ASSURANT®

American Bankers Insurance Company of Florida
American Bankers Life Assurance Company of Florida

April 15, 2021

WON HYUK CHO
10905 74 AVE NW
EDMONTON AB T6G2T6
CANADA

Claim Number:	10048446001
Account Number Ending In:	0306
Date of Loss:	03/01/2020
Coverage Type:	Loss of Self Employment

Additional information is needed to determine benefit eligibility.

Dear WON HYUK CHO:

We have received your claim for benefits under TD Bank Credit Card Balance Protection Plus. Some of the information provided was not complete. In order to determine benefit eligibility additional information is needed.

Please provide the following:

- The cause of your loss is required to submit a claim.
- The completed enclosed Initial Claim Form. Please read the instructions on page one to determine which sections are required.
- Provide the hours per week that you were employed prior to the Date of Loss.
- The completed enclosed self-employment affidavit. Please have the completed form notarized and send the original copies, with the notary public or commissioner of oath legal seal stamp.

ACTION REQUIRED:

- Return by one of the methods listed below
- Must be received by 05/14/2021

Important Reminder: Please continue to make at least the Minimum Monthly Payment due on your Account until you are notified that your request has been approved.

To ensure we are providing you with timely and accurate service, please include the above claim number, in future correspondence with our office.

If you have any questions or concerns, please do not hesitate to contact one of our Customer Service Representatives by any of the methods listed below.

Please contact TD Bank if you have any questions regarding the status of your credit card account.

Get Information | Submit Documents | Contact Us

Online: cardbenefits.assurant.com

Phone: 1-866-315-9069

Fax: 1-800-645-9405

Mail: Assurant Financial Claims Team
P.O. Box 7000
Kingston, Ontario K7L 5V3
A return envelope is enclosed.

Sincerely,

Assurant Financial Claims Team
1-866-315-9069
Monday - Friday 8 a.m. - 8 p.m. ET

TD Bank Credit Card Balance Protection Plus is underwritten by American Bankers Insurance Company of Florida (ABIC) and American Bankers Life Assurance Company of Florida (ABLAC). ABIC and ABLAC carry on business in Canada under the trade name of Assurant®. ®Assurant is a registered trademark of Assurant, Inc.

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LOSS OF SELF-EMPLOYMENT CLAIM FORM

WE'RE HERE TO HELP! Please note the following important information regarding filing a claim with Assurant.

- It is important that you complete all required sections and include documentation to avoid delays in processing your claim.
- If required, use a separate sheet of paper to include the name and account numbers of multiple accounts also covered by Assurant.
- You are responsible for continuing to make payments on your account until a decision is made by us on any claim submitted under the Certificate.

Complete sections for your claim type as identified below:

Review the checklist to make sure that you have provided all required documentation and have completed, signed and obtained signatures for all required sections in full.

1

FOR ALL CLAIMS:

☐ Complete and sign Section 1 & 2.

☐ NOTE: If you wish to authorize a family member or friend to speak on your behalf, please complete the 'Verbal Release of Information', part of Section 2. This authorization will allow them to discuss your claim with a representative of Assurant if you are not available.

2

FOR LOSS OF SELF-UNEMPLOYMENT

☐ For Loss of Self-Employment, please submit your claim form after 90 consecutive days of Loss of Self-Employment.

☐ Please return the **original** Self-Employment Affidavit notarized by a Notary Public or a Commissioner of Oaths.

3

MAIL THE COMPLETED FORMS AND ALL SUPPORTING DOCUMENTATION

Assurant, Financial Claims
P.O. Box 7000, Kingston, Ontario, K7L 5V3

We recommend that you retain copies of all documentation submitted to us for review.

Once your claim has been submitted, please allow 15 business days for processing. All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

WE'RE HERE TO HELP!
Call us if you have a question about submitting a claim.
Call toll-fee: 1-866-315-9069

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Financial Claims, P.O. Box 7000, Kingston, Ontario, K7L 5V3
Telephone: 1-866-315-9069
Fax: 1-800-645-9405

PLEASE PRINT

SECTION 1
CLAIMANT INFORMATION
Please complete for all claims being submitted

CREDITOR NAME:	ACCOUNT NUMBER:
TD Bank	**0306**

NAME OF CLAIMANT

LAST NAME	FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH: MM/ DD/ YY	AGE:
Cho	Wonhyuk	09 / 17 / 90	30

PREFERRED METHOD OF CONTACT	EMAIL ADDRESS:
☐ Mail ☐ Email	

ADDRESS:

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER:
10905 74Ave	Edmonton	AB	T6G 2T6	(780) 203 3879

DO YOU QUALIFY TO RECEIVE UNEMPLOYMENT BENEFITS FROM SERVICE CANADA?	HAVE YOU RETURNED TO WORK?	IF YES, WHAT DATE DID YOU RETURN TO WORK?
☑ YES ☐ NO	☐ YES ☑ NO	MM/ DD/ YY

NAME OF PRIMARY CARDHOLDER: (FIRST NAME ON BILLING STATEMENT)

LAST NAME	FIRST NAME, MIDDLE INITIAL	RELATIONSHIP TO CLAIMANT:
Cho	Wonhyuk	ME

SECTION 2
AUTHORIZATION
Please certify that the information given here is true and correct.

I AUTHORIZE any current or former employer, worker's compensation body, physician, hospital, clinic, insurance company, law enforcement agency, fire department, or other entity or person, including the group policyholder, that has any personal, financial or medical records or knowledge in regard to the claimant/deceased, to release and provide full details (including furnishing copies) of all available personal, financial and medical information records and knowledge, including prior medical history, toxicological or pathological findings which they may possess to the above noted insurer(s) in regard to the claim, its authorized administrator (ASSURANT), its re-insurer, or their respective agents.

The information is to be used in the evaluation of an insurance claim and for the purposes relating to such claim. This consent shall be valid during the continuation of such claim.

I also authorize the insurer, its authorized administrator, its re-insurers, the group policyholder and their respective agents to exchange and or transmit information concerning this claim to the organization listed above as necessary to evaluate this claim.

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.

CLAIMANT SIGNATURE:	DATE: MM/ DD/ YY
[signature]	27 / 04 / 21

VERBAL RELEASE OF INFORMATION

Customer privacy and the protection of private and confidential information is important to us. We do understand that in some cases, a claimant may wish to have someone speak to Assurant on his or her behalf. Please complete this authorization section if you wish to have another individual discuss the details of your claim. Without this authorization we are unable to speak to anyone other than the claimant.

I give my authorization to Assurant to speak to hyesen ko,

who is my Mom, with regard to my claim.

CLAIMANT SIGNATURE:	DATE: MM/ DD/ YY
Gina	27 / 04 / 21

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Telephone: 1-866-315-9069
Fax: 1-800-645-9405

PLEASE PRINT

SELF-EMPLOYMENT AFFIDAVIT

CREDITOR NAME:	ACCOUNT NUMBER:	DATE LAST WORKED: ____ / ____ / ____ (MM / DD / YY)
TD Bank	0306	

CLAIMANT'S NAME

LAST NAME:	FIRST NAME, MIDDLE INITIAL:
Cho	wonhyuk

ADDRESS

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER:
109 of 74Ave	Edmonton	AB	T6G 2T6	(780) 2003879

HOME TELEPHONE NUMBER: ( )	E-MAIL ADDRESS (IF AVAILABLE):

ARE YOU STILL OFF WORK?	IF NO, DATE YOU RETURNED TO WORK:	NUMBER OF HOURS WORKED PER WEEK:	EXPECTED RETURN TO WORK DATE:
☑ YES ☐ NO	____ / ____ / ____ (MM / DD / YY)	40	____ / ____ / ____ (MM / DD / YY)

WHAT PERCENTAGE OF YOUR TIME WAS SPENT AT EACH OF THE FOLLOWING: SUPERVISORY / ADMINISTRATIVE _____% MANUAL WORK _____%

MY OCCUPATION IS:	WHAT DATE DID YOUR BUSINESS START:	WHAT DATE DID YOUR BUSINESS CLOSE:
Chef	02 / 02 / 2019 (MM / DD / YY)	03 / 3 / 2020 (MM / DD / YY)

REASON FOR CLOSURE: ☐ BANKRUPTCY ☐ FINANCIAL REASONS ☐ SEASONAL ☑ LACK OF WORK ☐ INJURY/ILLNESS ☐ OTHER _____

BUSINESS INFORMATION

WAS BUSINESS INCORPORATED OR REGISTERED:	WHAT DATE WAS BUSINESS INCORPORATED OR REGISTERED:
☑ YES ☐ NO	____ / ____ / ____ (MM / DD / YY)

BUSINESS NAME:	MY BUSINESS IS OPERATED FROM MY RESIDENCE:
Butternut tree	☐ YES ☐ NO

STREET	CITY	PROVINCE	POSTAL CODE	CONTACT TELEPHONE NUMBER:
9707 110 ST NW	Edmonton	AB	T5K 2L9	(780) 760 2271

BUSINESS TELEPHONE NUMBER: ( )	FAX NUMBER: ( )
BUSINESS LICENSE NUMBER:	GST 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: 04 / 27 / 21 (MM / DD / YY)

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

Signature: _____.

Province of AB this date 04 27 of _____, 2021.

NOTARY PUBLIC OR COMMISSIONER OF OATHS LEGAL SEAL STAMP.

A COPY OF THIS FORM WILL NOT BE ACCEPTED.