

#### American Bankers Insurance Company of Florida

P.O. Box 7300 Kingston, Ontario K7L 0B2 Toll Free: 1-888-409-4442 Fax: 1-888-315-7377 Email: inclusive.benefits@assurant.com

# EXTENDED WARRANTY CLAIM FORM

SECTION 1 -	- DOCUMENT	S REQUIRED	TO PROCESS CLAIM								
			g with the following documents to the please do keep a copy for your record		to avoid a delay in processing						
The orig	inal sales receir	ot detailing the	cost, date and description of purcha	se.							
The Desjardins credit card account statement showing the charge and/or the redemption of your BONUSDOLLARS.											
A copy of your Desjardins credit card account statement at date of loss.											
A copy of the Original Manufacturer's Warranty.											
A copy of the written repair estimate (for damage claims).											
A police, fire, insurance claim or loss report or other report of the occurrence of the loss sufficient for determination of eligibility for the benefits hereunder.											
At the sole disc order to suppo		surer, you may be	e required to send, at your own expens	se, the damaged item on which a cl	aim is based to the Insurer in						
SECTION 2 -	INSURED IN	FORMATION									
NAME OF CAR	RDHOLDER (LAS	ST, FIRST)	DESJARDINS CREDIT CARD NUMBER (FIRST 6 - L								
EMAIL ADDRE	SS (OPTIONAL)	)		HOME TELEPHONE NUMBER							
				-							
ADDRESS OF	CARDHOLDER										
SECTION 3 -	CLAIMED IT	EM INFORMA	TION (PLEASE ATTACH ADDIT	IONAL ITEM(S) LIST AS NEE	DED)						
DESCRIPTION OF ITEM			MANUFACTURER	MODEL NUMBER	SERIAL NUMBER						
PURCHASE DATE			NAME OF VENDOR WHERE ITEM V	PURCHASE PRICE							
YYYY MM DD				\$							
WAS THE ITEM	M(S) GIVEN AS A	A GIFT(S)?									
NO [	YES (IF YES,	PLEASE PROV	IDE NAME AND ADDRESS OF RECI	PIENT(S) BELOW)							
SECTION 4 -	DETAILS OF	LOSS									
EXPLAIN HOW	/ THE MALFUNG	CTION OCCURF	RED								
DATE MALFUN	NCTION OCCUF	RRED	MALFUNCTION TYPE								
			MECHANICAL BREAKDOWN	FAILURE	OTHER (PROVIDE DETAILS:)						
YYYY	MM	DD									



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### SECTION 5 - REPAIR FACILITY INFORMATION

SECTION 3 - REPAIR FACILITY IN ORMATION													
REPAIR FACILITY NAME	TELEPHONE	NUM	1BER		EST	IMATE AMOUNT							
	(	)		-	\$								
STREET ADDRESS	CITY			PROVINCE	POS	TAL CODE							
SECTION 6 – OTHER INSURANCE/PROTECTION INFORMATION													
DO YOU HAVE ANY OTHER PERSONAL INSURANCE OR PROTECTION THAT WILL COVER THIS LOSS? (CHECK ONE)													
NO YES (IF YES, PLEASE SUBMIT A COPY OF THE PROVIDER'S WRITTEN DECISION REGARDING COMPENSATION FOR YOUR CLAIM.)													
NAME OF MERCHANT / PROVIDER			TELEPHONI	E NUMBER	_								
POLICY/PLAN NUMBER			TOTAL AMO	OUNT PAID BY OVIDER	\$								
PLEASE SUBMIT A COPY OF THE EXPLANATION OF BENEFITS THAT YOU RECEIVED FOR YOUR CLAIM.													
SECTION 7 – CERTIFICATION AND AUTHORIZATION													
I certify that the information I provided is true and correct to the best of my knowledge. I understand that this claim form must be complete and all required documentation submitted before my claim can be processed. I understand that this claim shall be void if, whether before or after the loss, I concealed or misrepresented any facts, or if any documents submitted have concealed or misrepresented any fact or circumstance concerning this claim.													
I authorize the policyholder, its agents and administrators to release to American Bankers Insurance Company of Florida ("Insurer"), its agents and administrators, all required information regarding my claim; and I authorize the Insurer, its agents and administrators to release to the policyholder, its agents and administrators, all required information regarding my claim. I further authorize the Insurer, its agents and administrators to obtain copies of any investigative reports or information appropriate for the processing of this claim. I am aware and understand that by providing my email address above, I may receive communications, notifications and documentation relating to my claim via email and that the Insurer cannot guarantee the security or privacy of such e-mail correspondence.													
I understand that American Bankers Insurance Company of Florida, and affiliates may collect, use and share personal information provided to them by me and obtained from others with my consent. They may use the information to establish and serve me as a customer or when required or permitted by law. My information may be processed and stored in the United States and may be subject to applicable laws. I hereby consent to the use of the personal information about me disclosed in all documents or information provided in connection with this claim for the purposes identified herein.													
CARDHOLDER'S SIGNATURE	DATE												
				Y	YYY	MM	DD						
For complete coverage information, please refer to your Certificate of Insurance. Insurance is underwritten by American Bankers Insurance Company of Florida. Claim payment and administrative services are provided by Assurant®.													
American Bankers Insurance Company of Florida and its subsidiaries and affiliates carry on business in Canada under the name of Assurant®.													
® Assurant is a registered trademark of Assurant, Inc.													