AMERICAN BANKERS INSURANCE COMPANY OF FLORIDA
AMERICAN BANKERS LIFE ASSURANCE COMPANY OF FLORIDA
Financial Claims, P.O. Box 7000, Kingston, Ontario K7L 5V3
Telephone: 1-800-361-5344
Fax: 1-800-645-9405

SELF-EMPLOYMENT AFFIDAVIT

INSURED'S NAME:	ACCOUNT NUMBER:	DATE LAST WORKED:
INSURED'S ADDRESS:		
HOME TELEPHONE NUMBER:	EMAIL ADDRESS (IF AVAILABLE):	

ARE YOU STILL OFF WORK? ☐ YES ☐ NO

IF NO, DATE YOU RETURNED TO WORK:

I hereby certify that I was employed for wages or profit for at least _________ hours per week.
(Please fill in how many hours per week you worked)

What date did your business start ___________________ to ___________________ ?

My occupation is:____

BUSINESS NAME & ADDRESS:

MY BUSINESS IS OPERATED FROM MY RESIDENCE: ☐ YES ☐ NO

BUSINESS TELEPHONE NUMBER:	FAX NUMBER:
BUSINESS LICENSE NUMBER:	TAX IDENTIFICATION NUMBER:

CLAIMANT'S AUTHORIZATION

I certify that the above information is true and correct. I authorize any Employer, Physician, Hospital, Insurer or other organization, or person having my records, data or information concerning this claim, to furnish such record, data or information to Assurant or authorized representative if requested. I understand that in executing this authorization, I waive the right for such information to be privileged.

CLAIMANT'S SIGNATURE:	DATE:

Subscribed and sworn before me, a Notary Public or Commissioner of Oaths for the Country of ____________________________________,

Signature: ____.

Province of ____________________________________ this date ______________________ of ______________________________, 20____.

NOTARY PUBLIC OR COMMISSIONER OF OATHS LEGAL SEAL STAMP.

A COPY OF THIS FORM WILL NOT BE ACCEPTED.

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SELF-EMPLOYMENT QUESTIONNAIRE

INSURED'S NAME	ACCOUNT NUMBER	DATE LAST WORKED

☐ STILL OFF WORK ☐ DATE RETURNED TO WORK: ________________________

A. NATURE OF BUSINESS

COMPLETE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR BUSINESS.

ARE YOU THE SOLE PROPRIETOR? – IF NO, LIST PARTNER(S)

☐ YES ☐ NO ____

STARTING DATE OF THIS BUSINESS: ____

B. JOB DUTIES

WHAT ARE YOUR JOB DUTIES IN CONNECTION WITH THIS BUSINESS? ________________________________

IF LIFTING? ☐ YES ☐ NO PLEASE GIVE MAXIMUM WEIGHT YOU WILL BE LIFTING ________________________

DO YOU HAVE ANY EMPLOYEES? ☐ YES ☐ NO IF YES, HOW MANY? ________________	HAVE ADDITIONAL EMPLOYEES BEEN HIRED TO REPLACE YOU DURING YOUR ABSENCE AT WORK? ☐ YES ☐ NO

WHAT PERCENTAGE OF YOUR TIME WAS SPENT AT EACH OF THE FOLLOWING PRIOR TO THE ONSET OF YOUR DISABILITY?

SUPERVISORY / ADMINISTRATIVE ________________% MANUAL WORK ________________%

IF YOU DO NOT PERFORM THE VARIOUS ADMINISTRATIVE DUTIES (ie, TAX ACCOUNTING, BOOKKEEPING), PLEASE PROVIDE THE NAME(S) AND ADRESSE(S) OF THE PERSON(S) OR BUSINESS(ES) THAT PERFORM THESE DUTIES.

WERE YOU WORKING FULLTIME (ie, 30 HOURS PER WEEK) PRIOR TO THE ONSET OF YOUR DISABILITY? – IF NO, PLEASE EXPLAIN.

HAVE YOU RETURNED TO WORK IN ANY CAPACITY – IF SO, PLEASE STATE THE DUTIES PERFORMED, THE NUMBER OF HOURS PER WEEK AND THE DATE RETURNED.

IF YOU HAVE NOT RESUMED ANY DUTIES, WHEN DO YOU ANTICIPATE YOU WILL BE RETURNING TO EITHER FULLTIME OR PART TIME DUTIES.

I certify that the above information is true and correct

CLAIMANT'S SIGNATURE:	DATE:

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