



**TD Insurance**  
**Instructions for completing the claim package for**  
**Credit Protection Critical Illness Insurance**  
**- Life-Threatening Cancer**

**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 Credit Protection Critical Illness Insurance - Life Threatening Cancer Claim Package contains three parts:**

- **Part A: Claim for Credit Protection Critical Illness Insurance.**
- **Part B: Claimant's Statement for Credit Protection Critical Illness Insurance - Life Threatening Cancer.**
- **Part C: Attending Physician's Statement of Critical Illness Insurance - Life Threatening Cancer.**

**Note:**

- **Please print all information using a pen.**
- **Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).**
- **Completion of all three 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 visit your local TD Canada Trust branch to have a branch representative complete **Part A - Claim for Credit Protection Critical Illness Insurance.**
  - Please complete **Part B - Claim for Credit Protection Critical Illness Insurance - Life Threatening Cancer.**
    - 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 C - Attending Physician's Statement of Critical Illness Insurance - Life Threatening Cancer** 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 C** of this document can be detached and provided to the Attending Physician to complete and send separately to TD Life Insurance Company - Claims Department.
- 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

**OR**

**You may bring the original forms back to your TD Canada Trust branch in a sealed envelope to be sent to TD Life.**

**Instructions for Branch**

- Please complete **Part A - Claim for Credit Protection Critical Illness Insurance.**
- Be sure to enter the branch transit number, address, telephone number and name of contact person, should it be necessary for the TD Life Claims Department to contact you.
- The claimant may mail the claims package directly to TD Life or, if they wish, they may ask you to send the forms to us in the **TD Insurance green vinyl bag.**

# PART A - Claim for Credit Protection Critical Illness Insurance

## Statement of Claim (To be completed by your TD Canada Trust representative)

Product:

Mortgage

Branch/Transit Number: \_\_\_\_\_

Line of Credit

Mtg/LOC Number: \_\_\_\_\_

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

Name of the Insured: \_\_\_\_\_

(Last Name)

(First Name and Initial)

Address of the Insured: \_\_\_\_\_

(Number)

(Street)

(City)

(Province)

(Postal Code)

Insured Date of Birth: \_\_\_\_\_

(Month, Day, Year)

Date of Critical Illness: \_\_\_\_\_

(Month, Day, Year)

Current Principal Balance

Date of Last Regular Payment  
(Month, Day, Year)

Insurance Effective Date  
(Month, Day, Year)

Date Funds Advanced  
(Month, Day, Year)

Initial Mortgage Amount or Line of Credit Limit.

Refinancing Details

Yes  No

Branch Comments:

Branch Contact: \_\_\_\_\_

(Last Name, First Name)

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

(Month, Day, Year)

Telephone Number: ( ) -

\_\_\_\_\_ - \_\_\_\_\_

# PART B - Claimant's Statement for Credit Protection Critical Illness Insurance - Life Threatening Cancer

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## Statement of Claim (Completed by Claimant)

### Section 1 - Claimant's Statement

Ms.  Mrs.  Mr.

Name of Claimant: \_\_\_\_\_  
(Last Name) (First Name and Initial)

Address: \_\_\_\_\_  
(Number) (Street)

\_\_\_\_\_  
(City) (Province) (Postal Code)

Date of Birth: \_\_\_\_\_  
(Month, Day, Year)

Telephone Number: ( ) - - Alternate Telephone Number: ( ) - -

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### 1. Claim and related details

a) Please provide details of your Critical Illness.

\_\_\_\_\_

b) On what date was your condition diagnosed or surgery performed?

\_\_\_\_\_

c) (i) On what date did symptoms first commence?

\_\_\_\_\_

(ii) Please describe these symptoms.

\_\_\_\_\_

d) On what date did you first consult a medical practitioner in connection with your illness?

\_\_\_\_\_

e) Have you undergone any tests or investigations related to the diagnosis?  Yes  No  
If yes, please provide details and dates.

\_\_\_\_\_

f) Have you previously suffered from, or received treatment for, a similar or related condition?  Yes  No  
If yes, please give details including dates.

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(continued)

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**2. Medical Consultations**

a) (i) Please provide the name, address and phone number of your personal physician.

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(ii) How long had he/she been your personal physician?

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b) Please list the names, addresses and phone numbers of physicians seen in the past 5 years, other than those listed in (a) (i) above.

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c) List the names and locations of all hospitals and/or institutions where you were treated in the past 5 years. (include admission and discharge dates.)

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d) Please provide the names, addresses and phone numbers of any other physicians or specialists who have been consulted in connection with your illness.

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e) What treatment have you received and are you currently receiving in connection with your condition?

Type of treatment	Institution/Physician	Dates	
		From	To

**3. General**

a) Have any of your immediate family (mother, father, brother(s), sister(s)) had cancer, tumour, heart disease, diabetes, kidney disease, stroke, or suffered from a similar or related condition?

Yes  No

b) If yes, list relationship, condition, age at which illness was first diagnosed, and date of diagnosis.

Relationship	Condition	Age at which illness was first diagnosed	Date of diagnosis (Month, Day, Year)

c) Please provide any further information which you think might be helpful in support of your claim.

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## Critical 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.

Signed at: \_\_\_\_\_

Claimant: \_\_\_\_\_

Claimant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
(Month, Day, Year)

Witness: \_\_\_\_\_

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

# PART C - Attending Physician's Statement for Critical Illness - Life Threatening Cancer

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## Section 1 - Patient's Authorization

Ms.  Mrs.  Mr.

Patient's Name (Please Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
(Month, Day, Year)

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

Date: \_\_\_\_\_  
(Month, Day, Year)

Signature of Patient: \_\_\_\_\_

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## 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.

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

The above named is insured with The Canada Life Assurance Company against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **Cancer (life-threatening)** and, to enable the assessment of the claim, we would be grateful for your cooperation on the completion of this form.

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1. a) On what date did your patient first have symptoms?

Please list these symptoms:

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b) On what date did your patient first consult you for this condition?

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c) How long has the Insured been your patient?

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2. a) Please provide the date this cancer was diagnosed.

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b) Please provide the name of the doctor who diagnosed this cancer (if other than yourself).

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c) On what date was the patient advised of the diagnosis?

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3. Please provide a copy of the pathology report giving the following details:

a) Type of tumour

b) Site of tumour

c) Histology and staging

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer.

5. Has your patient previously suffered from cancer or any other conditions that may have contributed to his/her illness?  Yes  No  
If "Yes", please provide dates and details.

6. Is your patient HIV positive?  Yes  No

7. Is there any immediate family history of cancer, tumour, heart disease, stroke, or suffered from a similar or related condition?  Yes  No  
If yes, list condition, date of diagnosis and relationship to the patient.

Relationship	Condition	Date of diagnosis (Month, Day, Year)

8. Please provide details of your patient's tobacco or nicotine use including amount per day and date last used.

9. Please provide copies of clinical notes and hospital reports for our Medical Director's review.

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.**