**TD Insurance**
**Instructions for completing the Critical Accident Recovery Plan Insurance Dismemberment Claim Form**

**The Critical Accident Recovery Plan Insurance - Dismemberment claim package contains three parts:**

- ☐ **Part A:** Critical Accident Recovery Plan Insurance - Dismemberment claim form
- ☐ **Part B:** Attending Physician's Statement
- ☐ **Part C:** Additional Supporting Documentation

**Note:**

- ☐ **Request for medical records excludes any genetic test results. Please do not provide any genetic test results.**
- ☐ **Please print all information using a pen.**
- ☐ **Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).**
- ☐ **Completion of all parts is required, and any missing information may result in a delay of the processing of your claim.**
- ☐ **Checkboxes are provided below to assist you in completing the claim package.**
- ☐ **A claims analyst will send you a confirmation of receipt in writing within 10 business days of receiving your claim package.**
- ☐ **If you have any questions, please contact TD Life Insurance Company at 1-888-788.0839.**

**Check if completed:**

## Part A – Critical Accident Recovery Plan Insurance - Dismemberment claim Form

**Note: All sections in Part A** to be completed by the Insured Person with the injury or illness or an authorized representative of the Insured Person with the injury or illness.

- ☐ **Section 1 – Certificate Information**
- ☐ **Section 2 – Insured Person's Statement.**
- ☐ **Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**
  If your claim for benefits is $60,000 or less, you may choose to have the payment for these benefits deposited directly to your Bank account. Please complete section 3 and attach a void cheque if you wish to take advantage of this payment option.
- ☐ **Section 4 – Declaration, Authorization & Signature**

## Part B – Attending Physician's Statement

**Note: Part B** of this document can be detached and provided to the Attending Physician to complete and send separately to TD Life Insurance Company.

- ☐ **Section 1 – Insured Person's Authorization**
  - o The Insured Person's signature and date are required.
- ☐ **Section 2 - Attending Physician's Statement**
  - o Must be completed and signed by a licensed medical practitioner.

## Part C – Additional Supporting Documentation

- ☐ **Hospital Discharge Statement** – Please provide a copy, if available.
- ☐ **Accident report –** Please provide a copy if available.
- ☐ **Proof of Age of Insured Person** – Please provide a copy of one of the following:
  - o Birth Certificate
  - o Canadian Driver's License
  - o Permanent Residence Card
  - o Canadian Passport
  - o Canadian Citizenship Card

**TD Insurance**
TD Life Insurance Company
P.O. Box 1
TD Centre
Toronto ON M5K 1A2

## Part A – Critical Accident Recovery Plan Insurance - Dismemberment Claim Form

**In this form "Insured Person" means the person who is insured under this certificate "Claimant" means the person who is making the claim.**

## Section 1: Certificate Information

**Critical Accident Recovery Plan is insured by TD Life Insurance Company***

| | |
|---|---|
| **Certificate Number** | |
| **Issue Date** | |
| **Name of Insured Person** (please print full legal name) | |
| **Insured Person's Address** | |
| **Date of Birth** (mm/dd/yyyy) | |
| **Social Insurance Number of Insured Person:** | |
| **Type of Claim** | Dismemberment |
| **Amount of Coverage** | |

*TD Life Insurance Company is the authorized administrator for this insurance. For more details on insurer and/or administrator information, please refer to the Insurance Certificate.
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## Section 2: Claimant's Statement

| | |
|---|---|
| **Name of Claimant:**<br>(if different from Insured Person) | |
| **Claimant's Date of Birth:**<br>(if different from Insured Person) | |
| **Relationship to Insured Person:** | |
| **Claimant's Address:**<br>(if different from Insured Person) | |
| **Claimant's Contact Information: Residential/Cellular Phone**<br>(if different from Insured Person) | |
| **Claimant's Email Address:** | |
| **Nature of Injury:**<br><br>(Please describe where & how the injury occurred) | |
| **Date injury occurred:** (mm/dd/yyyy) | |
| **Date admitted to hospital:**<br>**(**mm/dd/yyyy) | |
| **Date discharged:**<br>(mm/dd/yyyy) | |
| **Hospital Name:** | |
| **Hospital Address:** | |
| **Name of Family Physician:** | |
| **Address of Family Physician:** | |
| **How long have you been consulting with this physician?** | |
| **If less than 2 years, please provide name & address of previous physician(s).** | |

| **Additional Comments:** |
|---|
| |

## Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

If your claim payment is $60,000 or less, at your request, we can deposit your benefit directly to your designated account. This will ensure that you receive your claim payment as quickly and efficiently as possible.

Do you wish to proceed with this option? ☐ Yes ☐ No

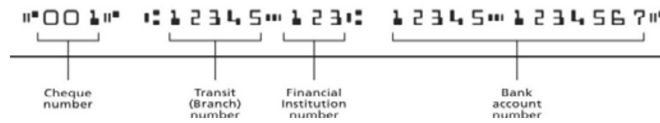
If Yes, please attach a void cheque that clearly identifies the Bank Account (the "Account") into which you wish the payment to be deposited into OR, enter this information in the space provided under **Account information** and sign and date this form at the bottom. Please note that if you are not a TD Canada Trust account holder and are not attaching a void cheque, we require your financial institution's address in order to deposit your benefit into your designated account.

Your account information can be verified by contacting your financial institution or by referencing the numbers at the bottom of your cheque:

**Branch Transit Number:** This is the 5-digit number that identifies your home banking branch

**Financial Institution Number:** Every Canadian Financial Institution has its own 3-digit number. For example, TD Canada Trust is 004

**Bank Account Number:** This is a unique 7-digit number that is used to refer to your personal account.




**Account Information**

________________ ____________________ ____________________________

Branch Transit Number    Financial Institution Number    Bank Account Number

____________________________________________________________________________ **Bank Address**

I ______________________________________ (please print name) as the Insured Person under the Insurance Policy (the "Insurance Contract"), issued by TD Life Insurance Company (TD Life), hereby irrevocably direct and authorize TD Life (both as insurer and as administrator to deposit all claim benefits payable under the Insurance Contract, through electronic funds transfer (direct deposit) to the account number as noted above and this shall serve as your good and sufficient authority for so doing. I consent to the collection, use and disclosure of my personal information for the purpose of paying this claim by this method. I fully release TD Life from any and all liability in regard to such payment upon its deposit in the above-described Account. If such account is a joint account with any other person or belongs to a third party, it shall not be TD Life responsibility should any funds be withdrawn by any person other than me or are used to pay down any indebtedness for which this account is responsible. I understand that TD Life is unable to verify the accuracy of an account number so I am responsible in the event that an incorrect account number is provided. I will ensure the information is accurate.

________________________________________ _______________________________

Signature    Date (mm/dd/yyyy)

## Section 4: Declaration / Authorization / Signature

**Insurer: TD Life Insurance Company**

- I declare that all the statements made in this claim form are accurate, true and complete. I understand that making false, misleading or incomplete statements may cause not only the claim to be denied, but insurance coverage to be void.
- By signing below, I agree that we may collect, use and disclose your Information as described in the Privacy Policy attached to my Insurance Policy including for, but not limited to, the purposes of identifying me, providing ongoing service, processing my claims, understanding my financial needs, protecting us both from fraud and error and complying with legal and regulatory requirements.
- I hereby authorize and request any physician, hospital, clinic, individual, law enforcement or government organization, insurance company, worker's compensation body, current or former employer, or other entity that has any personal and medical records, information or knowledge in regard to the Insured Person, to release and provide full details (including furnishing copies) of all available personal and medical information records and knowledge, including prior medical history, toxicological or pathological findings which they may possess to the above noted Insurer in regard to this claim, its re-insurers or their respective agents. This information is to be used in the evaluation of an insurance claim and for purposes relating to such claim.
- I also authorize the Insurer, its reinsurers and its respective agents to exchange and/or transmit information concerning this claim to the organizations listed above as is necessary to evaluate this claim. This consent shall be valid during the continuation of such claim.
- In providing this authorization to collect personal information about the Insured Person relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured Person to authorize the collection, use and disclosure of their personal information as authorized above and that the Insurer and its agents and reinsurers may rely and act upon my authorization.

Insured Person's Name:________________________________________ Date:_________________

(Please print) (mm/dd/yyyy)

Insured Person's Signature:________________________________________

**A photocopy/fax of this authorization is as valid as the original.**

## Section 2 - Attending Physician's Statement (Completed by Physician)

- This form has been specifically designed with the Physician in mind. By being comprehensive, it will hopefully reduce the physician's administrative workload. Please complete the sections relating to your patient and strike out non-applicable areas. In order to help the Insured Person, sufficient details of family and medical history, investigation, findings and treatment are essential.
- This form may be mailed directly to TD Life Insurance Company or given to the Claimant at the physician's discretion.
- The above named is insured with TD Life Insurance Company against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with a **Critical Accident Recovery Plan – Dismemberment** and, to enable the assessment of the claim, we would appreciate for your cooperation on the completion of this form.

| | |
|---|---|
| **Patient's Name:** (Please print) | |
| **Patient's Date of Birth:** (mm/dd/yyyy) | |

**I hereby authorize the release to my insurer any information requested in respect of this claim.**

**Signature of Patient:** ____________________________________________ **Date:** ________________________

***Any charges for the completion of this form are the responsibility of the claimant***

| | |
|---|---|
| **Date of Accident:** (mm/dd/yyyy) | |
| **When did patient first consult you for this condition?** (mm/dd/yyyy) | |
| **Your diagnosis and compete description of injuries sustained:** | |

**Did the accident result in loss of:**

| **Loss** | **Date** (mm/dd/yyyy) | **Location of amputation** |
|---|---|---|
| ☐ Right arm | | |
| ☐ Left arm | | |
| ☐ Right leg | | |
| ☐ Left leg | | |
| ☐ Right hand | | |
| ☐ Left hand | | |
| ☐ Right Foot | | |
| ☐ Left Foot | | |
| ☐ Right Index Finger | | **Complete and permanent severance of the digit** |

| | | |
|---|---|---|
| ☐ Left Index Finger | | **Complete and permanent severance of the digit** |
| ☐ Right thumb | | **Complete and permanent severance of the digit** |
| ☐ Left thumb | | **Complete and permanent severance of the digit** |

**Complete loss of vision:**

| | |
|---|---|
| **If injury necessitated removal of eye, date of removal:** (mm/dd/yyyy) | |
| **Vision in each eye prior to accident: Right**<br><br>**Left** | |
| **Present vision in each eye: Right**<br><br>**Left** | |
| **If use can be restored, please provide details:** | |

**Loss of hearing:**

| | |
|---|---|
| **Is deafness a direct result of an accident?** | ☐ Yes ☐ No |
| **Has the deafness been verified by audiological testing?**<br><br>**If yes, what were the results?** | ☐ Yes ☐ No<br><br>Results: |
| **Is the loss irrecoverable?** | ☐ Yes ☐ No |

**Loss of speech:**

| | |
|---|---|
| **Is speech loss a direct result of an accident?** | ☐ Yes ☐ No |
| **Has the speech loss been assessed by a speech therapist?**<br><br>**If yes, what were the results?** | ☐ Yes ☐ No<br><br>Results: |
| **Is the loss irrecoverable?** | ☐ Yes ☐ No |

(continued)

**Brain damage:**

| | |
|---|---|
| **Is brain damage a direct result of an accident?** | ☐ Yes ☐ No |
| **Has the brain damage been assessed by a specialist?** | ☐ Yes ☐ No |
| **What investigations were used to assess the severity of the injury?**<br><br>**If so, what were the results?** | |
| **Does the patient require any of the following:**<br>**Specialized Care**<br>**Specialized Feeding**<br>**Rehabilitation**<br>**Institutionalization** | <br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| **Do you expect improvement?** | ☐ Yes ☐ No |

**Loss of use due to hemiplegia, paraplegia or quadriplegia:**

| | |
|---|---|
| **Did the accident result in loss due to:** | ☐ Paraplegia ☐ Quadriplegia |
| **What was the extent of the injury to the spinal cord?** | |
| **Which, if any, tests were used to make the determination of the extent of injury.** | |
| **Is the loss irrecoverable?** | ☐ Yes ☐ No |
| **Please provide any additional details that may be applicable:** | |
| **Were the injuries or impairment sustained due solely to the above accident?** | ☐ Yes ☐ No |
| **If not, please provide details of any condition or disease, which in your opinion may have served as a contributory cause.** | |

**Coma:**

**Please provide us with copies of all consultation/investigation reports**

| | |
|---|---|
| **Is the coma a direct result of an accident?** | ☐ Yes ☐ No |
| **Is he/she on life support?** | ☐ Yes ☐ No |
| **Do you expect improvement?** | ☐ Yes ☐ No |

**Burns:**

| | |
|---|---|
| **Was the burn a direct result of an accident?** | ☐ Yes ☐ No |
| **Please indicate the degree of burn:** | ☐ 1st degree ☐ 2nd degree ☐ 3rd degree |
| **Location of burn?** | |
| **Treatment provided?** | |
| **Did the patient require admission to hospital as an in-patient ?**<br><br>**If Yes, provide date of hospital admission and date of hospital discharge.** (mm/dd/yyyy) | ☐ Yes ☐ No<br><br>Admission:<br><br>Discharge: |

| **Remarks:** |
|---|
| |

**Attach any specialist report, pathology or test results, if available. Please mail or fax this form to:**


**TD Insurance**
Claims Department
P.O. Box 1 TD
Centre
Toronto, Ontario M5K 1A2
**Tel: 1-888-788-0839**
Fax: 416-308-1223 / 1-877-838-2163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**Declaration: These statements are true and complete to the best of my knowledge and belief.**

**Physician's Name:** ________________________________ **Physician's Signature:** ____________________________
(Please print)

**Physician's Specialty:** ________________________________________________________________________

**Date:** _________________________ **Address:** ______________________________________________________

**Telephone Number:** ____________________ **Fax Number:** __________________________

**Thank you for taking the time to complete this form.**