TD Insurance
Instructions for completing the Accidental Death Common Carrier Claim Form

The Accidental Death/Common Carrier claim package contains three parts:

- ☐ **Part A:** Accidental Death/Common Carrier Claim Form
- ☐ **Part B:** Attending Physician's Statement – Proof of Death
- ☐ **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 – Accidental Death/Common Carrier Claim Form

Note: All sections in Part A to be completed by the Claimant (named beneficiary), unless otherwise specified. If the estate is the beneficiary, the authorized representative must complete the form. If the beneficiary is a minor, the guardian or other persons authorized by law to deal with the minor's property should complete the form on behalf of the minor. If there are multiple beneficiaries, each beneficiary must complete the form.

- ☐ **Section 1 – Certificate Information**
- ☐ **Section 2 – Claimant's Statement**
- ☐ **Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**
  - If you choose to have the payment for these benefits deposited directly to your bank account, please complete section 3 and attach a void cheque.
- ☐ **Section 4 – Declaration, Authorization & Signature**

Part B – Attending Physician's Statement – Proof of Death

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

Part C – Additional Supporting Documentation

- ☐ **Proof of Age of Insured Person** – Please provide a copy of one of the following:
  - Birth Certificate
  - Canadian Driver's License
  - Permanent Residence Card
  - Canadian Passport
  - Canadian Citizenship Card

(see over)

- ☐ **If Estate is the beneficiary**, provide a copy of the **Last Will and Testament form**
- ☐ **If the beneficiary is a minor,** provide certified copies **of Letters of Guardianship** or **Tutorship papers** (in Quebec)
- ☐ **If claiming Common Carrier benefits**, please provide a copy of the **Insured Person's ticket, accident report that was filed with the carrie**r and any other information pertaining to the accident.
- ☐ **A copy of the Police report, coroner's report**, if available.

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

Part A – Accidental Death/ Common Carrier Claim Form

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

Section 1: Certificate Information

Accidental Death/ Common Carrier insured by TD Life Insurance Company*

Certificate Number	
Issue Date	
Name of Insured Person (please print full legal name)	
Insured Person's Address:	
Type of Claim	Accidental Death/Common Carrier
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.

Section 2: Claimant's Statement

In what capacity or by what title do you claim the insurance?

☒ Executor or Administrator (Please attach a copy of the Last Will & Testament)

☐ Named Beneficiary

Insured Person's Name:	
Insured Person's Address:	
Insured Person's Social Insurance Number: (Required for income tax purposes)	
Insured Person's Date of Birth: (mm/dd/yyyy)	
Insured Person's Place of Birth:	
Insured Person's Date of Accident: (mm/dd/yyyy)	
Insured Person's Date of Death: (mm/dd/yyyy)	
Cause of Death:	
Place of Death:	
Details of Accident	
Please indicate type of Common Carrier:	☐ **Airline** (Provide copy of tickets, name of Airline and flight number) ☐ **Train** (Provide copy of tickets, rail carrier, destination and route) ☐ **Public Transport** (Provide copy of ticket and route number, if applicable) ☐ **Water Vessels** (Provide copy of tickets and name of carrier) ☐ **Taxi** (Provide copy of receipt) ☐ **Other** (indicate type)
Sum Insured: ($)	
If a smoker, please provide the last date used: (mm/dd/yyyy)	☐ Smoker ☐ Non-Smoker Date:
Please indicate type of tobacco product or use of any substance or product containing the following:	☐ Tobacco ☐ Nicotine ☐ Marijuana
Claimant's Name:	
Claimant's Social Insurance Number: (Required for income tax purposes)	
Claimant Address:	
Claimant Contact Information: Residential or Cellular Phone Number	
Business Contact Number:	
Claimant Email Address:	

Name of Insured Person's Family Physician:	
Address of Insured Person's Family Physician:	

Date of Consultations (mm/dd/yyyy)	**Reason**	**Result**

Other Physicians consulted, including any hospitals or institutions during the last 5 years:

Physician, Hospital, Institution	**Address**	**Date of Consultations** (mm/dd/yyyy)	**Reason**

Additional Life Insurance in force with our company or any other company:

Company	**Effective Date (mm/dd/yyyy)**	**Face Amount**

Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

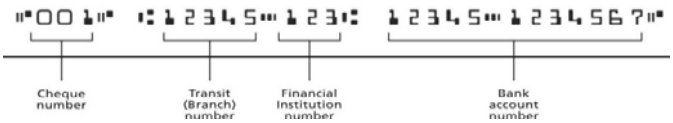
We are pleased to offer you the ease and convenience of depositing your benefit directly into your designated account. This will ensure that you receive your claim payment as quickly and efficiently as possible.

To proceed with direct deposit of your benefit, please complete, sign and date the authorization below. You also need to either attach a void cheque that clearly identifies the Bank Account (the "Account") into which you wish the payment to be deposited OR, enter this information in the space provided under Account Information below. 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: _____

Relationship to the Insured Person: _____

Claimant's Name: _____
(Please print)

Claimant's Signature: _____ Date: _____
(mm/dd/yyyy)

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

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

Part B – Attending Physician's Statement – Proof of Death

Notes:

- The Claimant 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.

Section 1: Claimant's Authorization

Accidental Death/Common Carrier Insurance insured by TD Life Insurance Company*

Certificate Number	
Insured Person's Name (please print)	
Date of Birth (mm/dd/yyyy)	

I hereby authorize the release of any information requested in respect of this claim to TD Life Insurance Company.

_____ _____

Signature of Claimant Date (mm/dd/yyyy)

*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.

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.
- 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 **Accidental Death/ Common Carrier benefit** 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)	
Patient's Date of Death: (mm/dd/yyyy)	
Place of Death:	
Death resulted from:	☐ Natural Causes ☐ Suicide ☐ Homicide ☐ Accident ☐ Other

- Disease or condition directly related to death: _____
  - Duration: _____
- Antecedent Causes: _____
  - Duration: _____

1. Date of first attendance of final illness: (mm/dd/yyyy)	
2. Date of last attendance of final illness: (mm/dd/yyyy)	
3. Was your patient a smoker? **If Yes, when was the last date used?** (mm/dd/yyyy)	☐ Yes ☐ No Date:
4. If accident, suicide, homicide, describe briefly:	
5. Was death solely due to this accident?	☐ Yes ☐ No
6. Was there an inquest?	☐ Yes ☐ No
7. Was there an autopsy? If Yes, please attach a copy.	☐ Yes ☐ No
If "Yes" to either question 6 or 7, by whom and with what result? • **Full name** • **Result**	
8. Have you treated or advised your patient during the last 5 years, prior to last illness?	☐ Yes ☐ No

9. Did your patient, to your knowledge, receive treatment during the last 5 years from any other Physician or in any Hospital or Institution?	☐ Yes ☐ No
If "Yes" to either question 8 or 9, please provide the following details: • **Full Name** • **Address** • **Nature of illness or injury** • **Date** (mm/dd/yyyy)	

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

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.