INVOLUNTARY UNEMPLOYMENT INSURANCE CLAIM FOR
W.S. BADCOCK CORPORATION
Customer Insurance Department
P.O. Box 497, Mulberry, Florida 33860 • (844) 556-9262 • Fax: (863) 869-7964

TO BE ELIGIBLE FOR BENEFITS, THE CLAIMANT MUST:

1. Be out of work as the result of INVOLUNTARY UNEMPLOYMENT for the specified time period as required by the policy.
2. Have been gainfully employed working for salary or wages as stated in the policy.
3. Be an insured individual.
4. Provide monthly proof of continuing unemployment as outlined in Section 4.
5. Not receive income for work performed during any period in which benefits may be due. (For example, a person who chooses an alternative pay method and is paid over a 12 month period, but only works 9 months).

IF THE LOSS IS DUE TO EITHER LAYOFF OR EMPLOYER TERMINATION, THE CLAIMANT MUST:

1. Provide Final Determination Letter from the State if reason for unemployment is termination or a separation letter from your employer.
2. Notify Creditor of loss within 30 days of loss.

IF THE LOSS IS DUE TO GENERAL STRIKE, UNIONIZED LABOR DISPUTE, OR LOCKOUT, THE CLAIMANT MUST PROVIDE THE COMPANY WITH PROOF OF LOSS FROM A UNION OFFICIAL OR OTHER SOURCE AT THE TIME OF LOSS.

CLAIMS WILL NOT BE HONORED IF:

1. The Claimant has voluntarily forfeited salary, wages, or other employment income.
2. The Claimant has resigned, retired, or is incarcerated.
3. The loss of income is due to disability caused by sickness, disease, accident, or pregnancy.

TO AVOID DELAY IN PROCESSING THIS CLAIM:

All questions must be fully answered in Sections 1, 2 and 3. Please return this completed form, along with a copy of the Insurance Election Form, to your local Badcock Store or to the address shown above.

Section 1. ACCOUNT HOLDER (CUSTOMER) INFORMATION (To Be Completed by Your Badcock Representative.)

Account Number and Store Code _____ Ins. Code_____ Year-to-Date _____/_____/_____

Account Holder's (Customer's) Name _____

Mailing Address _____ City/State/Zip Code _____

Social Security Number _____ Date of Birth_____/_____/_____ Telephone Number _____

Email Address _____

Due Date_____ Balance As of Date of Loss _____ Monthly Benefit Amount _____

I HEREBY CERTIFY THAT THE ABOVE IS COMPLETE AND CORRECT:

Authorized W.S. Badcock Corporation Representative _____ Date _____

Section 2. CLAIMANT INFORMATION (To Be Completed by the Customer.)

Reason for Unemployment: Terminated _____ Layoff _____ Voluntarily Resigned _____ Medical* _____

*If unemployment due to Medical, please complete Disability Claim Form

Name of Employer at Time of Unemployment _____

Complete Address of Employer _____

_____ Telephone Number _____

CLAIMANT AUTHORIZATION (Please Read, Sign and Date.)

I certify that the above information is true and correct. I AUTHORIZE any employer, union, or other organization or persons having any records, data, or information concerning this claim to furnish such records, data, or information to the Insurance Company or its authorized representative as requested. 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 that this information will be used by the Insurance Company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the term of the policy.

I hereby certify that I have read and understand the attached Fraud Warning Statement and unemployment guidelines.

Signature of Claimant _____ Date _____

Section 3. EMPLOYMENT INFORMATION Please have the Employer complete and sign the information below, or if unemployment is due to facility closure or shutdown, please provide your Letter of Separation and complete the following to the best of your knowledge.

Employer's Name _____ Telephone Number _____

Employer's Mailing Address _____ City/State/Zip Code _____

Employee's Job Description _____

Reason for Leaving (Check One):

- Layoff (other than seasonal)
- Seasonal Layoff
- Left Voluntarily or Retirement
- Facility Closure or Shutdown
- Lockout or Strike
- Medical
- Terminated*

_____/_____/_____ Employed from

_____/_____/_____ Employed through

***If Terminated, provide reason:** _____

(A copy of the Final Determination from the State, showing reason for unemployment, must be submitted with claim)

Employee was working for salary or wages? Yes: No:

Has Employee returned to work? Yes: No: If Yes, date of return: _____/_____/_____ Hours Worked _____

_____ Printed Name of Authorized Employer or Union Representative

_____ Title

_____ Date

_____ Signature of Authorized Employer/Union Representative

Section 4. PROOF OF CONTINUING UNEMPLOYMENT

Every month a continuation letter will be sent out requiring updated proof of continuing unemployment. You **must** fully complete these continuation letters, sign and date, then return to our office for further consideration of future benefits to be paid. Along with the signed and dated continuation letter, you must attach a copy of your unemployment check stub, bank statement showing direct deposit of unemployment funds or State Payment History.

STATE SPECIFIC FRAUD WARNINGS

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under this title.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas and New Mexico Residents: 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.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: 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.

Delaware and Idaho Residents: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of a claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia and Washington DC Residents: 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.

DETACH AND PROVIDE TO CUSTOMER

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana and Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Virginia Residents: 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 a denial of insurance benefits.

Maine Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota Residents: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. §638:20.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 violation.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: 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.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or application containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact may be guilty of an insurance fraud, which is a crime, and may be subject to prosecution.

Pennsylvania Residents: 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.

Texas, West Virginia and Alabama Residents: 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, or any combination thereof.

All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.