American Bankers Insurance Company of Florida

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.327.5288 • Fax 305.252.6910
Attn: DFS Claims Department

CONTINUING UNEMPLOYMENT CLAIM FORM

Mail or fax completed form and any attachments to 305.252.6910.

BENEFITS TOTALING $600.00 OR MORE WILL BE TAXED.

INSTRUCTIONS

1. **Complete Section A.**
2. **Attach a copy of your state unemployment or strike benefit check stub(s), or unemployment debit card statement(s), or verification from local union. Date shown on check(s) or proof of registration must be approximately the same as the dates you are claiming.**
3. **If you are not receiving unemployment benefits or your benefits have been exhausted, attach proof of registration with an employment agency or job service.**
4. **Have Section B completed if no other unemployment verification is available.**

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 by calling 1.800.327.5288.**
- **New charges made to your account during a claim period are not covered and will not be paid.**

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.

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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A claim form must be submitted with updated verification every 30 days for additional payments to be made.

A. CLAIMANT'S INFORMATION (must be completed for all claims) **PLEASE PRINT**

NAME AND ADDRESS ☐ CHECK BOX IF THIS IS A NEW ADDRESS	CLAIM NUMBER	POLICY NUMBER
	CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)	
	NAME OF FINANCIAL INSTITUTION/STORE (WHERE PAYMENT IS TO BE MADE)	

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

ARE YOU RECEIVING STATE UNEMPLOYMENT BENEFITS	IF NO, WHY NOT	IF YES, ATTACH A COPY OF UNEMPLOYMENT CHECK STUB(S)
☐ Yes ☐ No		
ARE YOU CURRENTLY OUT ON STRIKE	ARE YOU RECEIVING STRIKE PAY BENEFITS	IF YES, ATTACH A COPY OF YOUR BENEFIT CHECK OR DEBIT CARD STATEMENT, OR VERIFICATION FROM LOCAL UNION
☐ Yes ☐ No	☐ Yes ☐ No	

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 American Bankers Insurance Company of Florida. 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 American Bankers Insurance Company of Florida determines that the incorrect information constitutes 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.

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.

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 1.**

CLAIMANT'S SIGNATURE	TELEPHONE NUMBER	DATE
X	( )	/ /

B. EMPLOYMENT AGENCY/LOCAL UNION/JOB SERVICE STATEMENT (stamp may be used) **PLEASE PRINT**

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL HAS BEEN REGISTERED WITH THIS AGENCY/LOCAL UNION/JOB SERVICE OFFICE

FROM / / TO / / AND WAS LAST SEEN ON / /

NAME OF AGENCY/LOCAL UNION/JOB SERVICE	TELEPHONE NUMBER	EXTENSION	FAX NUMBER
	( )		( )

STREET ADDRESS	CITY	STATE	ZIP CODE

NAME OF AGENT (PLEASE PRINT)	SIGNATURE OF AGENT	TITLE	DATE
	X		/ /

FORM MUST BE FULLY COMPLETED, SIGNED AND DATED.