TD Insurance
Instructions for completing the claim package for All in One Medical

The All in One Medical Claim Instructions contains five sections:

- Section 1: Information about the Insured
- Section 2: Travel Details
- Section 3: Medical Information about the Insured
- Section 4: Other Insurance Coverage
- Section 5: Authorization and Declaration

Note:

- Please print all information using a ball point pen.
- Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).
- Completion of all five sections 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.
- If you have any questions, please contact our Administrator at 1-800-293-4941.

Instructions for the Claimant

Check if completed

- ☐ Please complete and sign the attached claim form. Note: Your Claim must be filed within 1 year of incident.
- ☐ Please provide the following documentation, if applicable, and check the appropriate box for each item included:
  - ☐ Proof of relationship if name differs from yours (i.e. marriage certificate/common law status/for children birth certificate naming parents)
  - ☐ All original medical bills and prescription receipts
  - ☐ A photocopy of the sick/injured person's provincial health card
  - ☐ Documentation confirming your departure and return dates (i.e airline tickets, gas receipts, etc...).
  - ☐ In the event that you have paid any eligible expenses, please provide proof of payment (i.e. credit card vouchers, cancelled cheques, etc)
- ☐ Retain a copy of the completed claim package for your records
- ☐ Return the original forms to:

Allianz Global Assistance
P.O. Box 277
Waterloo, ON
N2J 4A4
Fax: (519) 742-9471

TD Insurance
All in One Medical Claim Form

Section 1: Information about the Insured

Name of Insured:____ Case #:____________________
(Last Name) (First Name, Initial)

Address:____
(Number) (Street)

____
(City) (Province) (Postal Code)

Telephone Number: (___)____-_______ Date of Birth: ________________ ❑ Male ❑ Female
(Month, Day, Year)

Insured's Provincial Health Card Number: ______________________________ Version code (for some Ontario residents) ____________

Have you paid for treatment? ❑ No ❑ Yes If yes, total amount being claimed: $____________

If yes, please specify service provider name, amount paid and currency of payment. If you have additional expenses please attach an additional page.

❑ Partial or ❑ Paid in Full (submit proof of payment)

Service provider name:____________________________________ Amount paid: $___________

Address:____
(Number) (Street)

____
(City) (Province) (Postal Code)

❑ Partial or ❑ Paid in Full (submit proof of payment)

Service provider name:____________________________________ Amount paid: $___________

Address:____
(Number) (Street)

____
(City) (Province) (Postal Code)

❑ Partial or ❑ Paid in Full (submit proof of payment)

Service provider name:____________________________________ Amount paid: $___________

Address:____
(Number) (Street)

____
(City) (Province) (Postal Code)

For claims under the TD First Class Travel Visa Card, please complete the following questions.

Certificate Holder/Cardholder (If different from Insured)

Certificate Holder/Cardholder Name: _____________________________ Certificate No.:_________________ Date of Birth:___________
(Last Name) (First Name, Initial) (Month, Day, Year)

Relationship to Certificate Holder/Cardholder:___________________________________

Section 2: Travel Details

Departure Date: ______________ Anticipated/Scheduled Date of Return: _______________ Actual Return Date: _______________
(Month, Day, Year) (Month, Day, Year) (Month, Day, Year)

Nature of Travel: ❑ Business ❑ Vacation ❑ Study ❑ Medical Care ❑ Other: __________________________________

Destination: ____

Mode of Travel: ❑ Car ❑ Airplane ❑ Other: ____

If applicable, was Extension of Coverage purchased? ❑ No ❑ Yes (please specify)______________________________________

Section 3: Medical Information about the Insured

Please describe briefly why medical attention, including the diagnosis was sought.

____

____

Were medical services required as result of an accident? ❑ Yes ❑ No

If yes, please provide details and include an accident report with this form.

____

____

Name of Hospital: ______________________________ Date of Occurrence: ______________
(Month, Day, Year)

Address of Hospital: ______________________________
(Number) (Street)

____
(City) (Province) (Postal Code)

Has the Insured had any of these symptoms/conditions before? ❑ Yes ❑ No

If yes, indicate the date last seen or treated (including medications): ______________
(Month, Day, Year)

Please list all medications prescribed and taken before the departure date:

____

____

____

When were the medications last changed before the departure (includes type and dosage): ______________
(Month, Day, Year)

Name, Address and Phone No. of the Insured's Family Physician:

____

____

____

Name, Address and Phone No. of any Medical Specialist:

____

____

____

Date of the last medical visit (in Canada) before the trip? ______________
(Month, Day, Year)

Country where claim occurred: ______________________________

Section 4: Other Insurance Coverage

Please indicate all insurance coverage which may provide a benefit through any other insurer, including employer group benefits, union or pensioner plans or other travel insurance policies. Attach an additional page if required.

1) Name of Insurer: ____________________ Phone: ____________________

Address ____________________
(Number) (Street)

____
(City) (Province) (Postal Code)

Lifetime limit on policy? ❑ No ❑ Yes (please specify) $___________

Policy/Certificate #____________ Policy/Certificate #___________________

Name of Policyholder: __________________________________

2) Name of Insurer: ____________________ Phone: ____________________

Address ____________________
(Number) (Street)

____
(City) (Province) (Postal Code)

Lifetime limit on policy? ❑ No ❑ Yes (please specify) $___________

Policy/Certificate #____________ Policy/Certificate #___________________

Name of Policyholder: __________________________________

Have these bills been filed with any other company? ❑ No ❑ Yes (please specify)

____

Section 5: Authorization and Declaration

Special Direction for Government Health Insurance Plan and Other Insurance Coverage

- I direct and authorize my provincial government health insurance plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country health services to TD Life Insurance Company ("TD Life") or its administrator Allianz Global Assistance ("Allianz") doing business as Allianz, directly and I hereby release GHIP, upon payment to Allianz from any further claim or cause of action in connection herewith.
- I hereby consent and authorize GHIP, including OHIP, to directly or indirectly collect and use personal information including personal health information related to payment of my claim for out of country services.
- I consent to the disclosure by GHIP, including OHIP, to Allianz of such personal information including personal health information that is related to the processing and payment of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me. I understand that I may withhold my consent to the collection, use, disclosure of such information; however, if I do so there may not be sufficient information for the Insurer, TD Life, to process my claim.
- In consideration of payment made on my behalf, I authorize any benefits paid or payable by another insurance carrier in respect of this claim, to be assigned in whole or in part to TD Life and paid to Allianz or, if directed by Allianz, to TD Life.

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 authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with TD Life and its administrator Allianz or its representatives any and all information regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.
- I authorize any other insurance carrier to release and exchange with TD Life and its administrator Allianz or its representatives any medical or benefits payment information relating to this claim.
- The information provided with respect to this claim will be used by TD Life and its administrator Allianz or their representatives to investigate any losses, assess any entitlement to benefits and to administer this claim, and as otherwise indicated in the privacy terms provided in the Certificate of Insurance. We will investigate and administer this claim by consulting the insurer's existing files and by exchanging information with the undersigned and third parties, such as indicated in this authorization.

- 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, 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 authorize Allianz (including its representatives or affiliates) to disclose to TD Life any information relating to this claim that it may have in its possession including information it obtains from third parties. I am aware that any authorization I provide to Allianz to obtain information about this claim from any third party is also an authorization for TD Life to obtain copies of the information.
- 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 understand that if I am a dependant under this insurance coverage, the named insured will have access to information related to this claim in connection with the administration of this plan.
- I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

Name of Insured: ______________________________ Case #:____________
(Last Name) (First Name, Initial)

Address of Insured:______________________________
(Number) (Street)

____
(City) (Province) (Postal Code)

Signature of Insured: ______________________________ Date: ____________
(Month, Day, Year)

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.

Name of Authorized Representative:______________________________ Case #:____________
(Last Name) (First Name, Initial)

Address of Authorized Representative::______________________________
(Number) (Street)

____
(City) (Province) (Postal Code)

Signature of Authorized Representative:______________________________ Date:____________
(Month, Day, Year)