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 • 1.800.327.5288 • Fax 305.252.6910
Attn: DFS Claims Department

UNEMPLOYMENT CLAIM FORM

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

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.**
  - ☐ **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.**
- ☐ **3. Have your Most Recent Employer complete Section B.**
- ☐ **4. Have your Previous Employer complete Section C. (if most recent employment was less than 12 months).**
- ☐ **5. Have Section D completed if Sections B and C do not equal 12 months.**
- ☐ **6. Have your Financial Institution (creditor/retailer) that issued your insurance certificate complete Section E.**
  - ☐ **Attach a copy of Certificate of Insurance/Policy or Ledger card indicating premium charged.**
  - ☐ **If premiums are paid monthly, please submit Statement of Account for the month in which unemployment occurred.**
- ☐ **7. Follow your creditor's instructions for mailing the completed claim form.**

- **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 documentations 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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UNEMPLOYMENT CLAIM FORM

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.

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	TELEPHONE NUMBER
				( )

LAST DATE WORKED	REASON FOR INTERRUPTION OF EMPLOYMENT
/ /	☐ Laid Off ☐ Terminated ☐ Leave of Absence ☐ Assignment Ended ☐ Retired ☐ Quit ☐ Resigned ☐ Disability ☐ 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)
☐ Yes ☐ No	

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

Benefits totaling $600.00 or more will be taxed.

B. MOST RECENT EMPLOYER'S STATEMENT — PLEASE PRINT

TO BE COMPLETED BY EMPLOYER ONLY

EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)	DATE OF HIRE	HIRED FOR
	/ /	☐ Full Time ☐ Part Time ☐ 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

☐ Laid Off ☐ Quit ☐ Terminated ☐ Resigned ☐ Leave of Absence ☐ Disability ☐ Assignment Ended ☐ Retired ☐ Other_____

NAME OF EMPLOYER	TELEPHONE NUMBER	EXTENSION
	( )	

STREET ADDRESS	CITY	STATE	ZIP CODE

COMPLETED BY (PRINT NAME)	SIGNATURE	DATE
	X	/ /

C. PREVIOUS EMPLOYER'S STATEMENT (complete only if most recent employment was less than 12 months) — PLEASE PRINT

TO BE COMPLETED BY EMPLOYER ONLY

EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)	DATE OF HIRE	TYPE OF EMPLOYMENT
	/ /	☐ Full Time ☐ Part Time ☐ 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

☐ Laid Off ☐ Quit ☐ Terminated ☐ Resigned ☐ Leave of Absence ☐ Disability ☐ Assignment Ended ☐ Retired ☐ Other_____

NAME OF EMPLOYER	TELEPHONE NUMBER	EXTENSION
	( )	

STREET ADDRESS	CITY	STATE	ZIP CODE

COMPLETED BY (PRINT NAME)	SIGNATURE	DATE
	X	/ /

D. EMPLOYER'S STATEMENT (complete if Sections C and D do not equal 12 months of employment) — PLEASE PRINT

TO BE COMPLETED BY EMPLOYER ONLY

EMPLOYEE'S NAME (FIRST/MIDDLE/LAST	DATE OF HIRE	TYPE OF EMPLOYMENT
	/ /	☐ Full Time ☐ Part Time ☐ 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		/ /

E. 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
	/ /	/ /	$

WAS THIS LOAN REFINANCED	PREVIOUS LOAN #	PREVIOUS POLICY # / CERTIFICATE #
☐ Yes ☐ No		

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	/ /	( )