

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**

- Have your former employer complete Section 3, or if self-employed please complete the Self-Employment Affidavit.
- 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.

3**MAIL OR FAX THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION**

- **Mail:** Assurant, Financial Claims, P.O. Box 7000, Kingston, ON, K7L 5V3
- **Fax:** 1-800-645-9405

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.

WE'RE HERE TO HELP!

**Call us if you have a question about submitting a claim.
Call toll-free: 1-800-361-5344 or Fax: 1-800-645-9405**



SECTION 1

PLEASE PRINT

CLAIMANT INFORMATION

Please complete for all claims being submitted

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

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.

CLAIMANT SIGNATURE:	DATE: MM/ DD/ YY
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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.

CLAIMANT SIGNATURE:	DATE: MM/ DD/ YY
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SECTION 3**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

EMPLOYEE'S NAME:

LAST NAME:

FIRST NAME, MIDDLE INITIAL:

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:

FROM:

MM / DD / YY

TO:

MM / DD / YY

BRIEF DESCRIPTION OF DUTIES:

DATE OF JOB LOSS NOTICE PROVIDED:

LAST DAY WORKED:

DATE RETURNED TO WORK:

MM / DD / YY

MM / DD / YY

MM / DD / YY

REASON FOR INTERRUPTION OF EMPLOYMENT:

DID EMPLOYEE RECEIVE SEVERANCE?

DATE SEVERANCE ENDS:

 YES NO

MM / DD / YY

HAS EMPLOYEE RESUMED FULL
DUTIES?IF YES, PROVIDE NUMBER OF
HOURS WORKED PER WEEK: YES NO

IF NO, WHAT DUTIES ARE THEY ABLE TO PERFORM?

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 / YY

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ABIC and ABLAC, use and share personal information provided to them by you and obtained from others with your consent. They 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.



PLEASE PRINT

SELF-EMPLOYMENT AFFIDAVIT

CREDITOR NAME:		ACCOUNT NUMBER:		DATE LAST WORKED: <u> </u> / <u> </u> / <u> </u> MM / DD / YY	
CLAIMANT'S NAME					
LAST NAME:			FIRST NAME, MIDDLE INITIAL:		
ADDRESS					
STREET		CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER: ()
HOME TELEPHONE NUMBER: ()			E-MAIL ADDRESS (IF AVAILABLE):		
ARE YOU STILL OFF WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, DATE YOU RETURNED TO WORK: <u> </u> / <u> </u> / <u> </u> MM / DD / YY	NUMBER OF HOURS WORKED PER WEEK:		EXPECTED RETURN TO WORK DATE: <u> </u> / <u> </u> / <u> </u> MM / DD / YY	
WHAT PERCENTAGE OF YOUR TIME WAS SPENT AT EACH OF THE FOLLOWING: SUPERVISORY / ADMINISTRATIVE _____% MANUAL WORK _____%					
MY OCCUPATION IS:		WHAT DATE DID YOUR BUSINESS START: <u> </u> / <u> </u> / <u> </u> MM / DD / YY		WHAT DATE DID YOUR BUSINESS CLOSE: <u> </u> / <u> </u> / <u> </u> MM / DD / YY	
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: <u> </u> / <u> </u> / <u> </u> MM / DD / YY		
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.					
CLAIMANT'S SIGNATURE:				DATE: <u> </u> / <u> </u> / <u> </u> MM / DD / YY	
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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CREDITOR INFORMATION

Please complete for all claims being submitted

NAME OF CREDITOR / LIENHOLDER		ACCOUNT NUMBER / CERTIFICATE NUMBER:	
BRANCH ADDRESS:			
STREET		CITY	PROVINCE
			POSTAL CODE
EFFECTIVE DATE OF LOAN	1ST PAYMENT DATE	WHEN IS YOUR NEXT SCHEDULED PAYMENT DUE?	EXPIRY DATE OF LOAN
MM / DD / YY	MM / DD / YY	MM / DD / YY	MM / DD / YY
PAYMENT INFORMATION			
FREQUENCY OF PAYMENT		PAYMENT AMOUNT	MONTHLY PAYMENT DUE DATE
<input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> WEEKLY		\$	MM / DD / YY
CONTACT INFORMATION			
BRANCH REPRESENTATIVE NAME:		EMAIL ADDRESS:	CONTACT TELEPHONE NUMBER: FAX #
			() ()