

Dear Customer:

You made a wise decision when you decided to enroll in the SafeLine® Account Protection Plus Plan in connection with your WebBank/Fingerhut Credit Account.

On the reverse side of this letter is the SafeLine Benefit Activation Application you requested.

Please complete the Benefit Activation Application and send it back to us with the documentation requested on the form. For unemployment applicants, please send proof of unemployment from your state. Acceptable proof would include a confirmation of unemployment benefits letter from your state, a check stub, or copies of your bank statements showing the direct deposits from your state unemployment office. For hospitalization applicants, acceptable proof would include a doctor's statement, or a hospital statement/bill.

Please return the completed form within 30 days. When we have received all the required information, we will review your request for benefit activation and send you notification confirming the status of your request.

If you have any further questions on this matter, please call Customer Service at 1-800-208-2500, or write to the address below.

Customer Service SafeLine Account Protection Plus Plan 6250 Ridgewood Rd St. Cloud, MN 56303

Sincerely,

Fingerhut
Customer Service

7552/

SAFELINE® ACCOUNT PROTECTION PLAN

OFFERED BY WEBBANK C/O FINGERHUT 6250 RIDGEWOOD RD ST. CLOUD, MN 56303

SAFELINE BENEFIT ACTIVATION APPLICATION

Please Circle Claim Type:	Unemployment	Disab	oility L	eave of Absence I	Iospitalization
*For unemployment and leave of absence complete contact information and employment sections. **For disability and hospitalization					
complete ALL sections. NAME AND ADDRESS			10	10 DIGIT CUSTOMER NUMBER	
			_		
			Т	ELEPHONE NUMBER	
			_		
Lauthoriza any porson institution or	organization in nosse	ession of inform	ation concerni	na my medical or employmen	t history including any
I authorize any person, institution or organization in possession of information concerning my medical or employment history including any hospitalization, consultation, diagnosis, treatment or prescriptions, to provide the information requested below to WebBank and furnish Fingerhut with such information including, copies of all employment or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.					
CLAIMANT'S SIGNATURE	SOCIAL SECUR			Y NUMBER	DATE
Employer Name	Employer Phone Number				
Employer Address			C	City, State, Zip Code	
Employed From	То		Н	lours per Week	
Date of Unemployment or Leave of A	Absence		L	ength of Leave of Absence	
Reason for Unemployment or Leave of Absence					
DOCTOR'S STATEMENT (to be furnished without any expense to SafeLine Account Protection Plan or its affiliates.)					
FINDINGS: (Please provide a brief description of the patient's disabilities or reason for hospitalization.)					
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IS DISABILITY PERMANENT? YES NO (circle one) CAN PATIENT PERFORM ACTIVITIES OF DAILY LIVING? YES NO (circle one)					
GIVE EXACT DATES OF DISABILITY OR HOSPITALIZATION (unable to work) FROM: / / TO: / /					
"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my					
knowledge and belief."					
PHYSICIAN'S NAME AND DEGREE (PRINT NAME) STREET ADDRESS/CITY/STATE/ ZIP CODE					
PHYSICIAN'S SIGNATURE	DATE	MEDICAL II	D NIIMRER	TELEPHONE NUMBER	FAX NUMBER
	DILLE	MEDICALI	DIGNIDER	LEEL HOME NUMBER	1711 HOMBER
X	, ,			()	