

**UNEMPLOYMENT CLAIM FORM**

**Fax completed form and any attachments to 305.252.6910**

**Benefits totaling \$600.00 or more will be taxed.**

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

**INSTRUCTIONS**

After 30 consecutive days of unemployment: (Example: Unemployed 1/1/12, complete form after 2/1/12) (Check box after each item is completed.)

- 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.

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.

**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.

**For Florida 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.**

# American Bankers Management Company

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.366.2286 • Fax 305.252.6910

Attn: DFS Claims Department

## 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
LAST DATE WORKED / /	NAME OF EMPLOYER	TELEPHONE NUMBER ( )	EXTENSION
ARE YOU RETIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DATE RETIRED / /	REASON FOR INTERRUPTION OF EMPLOYMENT OR RETIREMENT <input type="checkbox"/> Laid Off <input type="checkbox"/> Terminated <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Quit <input type="checkbox"/> Resigned <input type="checkbox"/> Disability <input type="checkbox"/> Other _____	
1. RECEIVING UNEMPLOYMENT BENEFITS <input type="checkbox"/> Yes <input type="checkbox"/> No		2. REGISTERED WITH THE STATE UNEMPLOYMENT OFFICE <input type="checkbox"/> Yes <input type="checkbox"/> No	
		3. REGISTERED WITH A JOB SERVICE/EMPLOYMENT AGENCY <input type="checkbox"/> Yes <input type="checkbox"/> 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 E-MAIL 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 reinsurance 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 an 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 1.**

CLAIMANT'S SIGNATURE <b>X</b>	CLAIMANT'S SOCIAL SECURITY NUMBER	DATE / /
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## 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) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self-Employed	
REASON FOR INTERRUPTION OF EMPLOYMENT <input type="checkbox"/> Laid-Off <input type="checkbox"/> Terminated <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retired <input type="checkbox"/> Quit <input type="checkbox"/> Resigned <input type="checkbox"/> Disability <input type="checkbox"/> Other _____		
PLEASE EXPLAIN REASON FOR INTERRUPTION OF EMPLOYMENT		
LAST DAY WORKED / /	HAS EMPLOYEE RETURNED TO WORK <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	DATE RETURNED TO WORK / /
NAME OF COMPANY	TELEPHONE NUMBER ( )	EXTENSION
STREET ADDRESS	CITY	STATE    ZIP CODE
COMPLETED BY (PRINT NAME)	SIGNATURE <b>X</b>	DATE / /