American Bankers Insurance Company of Florida

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.407.8425 • Fax 305.252.6910
Attn: DFS Claims Department

PAYMENT POWER LEAVE OF ABSENCE CLAIM FORM

All benefit payments will be shown on your monthly utility bill.

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 LEAVE
(Example: Leave began 01/01/2012, complete form after 02/01/2012)

☐ **1. Complete Section 1.**

☐ **2. Have your employer at the time of your leave complete Section 2.**

☐ **3. Attach a copy of your <u>ENTIRE</u> MONTHLY UTILITY BILL for the month in which your leave started.**

- **To avoid late fees, continue to make payments until you receive notification that your claim has been approved.**
- If your claim is approved, a continuing claim form along with a copy of your ENTIRE monthly utility bill 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

<u>ONCE YOUR CLAIM IS RECEIVED</u>

- **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.**

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.

American Bankers Insurance Company of Florida

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.407.8425 • Fax 305.252.6910
Attn: DFS Claims Department

PAYMENT POWER LEAVE OF ABSENCE CLAIM FORM

SECTION 1 - CLAIMANT'S INFORMATION — PLEASE PRINT

NAME OF CREDITOR/UTILITY COMPANY/GAS CARD COMPANY			ACCOUNT NUMBER		
CUSTOMER'S NAME (NAME ON MONTHLY BILLING STATEMENT)	DATE OF BIRTH / /		PLACE OF EMPLOYMENT		HOURS WORKED PER WEEK
NAME OF CLAIMANT	DATE OF BIRTH / /		PLACE OF EMPLOYMENT		HOURS WORKED PER WEEK
CLAIMANT'S STREET ADDRESS/APT #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER (DAY) ( )	TELEPHONE NUMBER (EVENING) ( )
WHAT IS YOUR OCCUPATION			ARE YOU SELF-EMPLOYED - CHECK ONE ☐ Yes ☐ No		

REASON FOR LEAVE
☐ Illness-Family Member ☐ Military Duty
☐ New Birth or Adoption ☐ A Federally Declared Disaster ☐ Other_____

TYPE OF DISASTER (FLOOD, FIRE, HURRICANE, ETC.)	COUNTY IN WHICH YOU RESIDE		
WHOSE NEEDS WILL YOU BE ATTENDING - GIVE FULL NAME	RELATIONSHIP	AGE	DATE OF BIRTH / /
HOW LONG DO YOU EXPECT TO BE OUT OF WORK AS A RESULT OF LEAVE	WILL YOU RECEIVE ANY MONETARY COMPENSATION WHILE ON LEAVE ☐ Yes ☐ No		

I hereby assign to **my utility/gas company**, Assignee, the proceeds due or to become due under this policy, when issued to the extent of any indebtedness due by me to said Assignee. I specifically agree that this assignment is irrevocable until all indebtedness due Assignee by me has been paid in full and that the rights and interests of any beneficiary under this policy are subordinate to the rights and interests of the Assignee.

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 2.**

MICHIGAN RESIDENTS ONLY

Unless indicated, I hereby assign to **my utility/gas company**, Assignee, the proceeds due or to become due under this policy, when issued to the extent of any indebtedness due by me to said Assignee. I specifically agree that this assignment is irrevocable until all indebtedness due Assignee by me has been paid in full and that the rights and interest of any beneficiary under this policy are subordinate to the rights and interest of the Assignee. ☐ **Do not assign benefits.**

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

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
	/ /	

REASON FOR LEAVE

☐ Illness-Family Member ☐ A Federally Declared Disaster

☐ New Birth or Adoption ☐ Military Duty ☐ Other_____

WAS LEAVE APPROVED	WILL EMPLOYEE RECEIVE COMPENSATION DURING THE LEAVE	IF YES, GIVE DATES OF COMPENSATION
☐ Yes ☐ No	☐ Yes ☐ No	FROM / / TO / /

LAST DAY WORKED	DATE RETURNED TO WORK	EMPLOYEE'S JOB TITLE
/ /	/ /	

TYPE OF EMPLOYMENT

☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Temporary ☐ Self-Employed

NAME OF COMPANY	TELEPHONE NUMBER	EXTENSION
	( )	

STREET ADDRESS	CITY	STATE	DATE
			/ /

COMPLETED BY (PRINT NAME)	SIGNATURE	DATE
	X	/ /