ASSURANT®

Caribbean American Life Assurance Company
Caribbean American Property Insurance Company

CREDIT CARD PROTECTION PLAN FORM | **FOR INITIAL UNEMPLOYMENT COVERAGE CLAIM**

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WE ARE HERE TO SERVE!

Please take note of the following information on how to submit a claim to Assurant.

- You are responsible for continuing to make your monthly payments until a decision is made by us on any claim submitted.
- If required, use a separate sheet of paper to include the name and account numbers of any account also covered by Assurant.
- To avoid any delays with your claim, review the forms to make sure you've included all documentation required and have duly signed all forms.
- We recommend that you save copies of all documentation submitted to us for review.

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FOR INITIAL UNEMPLOYMENT COVERAGE CLAIMS

- You should submit your claim after being unemployed for 30 consecutive days.
- Complete and sign sections 1 & 3.
- Attach a copy of credit card statement with closing date immediately following the start date of the unemployment and copy of a photo identification.
- Attach copies of your unemployment checks or your registration card and copy of the letter that states you are eligible for the benefits from the month you started being unemployed.
- Have your employer complete section 2. If the employer cannot provide the required information, you should submit your termination letter and copy of your Employment Record.
- If you would like to authorize a third-party to manage the claim for you, you should fill the "Verbal Information Disclosure" included in Section 4. This authorization will allow them to discuss your claim with any Assurant representative if you are unavailable.
- While unemployed, you should update your information every month using the **Continued Unemployment** claims form found in our self-service portal: pr.assurantcustomerportal.com.

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SEND US THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION BY:

Mail
350 Carlos Chardón Ave.
Torre Chardón Suite 1101
San Juan, PR 00918

Email:
reclamaciones@assurant.com

Online by visiting:
claimspr.assurant.com

Once your claim has been received, please allow 15 business days for processing.
All benefit payments are paid directly to the creditor.

NEED HELP?

Visit claimspr.assurant.com
24 hours a day, 7 days a week or
call our toll-free number 1-800-981-8888
We're available Monday through Friday from 8:00 am to 5:00 pm

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SECTION 1: INSURED'S INFORMATION

THIS SECTION IS REQUIRED TO EVALUATE YOUR CLAIM. Please print.

NAME OF THE FINANCIAL INSTITUTION	CREDIT CARD NUMBER

NAME OF THE INSURED	DATE OF BIRTH	AGE
	MONTH ____ DAY ____ YEAR ____	

PHYSICAL ADDRESS	
MAILING ADDRESS	

SOCIAL SECURITY NUMBER		LICENSE NUMBER	

MOBILE NUMBER	SECONDARY NUMBER	ALTERNATE NUMBER

DO YOU AUTHORIZE US TO SEND YOU EMAILS?	☐ YES ☐ NO
EMAIL	

WE AND OTHERS ACTING ON OUR BEHALF MAY USE THE INFORMATION WE GATHER TO OPERATE OUR PRODUCT AND OUR SERVICE. FOR EXAMPLE, WE MAY USE THE INFORMATION WE COLLECT OR RECEIVE TO TRY AND CONTACT YOU THROUGH EMAIL TO PROVIDE SUPPORT AND ASSISTANCE DURING THE CLAIM PROCESS, AS PERMITTED BY LAW.

HAVE YOU EVER FILE ANY TYPE OF CLAIM WITH US BEFORE?	☐ YES ☐ NO
IF YOU ANSWERED "YES", PLEASE PROVIDE US WITH THE CLAIM NUMBER(S)	

UNEMPLOYMENT INFORMATION

START DATE OF UNEMPLOYMENT		REASON FOR UNEMPLOYMENT
	MONTH ____ DAY ____ YEAR ____	

ARE YOU RECEIVING ANY UNEMPLOYMENT BENEFITS FOR THIS	IF YOU ANSWERED "NO", WHY?
☐ YES ☐ NO	

ARE YOU CURRENTLY WORKING?	IF YOU ANSWERED "YES", WHEN DID YOU STARTED WORKING?	
☐ YES ☐ NO		MONTH ____ DAY ____ YEAR ____

IF YOU ARE REGISTERED ON ANY LOCAL OR STATE UNEMPLOYMENT AGENCY, PLEASE INCLUDE YOUR REGISTRATION CARD.

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SECTION 2: EMPLOYER'S DECLARATION

To be completed by Employer
"I am the employer of the named insured and, in order to provide information to the company that facilitates the payment of the claim of said insured, I certify the following:"

EMPLOYEE'S INFORMATION

EMPLOYEE'S FULL NAME							
HIRING DATE	MONTH	DAY	YEAR	LAST DAY WORKED	MONTH	DAY	YEAR
REASON FOR EMPLOYMENT INTERRUPTION							
TYPE OF EMPLOYMENT	☐ FULL TIME ☐ PART-TIME ☐ SEASONAL ☐ TEMPORARY			NUMBER OF HOURS WORKED PER WEEK			
EMPLOYEE'S JOB TITLE				BRIEF DESCRIPTION OF DUTIES			
DATE THE EMPLOYEE RETURNED TO WORK	MONTH	DAY	YEAR	HAS THE EMPLOYEE RESUMED ALL RESPONSIBILITIES? ☐ YES ☐ NO			IF YOU ANSWERED "YES", HOW MANY HOURS IS THE EMPLOYEE WORKING PER WEEK?
ADDITIONAL COMMENTS							

EMPLOYER'S INFORMATION

COMPANY NAME	CONTACT NUMBER	FAX NUMBER
COMPANY ADDRESS		
COMPLETED BY NAME		
TITLE	EMAIL	
SIGNATURE:	MONTH DAY YEAR	

If you are unable to provide an original signature, please read and complete the following section:

I declare I have provided reasonable and relevant information with regards to the unemployment claim form that the insured is about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process the insured's claim. Furthermore, I certify I have read and completed in all its parts the section of the form that applies to me, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.

☐ In witness whereof, I sign this declaration by checking the box here provided.

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SELF-EMPLOYED QUESTIONNAIRE

Please certify that all the information provided here is correct and reliable.

INSURED'S INFORMATION

INSURED'S FULL NAME	HAVE YOU RETURNED TO WORK?	CREDIT CARD NUMBER
	☐ YES ☐ NO	

LAST DAY WORKED	_____ MONTH	_____ DAY	_____ YEAR	IF YOU ANSWERED "YES", WHEN DID YOU STARTED WORKING AGAIN?	_____ MONTH	_____ DAY	_____ YEAR

BUSINESS INFORMATION

BUSINESS' NAME	DATE WHEN THE BUSINESS STARTED	_____ MONTH	_____ DAY	_____ YEAR

BUSINESS ADDRESS		
WORK NUMBER	FAX	EMAIL

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SECTION 3: AUTHORIZATION

Please certify that all the information provided here is correct and reliable.

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., insurance or reinsuring Company, insurer, law enforcement agency, fire department, or other organization, or person having any records, data or information concerning this claim to furnish such record, data or information to Caribbean American Life Assurance Company/Caribbean American Property Insurance Company or its authorized representative(s) as requested. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as affective and valid as the original. I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above. This authorization shall remain valid for 6 months after the date of the signature.

VERBAL INFORMATION DISCLOSURE

It is important for us to safeguard the privacy of our customers and protect private and confidential information. We also understand that, on occasion, a claimant may want to authorize third parties to speak with Assurant on their behalf. Please complete this authorization section so others can discuss details of your claim. Without this authorization we cannot talk to anyone except the claimant.

I authorize Assurant to speak with , who is my , about my claim.

RESPONSIBILITY FOR FRAUDULENT INFORMATION

ANY PERSON who knowingly and with the intention to commit fraud provides false information in an insurance application, or submits, helps or causes the submission of a fraudulent insurance claim for the payment of a loss or any other benefit, or submits more than one claim for the same damage or loss, will incur in a felony and, upon conviction thereof, shall be punished, for each violation, with a fine not less than five thousand ($5,000) dollars, nor greater than ten thousand ($10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances are present, the fixed penalty established could be increased up to a maximum of five (5) years; if attenuating circumstances are present, the penalty could be reduced to a minimum of two (2) years.

INSURED'S SIGNATURE

SIGNATURE	_____ MONTH	_____ DAY	_____ YEAR

If you are unable to provide an original signature, please read and complete the following section to confirm your consent:

I declare I have received reasonable and relevant information with regards to the unemployment claim form that I am about to submit. I authorize, confirm and I am aware that the information provided in this form is being certified and that said certified information is necessary to process my claim. Furthermore, I certify I have read and completed the form and all its parts, and understand all certified information and its representations I have provided are true, complete and correct, and that I have taken all reasonable steps to ensure the accuracy of the information.

☐ In witness whereof, I sign this declaration by checking the box here provided.