

American Bankers Insurance Company of Florida

P.O. Box 977122, Miami, FL 33157 • 1.800.327.5288 • Fax 1.305.252.6910

UNEMPLOYMENT CLAIM FORM

Mail or fax completed form and any attachments to 1.305.252.6910.

All benefit payments are paid directly to your creditor.

ELIGIBILITY NOTICE

To qualify for involuntary unemployment benefits, you must first verify that you were employed continuously during a PERIOD immediately before the effective date of your insurance certificate. Also, this employment must have been for salaries or wages and you must have been working at least 30 hours per week.

To obtain the length of your QUALIFICATION PERIOD, please refer to your certificate of insurance or contact the Financial Institution (creditor, retailer) where the insurance was purchased.

Verification of continuous employment during the QUALIFICATION PERIOD may require statement from more than one previous employer.

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.)**

AFTER 30 CONSECUTIVE DAYS OF UNEMPLOYMENT

- 1. Read Eligibility Notice.
- 2. Complete Section A.
- 3. Attach a copy of **your state determination letter, unemployment check stub(s), unemployment debit card statement(s) or Registration Card from a recognized Employment Agency or Job Service** for the dates you are claiming.
- 4. Have your **Financial Institution** (creditor/retailer) that issued your insurance certificate complete Section B.
- 5. Attach a copy of Certificate of Insurance/Policy or Ledger Card indicating premium charged.
- 6. If premiums are paid monthly, please submit Statement of Account for the month in which unemployment occurred.
- 7. Have your **Most Recent Employer** complete Section C.
- 8. Have your **Previous Employer** complete Section D (if most recent employment was less than 12 months).
- 9. Have Section E completed if Sections C and D do not equal 12 months.

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.**
- After faxing or mailing your claim, please allow 15 business days for processing.
- If your claim is approved, a continuing claim form must be submitted every 30 days for additional payments to be made.

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.

FL residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

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.

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UNEMPLOYMENT CLAIM FORM

Benefits totaling \$600.00 or more will be taxed.

A. CLAIMANT'S STATEMENT				PLEASE PRINT	
NAME OF CLAIMANT		DATE OF BIRTH		CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)	
STREET ADDRESS/APT #		CITY		STATE	ZIP CODE
LAST DATE WORKED		REASON FOR INTERRUPTION OF EMPLOYMENT			
/ /		<input type="checkbox"/> Laid Off <input type="checkbox"/> Terminated <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Retired <input type="checkbox"/> Quit <input type="checkbox"/> Resigned <input type="checkbox"/> Disability <input type="checkbox"/> Other			
ARE YOU RECEIVING STATE UNEMPLOYMENT BENEFITS FOR THIS PERIOD OF YOUR UNEMPLOYMENT		IF YOU ARE NOT RECEIVING STATE UNEMPLOYMENT BENEFITS, PLEASE EXPLAIN WHY (If you have signed up with a state or local employment service, please provide us with a copy of the card)			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
HAVE YOU RETURNED TO WORK		DATE RETURNED TO WORK		# OF HOURS PER WEEK	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time		/ /			
IF YOU HAVE PREVIOUSLY FILED A CLAIM WITH US, PLEASE INDICATE THE DATE YOU RETURNED TO WORK FROM THAT LOSS					
/ /					

I. I AUTHORIZE any employer, physician, hospital, 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 unde reported 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 1.**

CLAIMANT'S SIGNATURE	SOCIAL SECURITY NUMBER	DATE
X	- -	/ /

B. CREDITOR'S STATEMENT						(to be completed by Creditor/Retailer that issued certificate)	PLEASE PRINT
CERTIFICATE NUMBER (include prefix)		DATE OF ISSUE	TERM IN MONTHS	AGENT'S CODE	BRANCH NO.	FORM NUMBER (of certificate)	
ACCOUNT/LOAN NUMBER		POLICY EXPIRES	DATE OF LOAN		MONTHLY PAYMENT AMOUNT		
<input type="checkbox"/> Yes <input type="checkbox"/> No		PREVIOUS LOAN #	PREVIOUS POLICY # / CERTIFICATE #				
NAME OF INSURED DEBTOR			FIRST BENEFICIARY - CREDITOR				
STREET ADDRESS OF FIRST BENEFICIARY - CREDITOR			CITY	STATE	ZIP CODE		
AUTHORIZED REPRESENTATIVE (Please print)		SIGNATURE OF AUTHORIZED REPRESENTATIVE		DATE	TELEPHONE NUMBER		
		X		/ /	()		

C. MOST RECENT EMPLOYER'S STATEMENT						(TO BE COMPLETED BY EMPLOYER ONLY)	PLEASE PRINT
EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)			DATE OF HIRE	HIRED FOR			
			/ /	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal			
NUMBER OF HOURS WORKED PER WEEK	NUMBER OF MONTHS WORKED	EMPLOYMENT INTERRUPTED					
		Last Day Worked / / Date Returned to Work / /					
EMPLOYEE'S JOB TITLE							
REASON FOR INTERRUPTION OF EMPLOYMENT							
<input type="checkbox"/> Laid Off <input type="checkbox"/> Quit <input type="checkbox"/> Terminated <input type="checkbox"/> Resigned <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Disability <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Retired <input type="checkbox"/> Other _____							
NAME OF EMPLOYER				TELEPHONE NUMBER		EXTENSION	
				()			
STREET ADDRESS			CITY	STATE	ZIP CODE		
COMPLETED BY (PRINT NAME)			SIGNATURE		DATE		
			X		/ /		

D. PREVIOUS EMPLOYER'S STATEMENT						(complete only if most recent employment was less than 12 months)	PLEASE PRINT
EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)			DATE OF HIRE	TYPE OF EMPLOYMENT			
			/ /	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal			
NUMBER OF HOURS WORKED PER WEEK	NUMBER OF MONTHS WORKED	EMPLOYMENT INTERRUPTED					
		Last Day Worked / / Date Returned to Work / /					
EMPLOYEE'S JOB TITLE							
REASON FOR INTERRUPTION OF EMPLOYMENT							
<input type="checkbox"/> Laid Off <input type="checkbox"/> Quit <input type="checkbox"/> Terminated <input type="checkbox"/> Resigned <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Disability <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Retired <input type="checkbox"/> Other _____							
NAME OF EMPLOYER				TELEPHONE NUMBER		EXTENSION	
				()			
STREET ADDRESS			CITY	STATE	ZIP CODE		
COMPLETED BY (PRINT NAME)			SIGNATURE		DATE		
			X		/ /		

E. EMPLOYER'S STATEMENT						(complete if Sections C and D do not equal 12 months of employment)	PLEASE PRINT
EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)			DATE OF HIRE	TYPE OF EMPLOYMENT			
			/ /	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal			
NUMBER OF HOURS WORKED PER WEEK	NUMBER OF MONTHS WORKED	EMPLOYMENT INTERRUPTED					
		Last Day Worked / / Date Returned to Work / /					
EMPLOYEE'S JOB DESCRIPTION AT TIME OF RELEASE							
REASON FOR INVOLUNTARY RELEASE							
NAME OF EMPLOYER			TELEPHONE NUMBER		EXTENSION	FAX NUMBER	
			()			()	
STREET ADDRESS			CITY	STATE	ZIP CODE		
COMPLETED BY (PRINT NAME)			SIGNATURE		TITLE	DATE	
			X			/ /	