

PROPERTY CLAIM FORM

All benefit payments are paid directly to your creditor.

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.)

- 1. Complete Sections 1 and 2.
- 2. Attach a copy of the sales ticket for each item being claimed and repair bill or estimate for damaged items. If repairs have been paid for, submit a copy of billing showing amount paid.
- 3. Attach a copy of the Police/Fire Department report, newspaper clipping, or other document verifying the incident causing the loss, or your claim will be returned.
- 4. If a loss is due to burglary, make sure police report indicates how entry was gained.
- 5. Attach a copy of your ENTIRE BILLING STATEMENT (including the top portion) for the month in which the incident occurred.

Fax completed form and all supporting documentation 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.

CA residents only: For your protection California law requires the following to appear on this form: 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.

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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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
 American Reliable Insurance Company
 Reliable Lloyds Insurance Company
 Voyager Indemnity Insurance Company**
 P.O. Box 977122, Miami, FL 33197-7122 • 1.800.859.0490 • Fax 305.252.6910
 Attn: DFS Claims Department

WWW.BENEFITACTIVATIONS.COM

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SECTION 1 - CLAIMANT'S INFORMATION

PLEASE PRINT

NAME OF FINANCIAL INSTITUTION OR STORE THAT ISSUED CARD		ACCOUNT NUMBER	
NAME OF CLAIMANT			
CLAIMANT'S STREET ADDRESS/APT. #		CITY	STATE ZIP CODE
TELEPHONE NUMBER (DAY) ()	TELEPHONE NUMBER (EVENING) ()	CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)	
<p>I AUTHORIZE any insurance or reinsuring company, insurer, law enforcement agency, fire department, or other organization, or person having any records, data, or information concerning this claim to furnish such record, 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 as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.</p> <p>I, or my authorized representative, have the right to receive a copy of this authorization.</p> <p>This authorization shall remain valid for the duration of the claim.</p>			
<p>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.</p>			
CLAIMANT'S NAME (PLEASE PRINT) X		CLAIMANT'S SIGNATURE X	DATE / /

SECTION 2 - PROPERTY CLAIM

PLEASE PRINT

TO BE COMPLETED BY ACCOUNTHOLDER			
NAME OF STORE WHERE ITEM(S) WAS PURCHASED	TYPE OF LOSS (FIRE, BURGLARY, ETC.)	CAN ITEM(S) BE REPAIRED <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE OF LOSS / /
HOW DID LOSS OCCUR (GIVE DETAILS)			

List all items purchased with your credit card that you are claiming as a loss.

ARTICLE/MODEL NUMBER	PURCHASE DATE	PURCHASE PRICE	TAX	REPAIR COST (ATTACH ESTIMATE)
	/ /	\$		\$
	/ /	\$		\$
	/ /	\$		\$
	/ /	\$		\$
	/ /	\$		\$
	/ /	\$		\$
TOTAL AMOUNT CLAIMED		\$		\$