TD Insurance

Instructions for completing the claim package for TD Protection Plan Terminal Illness Insurance (Mortgage)

This insurance benefit is underwritten by The Canada Life Assurance Company ("Canada Life"), and TD Life Insurance Company ("TD Life") is the authorized administrator*. TD Life will be managing this claim on behalf of Canada Life.

The TD Protection Plan Terminal Illness Insurance Claim Package contains two parts:

- **Part A: Claimant's Statement for TD Protection Plan Terminal Illness Insurance**
- **Part B: Attending Physician's Statement of Terminal Illness**

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 the delay of the processing of your claim.**
- **Checkboxes are provided below to assist you in completing the claim package.**
- **Within 10 business days of receiving your claim package, a claims analyst will send you a confirmation of receipt in writing.**
- **If you have any questions, please contact the TD Life Claims Department at 1-888-983-7070.**

Instructions for Claimant

Check if completed

☐ Please complete **Part A -** Claimant's Statement for TD Protection Plan Terminal Illness Insurance.

- Be sure to print your first and last name, date and sign all entries and include your telephone number.
- If you are not the Insured, you must be an authorized representative of the Insured.

☐ Please ensure that both sections of **Part B** - Attending Physician's Statement of Terminal Illness are completed.

Section 1 - Patient's Authorization - the Insured/patient's signature and date are required.
Section 2 - Attending Physician's Statement **must be completed and signed by a licensed medical practitioner .**

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

☐ Retain a photocopy of the completed claim package for your records.

☐ Return the original forms to:

TD Insurance
Claims Department
P.O. Box 1
TD Centre
Toronto, Ontario M5K 1A2

PART A - Claimant's Statement for TD Protection Plan Terminal Illness Insurance

Statement of Claim (Completed by Claimant)

The completion of the below product details is **mandatory** in order to process this claim. If you do not have the product details, please contact your TD Canada Trust branch before submitting the claim forms.

Branch/Transit Number: _____

Mortgage number: _____

Please provide details of any other credit insured mortgages, lines of credit or loans held by the Insured at TD Canada Trust.

_____

Section 1 - Claimant's Statement

Name of Insured: _____

Address of Insured: _____

Insured Date of Birth: _____

If you are not the Insured, please complete the Claimant details below and confirm what is your relationship to the Insured?

_____

Name of Claimant: _____
(Last Name) (First Name and Initial)

Address of Claimant: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Claimant Date of Birth: _____ Date of Diagnosis: _____
(Month, Day, Year) (Month, Day, Year)

Telephone Number: _____ Alternate Telephone Number: _____

Name and Address of Insured Family Physician:

_____

_____

How long has this doctor been the Insured Family Physician: _____

Other doctors consulted during the last 12 months, hospitals and institutions attended.

Physician, Hospital, Institution	Address	Nature of Illness or Injury	Dates

This claim form can be used for otherwise valid claims under discontinued policies.

1. Please provide details of your illness:

_____

_____

2. a) Are you confined to bed? ☐ Yes ☐ No

   b) Are you confined to your home? ☐ Yes ☐ No

   c) Are you a patient at a hospital? ☐ Yes ☐ No

   If Yes, please provide name and address of hospital.

_____

3. a) Does your health completely prevent you from working now? ☐ Yes ☐ No

   b) If not working, when do you anticipate returning to:

      1) your own job? _____ 2) another job?_____

   c) If now working

      1) Briefly state your duties._____

      2) When did you return to work? _____

      3) Are you now working on a gradual basis? ☐ Yes ☐ No

      If Yes, please confirm the number of hours per week: _____

Terminal Illness Insurance Claim Authorization

Insurer: The Canada Life Assurance Company ("Canada Life")

Claimant's Authorization and Declaration:

- 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 rescinded by the Insurer.
- 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 (if other than the Claimant), 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.
- I further authorize the Insurer or its administrator to release information relating to this claim (however, not including medical information) to The Toronto-Dominion Bank to allow the bank to manage the credit facility related to this insurance.

If I am not the Insured:

- In providing this authorization to collect personal information about the Insured relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured 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.

Claimant: _____
(Print Last name, First name and initial)

Claimant's Signature: _____ Date _____
(Month, Day, Year)

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

PART B - Attending Physician's Statement of Terminal Illness

Section 1 - Patient's Authorization

Patient's Name (Please Print): _____

Patient's Date of Birth: _____
(Month, Day, Year)

I hereby authorize the release of any information requested in respect of this claim, to the Insurer, The Canada Life Assurance Company and its authorized claims administrator, TD Life Insurance Company.

I understand that I can revoke this consent at any time but that without it my claim may not be assessed.

Date: _____ Signature of Patient: _____
(Month, Day, Year)

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 Claimant, sufficient details of family and medical history, investigation, findings and treatment are essential.

Note: Before you submit the form, please ensure you complete the Declaration section, including your signature.

The patient is responsible for securing this form and any charge which may be made for its completion.

Request for medical records excludes any genetic test results. Please do not provide any genetic test results.

1. Diagnosis

a) Primary: _____ Symptoms: _____

b) Secondary: _____ Symptoms: _____

c) Objective findings (including results of current X-rays, ECGs or any other special tests).
Please attach copies of any test results.

_____

d) Other contributing factors/complications:

_____

2. History

a) Symptoms began: _____
(Month, Day, Year)

b) Date of diagnosis: _____
(Month, Day, Year)

c) Date patient advised of diagnosis: _____
(Month, Day, Year)

d) What treatment and/or medication have been prescribed?

_____

How often do you see the patient?

_____

e) Has patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown

If "Yes", state when and describe:

_____

_____

_____

3. Clinical Findings and Investigations

Has your patient been referred to any other physicians or specialists? ☐ Yes ☐ No

If "Yes", complete the following chart

Physician's Name and Specialty	Date of Examination	Summary of Findings

4. Prognosis

What is your patient's prognosis?

_____

Based on your knowledge of your patient's condition and your experience, what is your estimation of your patient's life expectancy?

_____

Are any further treatment options being considered?

_____

If yes, when will this treatment commence?

_____

What is the expected outcome?

_____

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the Insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. I understand that I can revoke this consent at any time but that without it my patient's claim may not be assessed. By providing the information I consent to such unedited release of any information contained herein.

Attach any specialist report, if available.
You may mail or fax this form to the Administrator below:

TD Insurance
Claims Department
P.O. Box 1
TD Centre
Toronto, Ontario M5K 1A2
Tel: 1-888-983-7070
Fax: 416-308-1223 / 1-877-838-2163

Declaration: These statements are true and complete to the best of my knowledge and belief.

Physician's Signature: _____ Date: _____ (Month, Day, Year)

Specialty: _____

Print Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Thank you for taking the time to complete this form.