



**TD Insurance**  
**Instructions for completing the claim package for**  
**Credit Protection Accidental**  
**Dismemberment Insurance**

This insurance benefit is underwritten and administered by TD Life Insurance Company ("TD Life").

The Credit Protection Accidental Dismemberment Insurance Claim Package contains three parts:

- **Part A: Claim for Credit Protection Accidental Dismemberment Insurance.**
- **Part B: Claimant's Statement for Credit Protection Accidental Dismemberment Insurance.**
- **Part C: Attending Physician's Statement of Accidental Dismemberment.**

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 Accidental Dismemberment Insurance.**
  - Please complete **Part B - Claimant's Statement for Credit Protection Accidental Dismemberment 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 C - Attending Physician's Statement of Accidental Dismemberment** 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.
- 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 Accidental Dismemberment 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 Accidental Dismemberment Insurance

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

Product:

Mortgage

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

Line of Credit

Mortgage/Line of Credit/Loan number: \_\_\_\_\_

Loan

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

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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 Accident:

(Month, Day, Year)

Current Principal Balance  
(Month, Day, Year)

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

Insurance Effective Date  
(Month, Day, Year)

Date Funds Advanced  
(Month, Day, Year)

Initial Loan/Mortgage Amount,  
or Line of Credit Limit

Refinancing Details

Yes  No

Branch Comments

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Branch Contact:

(Last Name)

(First Name)

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

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

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

(Month, Day, Year)

Telephone Number:

( )

- \_\_\_\_\_

# PART B - Claimant's Statement for Credit Protection Accidental Dismemberment Insurance

## 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: ( ) - -

If you are not the Insured, what is your relationship to the Insured? \_\_\_\_\_

Name and Address of Family Physician:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### Details of Accident ("you and your refer to the Insured, if other than the claimant")

1. Date of Accident: \_\_\_\_\_

2. Complete details of accident: where and how did it happen? Please provide an accident report if available.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. If you were involved in a motor vehicle accident and you were the driver, please attach a copy of the police report and motor vehicle accident report.

4. Which covered loss are you claiming?  loss of limb  
 paralysis  
 loss of sight

5. List of all physicians you have seen since your accident.

Physician	Address	Dates	Any hospitalizations; provide dates of admission/discharge	
			From	To

(Please use a separate sheet for additional comments)

## Accidental Dismemberment Insurance Claim Authorization

**Insurer:** TD Life Insurance Company ("TD 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: \_\_\_\_\_

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

(Month, Day, Year)

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

(Print Last name, First name and initial)

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

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

# PART C - Attending Physician's Statement - Accidental Dismemberment

## Section 1 - Patient's Authorization

Ms.  Mrs.  Mr.

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

1. Date of accident \_\_\_\_\_ (Month, Day, Year)      Date you were first consulted regarding the injuries  
resulting from this accident \_\_\_\_\_ (Month, Day, Year)

2. Your diagnosis and complete description of injuries sustained.  
\_\_\_\_\_  
\_\_\_\_\_

3. Did the accident result in loss of

<input type="checkbox"/> Right arm?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below elbow) _____
<input type="checkbox"/> Left arm?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below elbow) _____
<input type="checkbox"/> Right leg?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below knee) _____
<input type="checkbox"/> Left leg?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below knee) _____
<input type="checkbox"/> Right hand?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below wrist) _____
<input type="checkbox"/> Left hand?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below wrist) _____
<input type="checkbox"/> Right foot?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below ankle) _____
<input type="checkbox"/> Left foot?	Date _____ (Month, Day, Year)	Location of amputation (at, above or below ankle) _____

4. Complete loss of vision.

a) If injury necessitated removal of eye, date of removal \_\_\_\_\_  
(Month, Day, Year)

b) Vision in each eye prior to accident      Right \_\_\_\_\_      Left \_\_\_\_\_

c) Present vision, if any, in each eye      Right \_\_\_\_\_      Left \_\_\_\_\_

d) If use can be restored, provide details.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(continued)

5. Loss of use due to paraplegia or quadriplegia.

a) Did the accident result in loss due to

Paraplegia?

Quadriplegia?

Hemiplegia?

b) What was the extent of injury to the spinal cord?

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c) Which, if any, tests were used to make the determination of the extent of injury.

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d) Is loss irrecoverable?

Yes  No

e) Please provide any additional details that may be applicable.

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6. Were the injuries or impairment sustained due solely to the above accident?

Yes  No

If not, please provide details of any condition or disease which in your opinion may have served as a contributory cause.

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Attach any specialist report, if available.

You may mail or fax this form to the Insurer 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

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**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.**