	YYYY

Please include this document when returning your claim forms.

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