TD Insurance
Instructions for completing the Critical Illness Recovery Plan
Heart Attack Claim Form

The Critical Illness Recovery Plan – Heart Attack claim package contains three parts:

- ☐ **Part A:** Critical Illness Recovery Plan – Heart Attack claim form
- ☐ **Part B:** Attending Physician's Statement – Heart Attack
- ☐ **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 Illness Recovery Plan – Heart Attack Claim Form

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

- ☐ **Section 1 – Policy Information**
- ☐ **Section 2 – Insured Person'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 – Heart Attack

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**
  - The Insured Person'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

- ☐ **Hospital Discharge Statement** – Please provide a copy, if available.
- ☐ **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

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

Part A – Critical Illness – Heart Attack Claim Form

In this form "Insured Person" means the person who is insured under this policy.

Section 1: Policy Information

Critical Illness Recovery Plan insured by TD Life Insurance Company*

Policy Number	
Issue Date	
Name of Insured Person (please print full legal name)	
Policy Owner Name (if different than Insured Person)	
Type of Claim	Critical Illness – Heart Attack

*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 Policy.

Section 2: Insured Person's Statement

Insured Person's Name:	
Insured Person's Address:	
Insured Person's Date of Birth: (mm/dd/yyyy)	
Insured Person's Contact Details: Residence/Cellular	
Insured Person's Email address:	
Amount of Coverage: ($)	
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
Nature of Illness:	
Date Illness or symptoms first appeared (mm/dd/yyyy) **Please describe symptoms:**	
On what date did the Insured Person first consult a doctor in connection with their illness? (mm/dd/yyyy)	
Has the Insured Person undergone any tests or investigations related to this diagnosis? **If yes, please provide details and dates.** (mm/dd/yyyy)	☐ Yes ☐ No Details/Dates:
Has the Insured Person previously suffered from or received treatment for a similar or related condition? **If yes, please provide dates and details.**	☐ Yes ☐ No Details/Dates:
Have any immediate family (mother, father, brothers, sisters) had heart disease, stroke, diabetes, cancer or tumour or kidney disease prior to age 60? **If yes, please list relationship, nature of illness, date of diagnosis and relationship.**	☐ Yes ☐ No Details:
Date admitted to hospital: (mm/dd/yyyy)	
Date of release from hospital: (mm/dd/yyyy)	
Hospital Name:	

Hospital Address:	
Name of Family Physician:	
Address of Family Physician:	
How long have you been consulting 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)

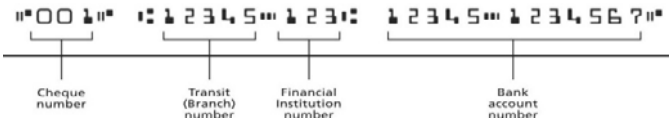
We are pleased to offer you the ease and convenience of depositing your benefit directly into your designated account. This will ensure that you receive your claim payment as quickly and efficiently as possible.

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

By signing below you—the insured person—also agree to the following unless you check the box below to indicate that you do not agree:

- If you do not qualify to claim for the Critical Illness Benefit, we may explain this to the Policy Owner. If other information negatively affects our claims decision, we may tell the Policy Owner whether the relevant information relates to your family history, medical information, or lifestyle.

☐ I do not agree to the disclosure of my personal information to the Policy Owner.

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.

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

Part B – Attending Physician's Statement

Critical Illness – Heart Attack

Notes:

- The Insured Person 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: Insured Person's Authorization

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

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

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

Signature of Insured Person: _____

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 Policy.

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 **Heart Attack** 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)	
On what date did your patient first consult you for this condition? (mm/dd/yyyy)	
How long has the insured been your patient? (years/months)	
Name and Address of Family Physician:	
When did the heart attack occur? (mm/dd/yyyy)	
On what date was the diagnosis made? (mm/dd/yyyy)	
Please provide the name of the cardiologist who made the diagnosis of heart attack. (if other than yourself)?	
Has your patient previously suffered from a previous heart attack? **If "Yes", please provide dates and details.**	☐ Yes ☐ No Details:

Please provide the following details pertaining to the insured's heart attack:

Date of onset of **chest pain** (mm/dd/yyyy):	
ECG changes in detail at time of event or provide tracings, if available:	
Please provide prior ECG tracings if applicable.	
Cardiac enzyme levels, include MB Band, at time of event:	

What other investigations have been performed? If any, please provide the following:

Date	Details	Copy of Reports
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

When did your patient first suffer symptoms or episodes of cardiovascular disease?

Date	Details

Please describe, including dates and symptoms, what disorder or risk factors has your patient had that may have contributed to his/her illness?

Date	Description & Symptoms

Have any immediate family (mother, father, brothers, sisters) had heart disease, stroke, diabetes, cancer or tumour or kidney disease prior to age 60? **If yes, please provide details:**	☐ Yes ☐ No
Is your patient a smoker? **If yes, please provide the year the patient started smoking and the last date used**	☐ Yes ☐ No
Are you related to or in a business relationship with this patient?	☐ Yes ☐ No

Remarks:

(see over)

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.