TD Insurance
Instructions for completing the Term Life Insurance Living Benefit Claim Form

The Term Life - Living Benefit claim package contains three parts:

- ☐ **Part A:** Term Life Insurance - Living Benefit 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 - Term Life Insurance - Living Benefit Claim Form

Note: All sections in Part A to be completed by the Insured Person.

- ☐ **Section 1 – Policy Information**
- ☐ **Section 2 – Insured Person's Statement and Claim Terms and Conditions Form.**
  Important Note: if you have named an irrecoverable beneficiary, their consent and signature is also required.
- ☐ **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

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 – Term Life Insurance - Living Benefit Claim Form

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

Section 1: Policy Information

Term Life Insurance 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	Living Benefit

*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: Insured Person's Statement

Insured Person's Name:	
Insured Person's Address:	
Insured Person's Date of Birth: (mm/dd/yyyy)	
Date of Diagnosis: (mm/dd/yyyy)	
Insured Person's Contact Details: Residence/Cellular	
Insured Person's Email address:	
Name and Address of Insured Person's Family Physician:	
How long has this doctor been the Insured Person's Family Physician:	
If a smoker, please provide the last date used	☐ Smoker ☐ Non-Smoker Date:
Please indicate type of tobacco product or use of any substance or product containing the following:	☐ Tobacco ☐ Nicotine ☐ Marijuana

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

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

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 the answer to 2(c) is Yes, please provide name and address of hospital:

   _____

Claim request Terms and Conditions

- I confirm my policy is in force and paid current and the terminal illness diagnosis has a life expectancy of 12 months or less;
- I understand I will be charged interest on the amount of the living benefit. Interest is set at the current prime rate and may be adjusted if prime fluctuates by 1% or more;
- I understand that the Term Life Insurance policy will be collateral for the Living Benefit amount paid as a loan;
- I understand that if there are any tax consequences in connection with the living benefit, I or my estate will be responsible for paying the taxes;
- I understand the amount of my Term Life insurance benefit payable to the beneficiary will be reduced by the amount of the living benefit, including any accumulated interest calculated from the day I received the living benefit;
- I understand that all terms and conditions of my policy will continue to apply; and
- I confirm that any irrevocable beneficiary and/or policy owner under this policy has consented to the payment of the benefit with their signature below.

I request to withdraw an amount from my Term Life insurance policy in accordance with the terms of my contract.

Amount requested $_____(up to a maximum amount of $100,000)**.**

By signing below, I confirm that I have read, understand and accept the information described above and consent to the insurance policy changes described on this form.

Insured Person's signature:_____Date_____

Witness Name: _____

Witness signature:_____Date_____

Policy Owner's signature

(If different than Insured Person):_____Date_____

Witness Name: _____

Witness signature:_____Date_____

By signing below, I confirm that I am an existing irrevocable beneficiary on this insurance, that I am of the age of majority in the province where I reside, I have read, understand and accept the information described above and that I consent to the insurance policy changes described on this form.

Irrevocable Beneficiary name _____Date_____

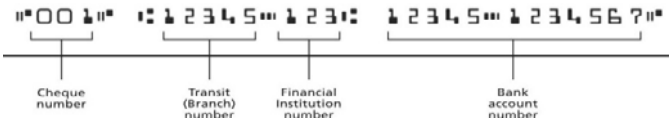
Irrevocable Beneficiary signature _____

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_____ 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

Term Life Insurance - Living Benefit

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

Term Life Insurance 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 **Term Life - Living Benefit** and, to enable the assessment of the claim, we would appreciate for your cooperation on the completion of this form.

Diagnosis

Primary	
Symptoms of Primary	
Secondary	
Symptoms of Secondary	
Objective findings (including results of current X-rays, ECGs or any other special tests) **Please attach copies of any test results.**	
Other contributing factors/complications	

History

Symptoms began (mm/dd/yyyy): _____

Date of Diagnosis (mm/dd/yyyy): _____

Date patient advised of diagnosis (mm/dd/yyyy): _____

What treatment and/or medication have been prescribed?	
How often do you see the patient?	
Has your patient ever had the same or similar condition?	☐ Yes ☐ No ☐ Unknown
If Yes, state when and describe	

Clinical Findings and Investigations

Has your patient been referred to any other physicians or specialists? ☐ Yes ☐ No
If Yes, complete the following chart (next page):

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

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?	

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.