ASSURANT®

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

MOBILE DEVICE INSURANCE CLAIM FORM

SECTION 1 – DOCUMENTS REQUIRED TO PROCESS CLAIM

Fully complete, sign, and return this form along with the following documents to the address indicated above in order to avoid a delay in processing your claim. When submitting original copies, please do keep a copy for your records.

- ☐ Original sales receipt detailing the non-subsidized retail cost of your mobile device, date, tax, and description of purchase.
- ☐ A copy of your Desjardins credit card account statement at date of loss.
- ☐ If you charged the full purchase price of your mobile device to your account, the account statement showing the charge.
- ☐ If your mobile device was funded through a wireless service provider's term plan, proof of non-interrupted monthly wireless bill payments charged to the account for 12 months immediately preceding the date of loss.
- ☐ A copy of the written repair estimate from an authorized repair centre (for mechanical failure and accidental damage claims).
- ☐ A copy of any other insurance claim filed for this occurrence.
- ☐ A police, fire, insurance claim or loss report or other report of the occurrence of the accidental damage or theft of your mobile device (for accidental damage or theft claims).
- ☐ A copy of the original manufacturer's warranty (for mechanical failure claims).

At the sole discretion of the insurer, you may be required to send, at your own expense, the damaged item on which a claim is based to the insurer in order to support your claim.

SECTION 2 – INSURED INFORMATION

NAME OF CARDHOLDER (LAST, FIRST)	DESJARDINS CREDIT CARD NUMBER (FIRST 6 - LAST 4)
	-
EMAIL ADDRESS (OPTIONAL)	HOME TELEPHONE NUMBER ( ) -
ADDRESS OF CARDHOLDER	

SECTION 3 – CLAIMED ITEM INFORMATION (PLEASE ATTACH ADDITIONAL ITEM(S) LIST AS NEEDED)

DESCRIPTION OF ITEM	MANUFACTURER	MODEL NUMBER	SERIAL NUMBER / IMEI
PURCHASE DATE YYYY MM DD	NAME OF VENDOR WHERE PURCHASED		
RETAIL PRICE (NON-SUBSIDIZED) $	PURCHASE PRICE $	TAX $	

WAS THE ITEM(S) GIVEN AS A GIFT(S)?

☐ NO ☐ YES (IF YES, PLEASE PROVIDE NAME AND ADDRESS OF RECIPIENT(S) BELOW)

PLEASE COMPLETE AND ATTACH ALL DOCUMENTS AS OUTLINED IN SECTION ONE. THANK YOU.

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SECTION 4 – DETAILS OF LOSS

EXPLAIN HOW THE LOSS OCCURRED	
DATE LOSS OCCURRED YYYY MM DD	TYPE OF LOSS ☐ MECHANICAL FAILURE ☐ ACCIDENTAL DAMAGE ☐ THEFT ☐ OTHER (PROVIDE DETAILS)

SECTION 5 – REPAIR FACILITY INFORMATION (FOR MECHANICAL FAILURE AND ACCIDENTAL DAMAGE CLAIMS)

REPAIR FACILITY NAME	TELEPHONE NUMBER ( ) -	ESTIMATE AMOUNT $
STREET ADDRESS	CITY PROVINCE	POSTAL 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	TELEPHONE NUMBER ( ) -
POLICY/PLAN NUMBER	TOTAL AMOUNT PAID BY OTHER PROVIDER $

PLEASE SUBMIT A COPY OF THE EXPLANATION OF BENEFITS THAT YOU RECEIVED FOR YOUR CLAIM.

SECTION 7 – NOTIFICATION PROVIDED TO CANADIAN WIRELESS SERVICE PROVIDER OF LOSS

HAVE YOU CONTACTED YOUR CANADIAN WIRELESS SERVICE PROVIDER TO ADVISE OF THIS OCCURANCE? (CHECK ONE)

☐ NO	☐ YES	
	DATE NOTIFIED YYYY MM DD	TIME NOTIFIED

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SECTION 8 – 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		
	YYYY	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®.

PLEASE COMPLETE AND ATTACH ALL DOCUMENTS AS OUTLINED IN SECTION ONE. THANK YOU.