TD Insurance
Instructions for completing the claim package for Business Credit Living Benefit Insurance Disability (Group Policy # 45073)

This insurance benefit is underwritten by Sun Life Assurance Company of Canada ("Sun Life"), and TD Life Insurance Company ("TD Life") is the authorized administrator. TD Life will be managing this claim on behalf of Sun Life.

The Business Credit Living Benefit Insurance - Disability Claim Package contains three parts:

Part A: Claim for Business Credit Living Benefit Insurance—Disability.
Part B: Claimant's Statement for Business Credit Living Benefit Insurance—Disability.
Part C: Attending Physician's Statement of Disability.

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 Business Credit Living Benefit Insurance—Disability.
☐ Please complete **Part B -** Claimant's Statement for Business Credit Living Benefit Insurance—Disability.
☐ 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 Disability 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

Check if completed:

- ☐ Please complete **Part A -** Claim for Business Credit Living Benefit Insurance—Disability.
- ☐ 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 Business Credit Living Benefit Insurance—Disability

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

Business Credit

Branch/Transit Number: _____

Master Loan number: _____

Name of the Business: _____

_____

Name of the Insured: _____
(Last Name) (First Name and Initial)

Address of the Insured: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Address of the Business: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Insured Date of Birth: _____
(Month, Day, Year)

Insured Telephone Number: ( ) _____

Business Number (BN): ( )_____

Insurance effective date **(Month, Day, Year)**	**Amount of Insurance:**	

Branch comments:

_____

_____

_____

Branch Contact: _____ Signature: _____
(Last Name, First Name)

Title: _____ Date: _____
(Month, Day, Year)

Telephone Number: ( ) _____- _____

PART B

Claimant's Statement for Business Credit Living Benefit Insurance—Disability

Statement of Claim (Completed by Claimant)

Section 1 - Claimant's Statement

Name of the Claimant: _____
(Last Name) (First Name and Initial)

Address: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Telephone number ( ) _____ Alternate telephone number ( ) _____

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

Details of Employment ('you' and 'your' refer to the Insured, if other than claimant)

Your occupation and job title: _____

Job Description: _____

Number of hours worked each week prior to your disability (If the Insured Person is a spouse of the owner or the guarantor of the business and not working, then please leave this space blank): _____

Name, address and telephone number of the business. (If the Insured Person is a spouse of the owner or the guarantor of the business and working, then employer may be different than business. If the Insured Person is a spouse of the owner or the guarantor of the business and not working, then please leave sections (a) and (b) blank).

a) At time of application _____

_____

b) Immediately prior to your disability _____

Details of Disability

1. To your knowledge, what is the diagnosis of your illness? _____
2. On what date did the first symptoms of your illness or injury appear? _____
3. On what date did you first consult a physician for your present illness or injury?
   _____
4. If disability is due to an accident, please provide the date of the accident:
   _____
5. From what date have you been unable to perform your regular occupation?
   _____

		From	To
6. a) Were you confined to bed?	☐ Yes ☐ No If "Yes", give dates		
b) Were you confined to your home?	☐ Yes ☐ No If "Yes", give dates		
c) Were you a patient at a hospital or sanitarium or drug/alcohol rehabilitation center?	☐ Yes ☐ No If "Yes", give dates		

7. a) Describe your present **condition**, its **cause** and **history** to date. If injured, indicate the nature of the accident. Please also advise when and where the accident occurred and how it came about.

b) 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.

8. Please provide responses to following questions.

a) Does your health completely prevent you from working now? ☐ Yes ☐ No

b) If not working, when do you anticipate returning to: 1) your own job? _____ 2) another job? _____

c) If now working 1) Briefly state your duties.

2) When did you return to work? _____

3) Are you now working on a gradual basis? ☐ Yes ☐ No If yes, please confirm the number of hours per week _____

d) Do you have another claim in regards to this loss? ☐ Yes ☐ No If yes, with whom?

9. If you were not employed at the time of your disability and you are spouse of the owner of the business or you are guarantor of the business, please provide a response to the following questions:

Do you need any special assistance to take care of your personal needs and grooming including the following (Please refer to Certificate of Insurance for definition): _____

Wash him/herself by sponge bath, or in a bathtub or shower ☐ Yes ☐ No ☐ By oneself with an assistive device	Put on and remove necessary clothing, braces, artificial limbs or other surgical appliances ☐ Yes ☐ No ☐ By oneself with an assistive device
Manage bladder and bowel hygiene with or without the use of protective undergarments ☐ Yes ☐ No ☐ By oneself with an assistive device	Get him/herself on and off the toilet and maintain personal hygiene ☐ Yes ☐ No ☐ By oneself with an assistive device
Consume food that has already been prepared and served ☐ Yes ☐ No ☐ By oneself with an assistive device	Move in or out of a chair, wheelchair or bed ☐ Yes ☐ No ☐ By oneself with an assistive device

- Are you able to do any housework? Yes _____ No _____
- Please provide details

a) How often do you do house work?

b) Have there been any changes in your ability to care for your household since your disability began? Yes ____ No ____

If yes, please provide details:

_____

10. a) Name and address of Family Physician. Number of Years:

b) Names of all Physicians who have attended you during this disability.

Name	Address	Dates From	Dates To

Please list your present medications:

Name of Medication	Dosage (mg)	How Often?	Date first prescribed
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

☐ Left ☐ Right

11. a) What is your level of education in Canada? _____

b) If educated outside Canada, what is the Canadian equivalent? _____

c) Have you attended any trade schools or received other special training? _____

d) List and give details of all previous occupations. (This question may not be applicable to you if you are the spouse of the owner of the business or you are a guarantor of the business and were not working before the date of disability)

e) In your opinion, how do your limitations and symptoms prevent you from performing your usual job duties?

f) Have you discussed returning to work or rehabilitation with your doctor? ☐ Yes ☐ No
If "Yes", what is his/her opinion?

(This question may not be applicable to you if you are spouse of the owner of the business or if you are guarantor of the business and were not working before the date of disability)

g) Have you contacted Employment Insurance Canada Rehabilitation Services on the possibilities of vocational retraining? ☐ Yes ☐ No

If yes, what is the name and address of the counselor in charge of your case, and what vocational plans have been made? (This question may not applicable to you if you are spouse of the owner of the business or you are guarantor of the business and were not working before the date of disability)

h) Have you ever smoked?

Cigarettes?	**Yes**	Start date: _____ (Month, Day, Year)	**No**	If quit, when?	_____ (Month, Day, Year)
Marijuana?	**Yes**	Start date: _____ (Month, Day, Year)	**No**	If quit, when?	_____ (Month, Day, Year)
Other Tobacco products?	**Yes**	Start date: _____ (Month, Day, Year)	**No**	If quit, when?	_____ (Month, Day, Year)

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Business Credit Living Benefit Insurance—Disability
Claimant Authorization and Declaration

Insurer: Sun Life Assurance Company of Canada ("Sun Life"),

- 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 further authorize the Insurer or its administrator to release information relating to this claim (not including medical information) to The Toronto-Dominion Bank ("TD Bank") to allow TD Bank to manage the credit facility related to this insurance.
- 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.

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.

Claimant: _____
(Print last name, first name and initial)

Claimant's Signature: _____ Date: _____
(Month, Day, Year)

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

PART C - Attending Physician's Statement—Disability

Section 1 - Patient's Authorization

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, Sun Life Assurance Company of Canada ("Sun Life") and its authorized claims administrator, TD Life Insurance Company.

Date: _____ Signature of Patient: _____
(Month, Day, Year)

Section 2 - Attending Physician Statement (Completed by Physician)

This form has been 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 securing this form and any charge which may be made for its completion.

I am the: ☐ Family Physician ☐ Consulting Specialist ☐ Other (please specify): _____

Request for medical records **excludes** any genetic test results. Please do not provide any genetic test results.

Please complete to the best of your knowledge.

Diagnosis
Primary:

_____

_____

Secondary and/or Complications: _____

_____

If Childbirth - Expected or Actual Delivery Date (Mm/dd/yyyy): _____

Is this condition due to:
Occupational Illness/injury? ☐ Yes ☐ No Auto accident: ☐ Yes ☐ No

If yes, date of event: _____ If yes, date of event: _____
(Mm/dd/yyyy) (Mm/dd/yyyy)

Have you completed any other disability claim forms recently for this patient? ☐ Yes ☐ No
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.):

Date of first visit to you pertaining to this condition: _____
(Mm/dd/yyyy)

First date of work absence due to condition: _____
(Mm/dd/yyyy)

Treatment (e.g. Special Programs, Therapies, Medications: (if not noted by patient in Section 1):

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other (describe): _____

Date of first visit: _____
(Mm/dd/yyyy)

Date of last visit: _____
(Mm/dd/yyyy)

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: _____ Treatment Provider: _____
(Mm/dd/yyyy)

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Please elaborate: _____ Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Response to Treatment

Please describe the response to treatment to date:

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No

If so, please explain: _____

Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No Is future hospitalization planned? ☐ Yes ☐ No

	Date of admittance (Mm/dd/yyyy)	**Date of discharge** (Mm/dd/yyyy)	**Institution Name**
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (Mm/dd/yyyy)	**Description**
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future? ☐ Yes ☐ No

Name of Specialist	Specialty	Date (Mm/dd/yyyy)
1.		
2.		

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? ☐ Improved ☐ No Change ☐ Retrogressed

Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:

Has any license held by the patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No

If yes, as of when?_____ (Mm/dd/yyyy) Type of license: _____

Do you have concerns about the patient's ability to manage his/her own affairs? ☐ Yes ☐ No

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals? Please elaborate: ☐ Yes ☐ No

Please provide detail of your patient's tobacco, nicotine or Marijuana use including amount per day and date last used:

_____

_____

Prognosis
Please provide the patient's prognosis for improvement and/or recovery:

_____

_____

_____

Return-to-Work
What return-to-work goals have been discussed with the patient? Please elaborate:

_____

_____

_____

_____

_____

Attach any specialist report, if available

Notice to Physician:
The information in this statement will be kept in a life, health, or disability benefits file with the Insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

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.