

American Bankers Insurance Company of Florida

Post Office Box 977122, Miami, FL 33197-7122 • 1.800.327.5288 • Fax 305.252.6910
Attn: DFS Claims Department

CONTINUING DISABILITY CLAIM FORM

Mail or fax completed form and any attachments to 305.252.6910.

INSTRUCTIONS

1. Complete Section A.
2. Have your Doctor complete Section B.

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

- After mailing your claim, please allow 15 business days for processing.
- Please include your claim number on all correspondence sent to our office.
- The status of your claim may be verified through our automated claims inquiry system, 1.800.327.5288.
- New charges made to your account during a claim period are not covered and will not be paid.
- A claim form must be submitted with updated verification every 30 days for additional payments to be made.

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.

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CONTINUING DISABILITY CLAIM FORM

A. CLAIMANT'S INFORMATION (must be completed for all claims)					PLEASE PRINT	
NAME AND ADDRESS <input type="checkbox"/> CHECK BOX IF THIS IS A NEW ADDRESS				CLAIM NUMBER		
				CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)		
				NAME OF FINANCIAL INSTITUTION/STORE/UTILITY COMPANY (WHERE PAYMENT IS TO BE MADE)		
HAVE YOU RETURNED TO WORK SINCE YOU BECAME DISABLED <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time				DATE RETURNED TO WORK / /		# OF HOURS PER WEEK
HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY <input type="checkbox"/> Yes <input type="checkbox"/> No		ARE YOU RECEIVING SOCIAL SECURITY DISABILITY <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR SOCIAL SECURITY AWARD LETTER OR VERIFICATION THAT YOU ARE RECEIVING SSDI.		
<p>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 other organization or person having any records, data, or information concerning this claim to furnish such record, data, or information to American Bankers Insurance Company of Florida. 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 effective and valid as the original.</p> <p>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.</p> <p>The above information is true and correct. If, in fact, the furnished information is false thereby inducing payment of claim and American Bankers Insurance Company of Florida determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, American Bankers Insurance Company of Florida 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 American Bankers Insurance Company of Florida the right to void my policy.</p> <p>I, or my authorized representative, have the right to receive a copy of this authorization.</p> <p>This authorization shall be valid for the duration of the claim.</p>						
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 X				TELEPHONE NUMBER ()		DATE / /
B. DOCTOR'S STATEMENT (to be furnished without expense to the Insurance Company)					PLEASE PRINT	
PATIENT'S FULL NAME				DIAGNOSIS (CODE(S)) <input type="checkbox"/> ICD-9 <input type="checkbox"/> CPT <input type="checkbox"/> 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 / / <input type="checkbox"/> His/Her Occupation <input type="checkbox"/> Any Occupation			GIVE EXACT DATES OF PARTIAL DISABILITY FROM / / TO / / <input type="checkbox"/> His/Her Occupation <input type="checkbox"/> Any Occupation			
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT <input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Non-Disabled			IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Longer than 9 months <input type="checkbox"/> Undetermined			
LAST TREATMENT DATE / /		NEXT VISIT / /		FREQUENCY OF VISITS <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other		
DID PATIENT HAVE SURGERY SINCE LAST REPORT <input type="checkbox"/> Yes <input type="checkbox"/> No		IF SO, DESCRIBE SURGERY			DATE PERFORMED / /	
HAS PATIENT PROGRESSED <input type="checkbox"/> Yes <input type="checkbox"/> No						
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION <input type="checkbox"/> Yes <input type="checkbox"/> No			IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK / /		IF NO, DATE PATIENT WAS RELEASED / /	
"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."						
PHYSICIAN'S NAME (PRINT NAME)		PHYSICIAN'S SIGNATURE X		MEDICAL ID #	DEGREE	DATE / /
STREET ADDRESS		CITY	STATE	ZIP CODE	TELEPHONE NUMBER ()	FAX NUMBER ()

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