

**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**  
**AFTER 30 CONSECUTIVE DAYS OF UNEMPLOYMENT**

1. Read eligibility notice.
2. Complete Section A.
3. Attach a copy of your State Determination Letter, Unemployment check stub(s), Unemployment debit card statement(s) or Registration Card from a recognized Employment Agency or Job Service for the dates you are claiming.
4. Have your Financial Institution (creditor/retailer) that issued your insurance certificate complete Section B.
5. Attach a copy of Certificate of Insurance/Policy or Ledger card indicating premium charged.
6. If premiums are paid monthly, please submit Statement of Account for the month in which unemployment occurred.
7. Have your Most Recent Employer complete Section C.
8. Have your Previous Employer complete Section D.
9. Follow your creditor's instructions for mailing the completed claim form.

Mail completed form and all supporting documentation 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.

**UNEMPLOYMENT CLAIM FORM**  
**All benefit payments are paid directly to your creditor.**

**INSTRUCTIONS**

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 UNEMPLOYMENT**

- 1. Read Eligibility Notice.
- 2. Complete Section A.
- 3. Attach a copy of **your State Determination Letter, Unemployment check stub(s), Unemployment debit card statement(s) or Registration Card from a recognized Employment Agency or Job Service** for the dates you are claiming.
- 4. Have your **Financial Institution** (creditor/retailer) that issued your insurance certificate complete Section B.
- 5. Attach a copy of Certificate of Insurance/Policy or Ledger Card indicating premium charged.
- 6. If premiums are paid monthly, please submit Statement of Account for the month in which unemployment occurred.
- 7. Have your **Most Recent Employer** complete Section C.
- 8. Have your **Previous Employer** complete Section D (if most recent employment was less than 12 months).
- 9. Have Section E completed if Sections C and D do not equal 12 months.

**ELIGIBILITY NOTICE**

To qualify for involuntary unemployment benefits, you must first verify that you were employed continuously during a PERIOD immediately before the effective date of your insurance certificate. Also, this employment must have been for salaries or wages and you must have been working at least 30 hours per week.

To obtain the length of your QUALIFICATION PERIOD, please refer to your certificate of insurance or contact the Financial Institution (creditor, retailer) where the insurance was purchased.

Verification of continuous employment during the QUALIFICATION PERIOD may require statement from more than one previous employer.

**FAILURE TO COMPLETE REQUIRED SECTIONS AND PROVIDE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.**

- **To avoid late fees, continue to make your payments until you receive notification that your claim has been approved.**
- If your claim is approved, a continuing claim form must be submitted every 30 days for additional payments to be made.
- After mailing your claim, please allow 15 business days for processing.

**UNEMPLOYMENT CLAIM FORM**

**A. CLAIMANT'S STATEMENT PLEASE PRINT**

NAME OF CLAIMANT		DATE OF BIRTH / /		CLAIMANT'S E-MAIL ADDRESS (IF AVAILABLE)	
STREET ADDRESS/APT #		CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )
LAST DATE WORKED / /		REASON FOR INTERRUPTION OF EMPLOYMENT <input type="checkbox"/> Laid Off <input type="checkbox"/> Terminated <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Retired <input type="checkbox"/> Quit <input type="checkbox"/> Resigned <input type="checkbox"/> Disability <input type="checkbox"/> Other			
ARE YOU RECEIVING STATE UNEMPLOYMENT BENEFITS FOR THIS PERIOD OF YOUR UNEMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YOU ARE NOT RECEIVING STATE UNEMPLOYMENT BENEFITS, PLEASE EXPLAIN WHY (If you have signed up with a state or local employment service, please provide us with a copy of the card)			
HAVE YOU RETURNED TO WORK <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time		DATE RETURNED TO WORK / /		# OF HOURS PER WEEK	

**I. I AUTHORIZE** any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring 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 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 state specific Fraud Statements, see page 5.**

CLAIMANT'S SIGNATURE <b>X</b>	SOCIAL SECURITY NUMBER - -	DATE / /
----------------------------------	-------------------------------	-------------

**Benefits totaling \$600.00 or more will be taxed.**

B. CREDITOR'S STATEMENT					(to be completed by Creditor/Retailer that issued certificate)		PLEASE PRINT
CERTIFICATE NUMBER (include prefix)	DATE OF ISSUE	TERM IN MONTHS	AGENT'S CODE	BRANCH NO.	FORM NUMBER (of certificate)		
ACCOUNT/LOAN NUMBER	POLICY EXPIRES		DATE OF LOAN		MONTHLY PAYMENT AMOUNT		
WAS THIS LOAN REFINANCED <input type="checkbox"/> Yes <input type="checkbox"/> No		PREVIOUS LOAN #	PREVIOUS POLICY # / CERTIFICATE #				
NAME OF INSURED DEBTOR			FIRST BENEFICIARY - CREDITOR				
STREET ADDRESS OF FIRST BENEFICIARY - CREDITOR			CITY	STATE	ZIP CODE		
AUTHORIZED REPRESENTATIVE (Please print)		SIGNATURE OF AUTHORIZED REPRESENTATIVE		DATE	TELEPHONE NUMBER		
		X		/ /	( )		

C. MOST RECENT EMPLOYER'S STATEMENT				PLEASE PRINT
TO BE COMPLETED BY EMPLOYER ONLY				
EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)		DATE OF HIRE	HIRED FOR	
		/ /	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal	
NUMBER OF HOURS WORKED PER WEEK	NUMBER OF MONTHS WORKED	EMPLOYMENT INTERRUPTED		
		Last Day Worked / /    Date Returned to Work / /		
EMPLOYEE'S JOB TITLE				
REASON FOR INTERRUPTION OF EMPLOYMENT				
<input type="checkbox"/> Laid Off <input type="checkbox"/> Quit <input type="checkbox"/> Terminated <input type="checkbox"/> Resigned <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Disability <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Retired <input type="checkbox"/> Other				
NAME OF EMPLOYER			TELEPHONE NUMBER	EXTENSION
			( )	
STREET ADDRESS		CITY	STATE	ZIP CODE
COMPLETED BY (PRINT NAME)		SIGNATURE	DATE	
		X	/ /	

D. PREVIOUS EMPLOYER'S STATEMENT				PLEASE PRINT
(complete only if most recent employment was less than 12 months)				
TO BE COMPLETED BY EMPLOYER ONLY				
EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)		DATE OF HIRE	TYPE OF EMPLOYMENT	
		/ /	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal	
NUMBER OF HOURS WORKED PER WEEK	NUMBER OF MONTHS WORKED	EMPLOYMENT INTERRUPTED		
		Last Day Worked / /    Date Returned to Work / /		
EMPLOYEE'S JOB TITLE				
REASON FOR INTERRUPTION OF EMPLOYMENT				
<input type="checkbox"/> Laid Off <input type="checkbox"/> Quit <input type="checkbox"/> Terminated <input type="checkbox"/> Resigned <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Disability <input type="checkbox"/> Assignment Ended <input type="checkbox"/> Retired <input type="checkbox"/> Other				
NAME OF EMPLOYER			TELEPHONE NUMBER	EXTENSION
			( )	
STREET ADDRESS		CITY	STATE	ZIP CODE
COMPLETED BY (PRINT NAME)		SIGNATURE	DATE	
		X	/ /	

E. EMPLOYER'S STATEMENT				PLEASE PRINT
(complete if Sections C and D do not equal 12 months of employment)				
TO BE COMPLETED BY EMPLOYER ONLY				
EMPLOYEE'S NAME (FIRST/MIDDLE/LAST)		DATE OF HIRE	TYPE OF EMPLOYMENT	
		/ /	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal	
NUMBER OF HOURS WORKED PER WEEK	NUMBER OF MONTHS WORKED	EMPLOYMENT INTERRUPTED		
		Last Day Worked / /    Date Returned to Work / /		
EMPLOYEE'S JOB DESCRIPTION AT TIME OF RELEASE				
REASON FOR INVOLUNTARY RELEASE				
NAME OF EMPLOYER		TELEPHONE NUMBER	EXTENSION	FAX NUMBER
		( )		( )
STREET ADDRESS		CITY	STATE	ZIP CODE
COMPLETED BY (PRINT NAME)		SIGNATURE	TITLE	DATE
		X		/ /

**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.