ASSURANT Solutions®
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
E-mail: inclusive.benefits@assurant.com

PURCHASE PROTECTION CLAIM FORM

SECTION ONE – 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.

- ❑ the original sales receipt detailing the cost, date and description of purchase;
- ❑ the Desjardins Credit Card Account statement showing the charge and/or the redemption of Your BONUSDOLLARS;
- ❑ 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 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 TWO – INSURED INFORMATION (PLEASE PRINT)

NAME OF CARDHOLDER: (LAST, FIRST)	DESJARDINS CREDIT CARD NUMBER FIRST 6 DIGITS: | | | | | | LAST 4 DIGITS: | | | |
EMAIL ADDRESS:	HOME TELEPHONE NUMBER ( ) _____ - _____
ADDRESS OF CARDHOLDER:	

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

ITEM DESCRIPTION:	MANUFACTURER:	MODEL:	DATE OF PURCHASE (YYYY/MM/DD)	NET PURCHASE PRICE CHARGED TO DESJARDINS CREDIT CARD ACCOUNT
1.			_____ /_____ /_____	$_____
2.			_____ /_____ /_____	$_____
3.			_____ /_____ /_____	$_____
				TOTAL AMOUNT CLAIMED: $_____

WAS THE ITEM(S) GIVEN AS A GIFT(S)? ☐ **YES** (IF YES, PLEASE PROVIDE NAME AND ADDRESS OF RECIPIENT(S) BELOW) ☐ **NO**

SECTION FOUR – DETAILS OF LOSS

LOCATION WHERE INCIDENT OCCURRED: (CITY, PROVINCE / STATE, AND COUNTRY)

EXPLAIN HOW THE INCIDENT OCCURRED:

DATE INCIDENT OCCURRED (YYYY/MM/DD) _____ /_____ /_____	INCIDENT TYPE: ☐ LOST ☐ STOLEN ☐ OTHER (PROVIDE DETAILS:)

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

ASSURANT Solutions®
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
E-mail: inclusive.benefits@assurant.com

PURCHASE PROTECTION CLAIM FORM

SECTION FIVE – OTHER INSURANCE INFORMATION (PLEASE PRINT)

DO YOU HAVE ANY OTHER PERSONAL INSURANCE OR PROTECTION THAT WILL COVER THIS LOSS? (CHECK ONE)

☐ **YES** (IF YES, PLEASE SUBMIT A COPY OF THE INSURER'S WRITTEN DECISION REGARDING COMPENSATION FOR YOUR CLAIM.)

☐ **NO**

NAME OF MERCHANT / PROVIDER:	TELEPHONE NUMBER	POLICY / PLAN NUMBER
	( ) _____ - _____	
TOTAL AMOUNT PAID BY OTHER INSURANCE: $_____		| | | | | | | | | | | | | |

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

SECTION SIX – CERTIFICATION AND AUTHORIZATION

I certify that the information I provide 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 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 Solutions.

American Bankers Insurance Company of Florida and its subsidiaries and affiliates carry on business in Canada under the name of Assurant Solutions.

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