American Bankers Insurance Company of Florida
American Bankers Life Assurance Company of Florida
American Reliable Insurance Company
American Security Insurance Company
Reliable Lloyds Insurance Company
Standard Guaranty Insurance Company
Time Insurance Company
Voyager Indemnity Insurance Company

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.859.0490 • Fax 305.252.6910
Attn: DFS Claims Department

WWW.BENEFITACTIVATIONS.COM

CLAIM FORM

Fax completed form and any attachments to 305.252.6910.

All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

INSTRUCTIONS

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed.)

DISABLED

After 30 consecutive days of disability: (Example: Disabled 1/1/12, complete form after 2/1/12)

☐ 1. Complete Section 1:
   a. If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.
   b. If you are **self-employed** attach a copy of your **business license**.
☐ 2. Have **your doctor** complete Section 3.
☐ **3. Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) for the month in which your disability started.**

UNEMPLOYED

After 30 consecutive days of unemployment: (Example: Unemployed 1/1/12, complete form after 2/1/12)

☐ 1. Complete Section 1.
☐ 2. Have **your employer** at the time of your loss complete Section 2.
   a. If **self-employed**, complete **Section 2** yourself and attach a copy of your **business license**.
☐ 3. Attach a copy of **your state Determination Letter, Unemployment check stub(s) or Unemployment Debit Card statement(s) or Registration Card or letter from a recognized Employment Agency or Job Service** for the dates you are claiming.
☐ **4. Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) for the month in which your period of unemployment started.**

NOTE: Benefits totaling $600.00 or more will be taxed.

ON THE JOB TRAINING

After 6 consecutive months of unemployment and enrollment in a federal or state funded job retraining program, or an accredited educational institution:

☐ 1. Complete Section 1.
☐ 2. Attach proof of tuition payment for the educational institution, or
☐ 3. Attach verification of enrollment in a federal or state job retraining program.
☐ **4. Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) for the month in which your period of unemployment started.**

PROPERTY

☐ 1. Complete Sections 1 and 4
☐ 2. Attach a copy of the **sales ticket** for each item claimed and **repair bill or estimate for damaged items.**
☐ 3. Attach a copy of the **Police/Fire Department Report** verifying the incident causing the loss, or your claim will be returned.
☐ 4. If loss is due to **burglary**, make sure police report indicates how entry was gained.
☐ **5. Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) for the month in which the incident occurred.**

DEATH

☐ 1. Complete Section 1. **(To be completed by person reporting the claim.)**
☐ 2. Attach a copy of the **certified death certificate.**
☐ **3. Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) covering the date the insured passed away.**

FAILURE TO COMPLETE REQUIRED SECTIONS AND PROVIDE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.

- **To avoid late fees, continue to make your payments until you receive notification that your claim has been approved.**
- **If your claim is approved, a continuing claim form must be submitted every 30 days for additional payments to be made.**
- **After mailing your claim, please allow 15 business days for processing.**

SECTION 1 - CLAIMANT'S INFORMATION

PLEASE PRINT

NAME OF FINANCIAL INSTITUTION OR STORE THAT ISSUED CREDIT CARD | CREDIT CARD - ACCOUNT NUMBER

CREDITOR NAME - WHERE PAYMENT IS TO BE MADE | TELEPHONE NUMBER ( )

NAME OF PRIMARY CARDHOLDER | DATE OF BIRTH / / | PLACE OF EMPLOYMENT | HOURS WORKED PER WEEK

NAME OF CLAIMANT | DATE OF BIRTH / / | PLACE OF EMPLOYMENT | HOURS WORKED PER WEEK

NAME OF EMPLOYER | TELEPHONE NUMBER ( ) | EXTENSION

TYPE OF EMPLOYMENT ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Temporary ☐ Self-Employed | LAST DAY YOU WORKED / / | DATE YOU RETURNED TO WORK / /

HAVE YOU RESUMED DUTIES ☐ Yes ☐ No If yes, ☐ Full-Time ☐ Part-Time | NUMBER OF HOURS PER WEEK

ARE YOU RETIRED? ☐ Yes ☐ No | IF YES, DATE RETIRED / / | REASON FOR INTERRUPTION OF EMPLOYMENT ☐ Laid Off ☐ Terminated ☐ Assignment Ended ☐ Leave of Absence ☐ Retired ☐ Quit ☐ Resigned ☐ Disability ☐ Other

IF UNEMPLOYED ARE YOU:

1. Receiving Unemployment Benefits ☐ Yes ☐ No
2. Registered with the State Unemployment Office ☐ Yes ☐ No
3. Registered with a Job Service/Employment Agency ☐ Yes ☐ No

IF YOU HAVE PREVIOUSLY FILED A CLAIM WITH US, PLEASE INDICATE THE DATE YOU RETURNED TO WORK FROM THAT LOSS
/ /

CLAIMANT'S STREET ADDRESS/APT. # | CITY | STATE | ZIP CODE

TELEPHONE NUMBER ( ) | CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)

I. I AUTHORIZE any employer, physician, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or the organization or person having any records, data, or information concerning this claim to furnish such records, data, or information to the insurance company issuing my policy. 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 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.

The above information is true and correct. If, in fact, the furnished information is false, thereby inducing payment of claim, and the insurance company issuing my policy determines that the incorrect information constitutes aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false shall give the insurance company issuing my policy the right to void my policy.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall be valid for the duration of the claim.

II. Certification - Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions - You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also, see **Signing the Certification under Specific Instructions**.) Instructions will be mailed upon request.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties. **For other Fraud Statements see page 4.**

CLAIMANT'S SIGNATURE | CLAIMANT'S SOCIAL SECURITY NUMBER | DATE

X - - / /

SECTION 2 - EMPLOYER'S STATEMENT

PLEASE PRINT

TO BE COMPLETED BY YOUR EMPLOYER OR UNION REPRESENTATIVE

EMPLOYEE'S NAME | DATE HIRED / / | NUMBER OF HOURS PER WEEK

EMPLOYEE'S JOB TITLE | TYPE OF EMPLOYMENT (CHECK ALL THAT APPLY) ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Self-Employed

REASON FOR INTERRUPTION OF EMPLOYMENT
☐ Laid Off ☐ Terminated ☐ Assignment Ended ☐ Leave of Absence ☐ Retired ☐ Quit
☐ Resigned ☐ Disability ☐ Other _____

PLEASE EXPLAIN REASON FOR INTERRUPTION OF EMPLOYMENT

LAST DAY WORKED / / | HAS EMPLOYEE RETURNED TO WORK ☐ Yes ☐ No If yes, ☐ Full-Time ☐ Part-Time | DATE RETURNED TO WORK / / | NUMBER OF HOURS PER WEEK

NAME OF COMPANY | TELEPHONE NUMBER ( ) | EXTENSION

STREET ADDRESS | CITY | STATE | ZIP CODE

COMPLETED BY (PRINT NAME) | SIGNATURE X | DATE / /

SECTION 3 - DOCTOR'S STATEMENT

PLEASE PRINT

(to be furnished without expense to the Insurance Company)

PATIENT'S FULL NAME | DIAGNOSIS (CODE(S)) ☐ ICD-9_____ ☐ CPT_____ ☐ DSM III_____

CURRENT DIAGNOSIS

LIST THE NAMES OF ALL PRESCRIBED MEDICATIONS FOR THIS DIAGNOSIS

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK) FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation

GIVE EXACT DATES OF PARTIAL DISABILITY FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT ☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled

IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED ☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined

PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)
☐ Cass 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)
☐ Class 2 - Medium manual activity. (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

IS CONDITION DUE TO PREGNANCY ☐ Yes ☐ No | IF YES, DESCRIBE COMPLICATIONS | ESTIMATED DATE OF DELIVERY / /

WHEN DID SYMPTOMS FIRST APPEAR / / | WAS DISABILITY CAUSED BY AN ACCIDENT ☐ Yes ☐ No | IF YES, DATE OF ORIGINAL ACCIDENT / /

IF YES, DESCRIBE ACCIDENT

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION ☐ Yes ☐ No | GIVE DATES OF TREATMENT FOR SIMILAR CONDITION (MM/DD/YY)

DESCRIBE SAME OR SIMILAR CONDITION

GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF OTHER TREATING PHYSICIANS (ATTACH ADDITIONAL SHEET IF NECESSARY)

DATES OF TREATMENT FIRST VISIT / / LAST VISIT / / NEXT VISIT / / | FREQUENCY OF VISITS ☐ Weekly ☐ Monthly ☐ Other (specify) _____

HAS PATIENT BEEN HOSPITALIZED ☐ Yes ☐ No If yes, FROM / / THROUGH / / | NAME OF HOSPITAL

STREET ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( )

DID PATIENT HAVE SURGERY ☐ Yes ☐ No | IF YES, DESCRIBE SURGERY | DATE PERFORMED / /

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION ☐ Yes ☐ No | **IF PATIENT IS STILL UNDER YOUR CARE, GIVE ESTIMATED DATE WHEN PATIENT WILL RESUME WORK** / / | IF NOT, GIVE DATE PATIENT WAS RELEASED TO RESUME WORK / /

PROGNOSIS/COMMENTS (HAS PATIENT PROGRESSED)

"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."

STREET ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( ) | FAX NUMBER ( )

ATTENDING PHYSICIAN'S NAME (PLEASE PRINT) | ATTENDING PHYSICIAN'S SIGNATURE X | MEDICAL ID NUMBER | DEGREE | DATE / /

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY DOCTOR'S OFFICE

SECTION 4 - PROPERTY CLAIM

PLEASE PRINT

TO BE COMPLETED BY CARDHOLDER

NAME OF STORE WHERE ITEM(S) WAS PURCHASED	TYPE OF LOSS (FIRE, BURGLARY, ETC.)	CAN ITEM(S) BE REPAIRED ☐ Yes ☐ No	DATE OF LOSS / /

HOW DID LOSS OCCUR (GIVE DETAILS)

List all items purchased with your credit card that you are claiming as a loss.

ARTICLE/MODEL NUMBER	PURCHASE DATE	PURCHASE PRICE	TAX	REPAIR COST (ATTACH ESTIMATE)
	/ /	$		$
	/ /	$		$
	/ /	$		$
	/ /	$		$
	/ /	$		$
TOTAL AMOUNT CLAIMED		$		$

CA residents only: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO residents only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DC residents only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL residents only: Pursuant to § 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in § 775.082, § 775.083, or § 775.084, Florida Statutes.

KY residents only: Any person who knowingly and with intent to defraud any insurance company, or other person files a claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **HIGH LIMIT AD** - No statements made by the applicant may be changed without his written consent.

MD residents only: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ residents only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OK residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

RI residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TX residents only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VA residents only: *This notice is not applicable to life and health insurance.

WA residents only: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.