CLAIM AND WAIVER FORM- FAMSA FAMILYSAVINGS PLAN
CUSTOMER CLUB PROGRAM

Use this claim form for all Product Protection Waivers, Accidental Death and Dismemberment Claims, Courtesy Waivers and Unemployment Waivers. Complete the Store and Customer information on ALL waivers and claims. Then complete the appropriate box for type of waiver or claim being filed. **ALL WAIVERS AND CLAIMS MUST BE ACCOMPANIED WITH: A COPY OF THE MEMBERSHIP AGREEMENT, A COPY OF THE RENTAL AGREEMENT(S) AND A COPY OF THE PAYMENT HISTORY SHOWING CLUB PAYMENTS. SEND CLAIM FORM WITH SUPPORT INFORMATION TO: customerservice@benefitmarketingsolutions.com, FAX (405) 579-0534 OR MAIL TO CLAIMS DEPARTMENT, 900 36TH AVE. NW, SUITE 105 NORMAN, OK 73072. FOR QUESTIONS CALL TOLL-FREE 1-888-322-6705.**

STORE INFORMATION		CUSTOMER INFORMATION	
NAME		NAME	
STORE NUMBER		SOCIAL SECURITY NUMBER	
STREET ADDRESS		STREET ADDRESS	
CITY/STATE/ZIP		CITY/STATE/ZIP	
STORE MANAGER		DAYTIME PHONE ( )	
STORE PHONE ( )	TODAY'S DATE	DATE OF MEMBERSHIP	DATE OF LOSS

PRODUCT PROTECTION WAIVER

(Customer must provide police/fire report; Store must provide a print screen showing original cost of the merchandise and pictures.)

ITEMS CLAIMED MUST BE LISTED BELOW

❑ Burglary ❑ Fire ❑ Other: Describe _____

LIST OF PROPERTY:

IF ADDITIONAL SPACE IS NEEDED PLEASE ATTACH A SEPARATE SHEET OR USE A SECOND CLAIM FORM.

TOTAL AMOUNT BEING CLAIMED $

ACCIDENTAL DEATH & DISMEMBERMENT CLAIM / COURTESY WAIVER

(Customer must provide Certified Copy of Death Certificate.)

_____ (Date of Death) _____ (Location) _____ (Cause of Death)

_____ (Beneficiary) _____ Beneficiary's Current Address, City, State, Zip)

Briefly describe circumstances of accident: _____

INVOLUNTARY UNEMPLOYMENT WAIVER / ACCIDENT & SICKNESS WAIVER

(Unemployment: Customer must provide verification of loss from former employer and proof of registration with state unemployment office.)
(Accident/Sickness: Customer must provide letter from employer and statement from physician indicating length of time out of work.)

UNEMPLOYMENT BENEFITS ARE REPORTED TO THE INTERNAL REVENUE SERVICE (IRS) FOR TAX PURPOSES. INCOME TAX IS NOT WITHHELD FROM YOUR UNEMPLOYMENT BENEFITS. CONTACT THE IRS FOR ADDITIONAL INFORMATION. 1099 FORMS ARE MAILED IN JANUARY.

1A. Unemployment Wavier/Claim: How did unemployment occur? ❑ Laid Off ❑ Fired ❑ Strike ❑ Other:
(Disability is covered under Accident/Sickness. Must be continuously unemployed for 30 days.)
If other, explain: _____

1B. Accident/Sickness Waiver/Claim: How did unemployment occur? ❑ Sickness ❑ Injury ❑ Other:
If other, explain: _____
Have you visited your physician? ❑ Yes ❑ No Date of visit? _____

2. List the Name, Address and Phone Number of all Previous Employer(s) for the past 6 months and the Length of Time employed there.

_____

_____

3. Unemployment Waiver/Claim: Have you registered with State Unemployment Office or Agency? ❑ Yes ❑ No
Date Registered: _____
For both Involuntary Unemployment and Accident/Sickness member must be continuously employed for 6 months at a minimum of 30 hours per week prior to job interruption.

4. Date you expect to become employed or return to work: _____

CUSTOMER WARNING AND SIGNATURE

CUSTOMER WARNING (FOR INSURANCE CLAIMS 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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES. FOR STATE SPECIFIC FRAUD STATEMENTS SEE REVERSE SIDE OF THIS FORM.

Customer Signature _____ Date _____

(Claims Department Copy)