American Bankers Insurance Company of Florida
American Reliable Insurance Company
American Security Insurance Company
Standard Guaranty 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

UNEMPLOYMENT CLAIM FORM

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

IMPORTANT NOTICE
PLEASE READ CAREFULLY BEFORE COMPLETING YOUR CLAIM FORM

Failure to complete required sections and/or provide requested documentation will delay processing of your claim.

INSTRUCTIONS FOR COMPLETING FORM

AFTER 30 CONSECUTIVE DAYS OF UNEMPLOYMENT
(Example: Unemployed 01/01/2012, complete form after 02/01/2012)

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.)

☐ **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), 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 the top portion) for the month in which your period of unemployment started.**

- **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.**

Fax completed form and all supporting documentation to 305.252.6910 or mail to:
DFS Claims Department
PO Box 977122
Miami, FL 33197-7122

ONCE YOUR CLAIM IS RECEIVED

- **YOU WILL RECEIVE A LETTER ACKNOWLEDGING RECEIPT OF YOUR CLAIM. THE LETTER WILL CONTAIN YOUR CLAIM NUMBER.**
- **PLEASE ALLOW 15 BUSINESS DAYS FOR YOUR CLAIM TO BE PROCESSED.**
- **AFTER YOUR CLAIM HAS BEEN PROCESSED, YOU WILL RECEIVE A LETTER ADVISING OF APPROVAL, DENIAL OR REQUEST FOR ADDITIONAL INFORMATION.**

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 your protection **Arizona** law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA residents Only: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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: 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.

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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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? ☐ Yes ☐ No	IF YES, DATE RETIRED / /	REASON FOR INTERRUPTION OF EMPLOYMENT OR RETIREMENT
		☐ Laid Off ☐ Terminated ☐ Assignment Ended ☐ Leave of Absence ☐ Quit ☐ Resigned ☐ Disability ☐ Other_____

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, 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 the insurance company issuing my policy. 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.

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 remain 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.

NY 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **For other Fraud Statements see Page 2.**

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

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

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	DATE RETURNED TO WORK	# OF HOURS PER WEEK
/ /	☐ Yes ☐ No If Yes, ☐ Full-Time ☐ Part-Time	/ /	

NAME OF COMPANY	TELEPHONE NUMBER	EXTENSION
	( )	

STREET ADDRESS	CITY	STATE	ZIP CODE

COMPLETED BY (PRINT NAME)	SIGNATURE	DATE
	X	/ /