TD Insurance
Instructions for completing the claim package for Business Credit Living Benefit Insurance - Critical Illness /Stroke (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 - Critical Illness / Stroke Claim Package contains three parts:

Part A: Claim for Business Credit Living Benefit Insurance – Critical Illness /Stroke
Part B: Claimant's Statement for Business Credit Living Benefit Insurance - Critical Illness/ Stroke
Part C: Attending Physician's Statement of Critical Illness (Stroke)

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 –Critical Illness/Stroke.
☐ Please complete **Part B -** Claimant's Statement for Business Credit Living Benefit Insurance - Critical Illness/ Stroke.
☐ 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 for Critical Illness (Stroke) are completed.

Section 1 - Patient's Authorization - 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.

TD Life Insurance Company is the authorized administrator for this insurance. For more details on insurer and/or administrator information, please refer to the Certificate of Insurance. All trade-marks are the property of their respective owners.
® The TD logo and other TD trade-marks are the property of The Toronto-Dominion Bank.

Instructions for Branch

Check if completed:

- ☐ Please complete **Part A - Claim for Business Credit Living Benefit Insurance-Critical Illness/ Stroke.**
- ☐ 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 - Critical Illness/ Stroke

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

Branch/Transit Number: ____________________ Master Loan Number: ____________________

Name of 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: ____________________

Remarks:		

Branch Contact: ____________________ Signature: ____________________

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

Telephone Number: ( ) ______- ________

PART B

Claimant's Statement for Business Credit Living Benefit Insurance - Critical Illness/ Stroke

Statement of Claim (Completed by Insured/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?

____

1. Claim and related details ('you' and 'your' refer to the Insured, if other than claimant)

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? ____________

Please provide the physician's name, address and telephone number: ____________________

____

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

____

____

____

2. Medical Consultations

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

____

____

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

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.

____

____

____

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).

____

____

____

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

____

____

____

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

Type of treatment	Institution/Physician	Dates From	To

f) 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)

3. General

a) Have you or any of your immediate family (mother, father, brother(s), sister(s)) had cancer (including leukemia, lymphoma and Hodgkin's disease), a tumor, stroke/TIA, heart disease, heart attack or diabetes before the age of 60? ☐ 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.

____

Business Credit Living Benefit Insurance Critical Illness—Stroke.
Claimant's 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 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 (not including medical information) to The Toronto-Dominion Bank ("TD Bank") to allow TD 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 [am authorized to sign on their behalf] and 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: ______________________________

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 of Critical Illness - Stroke

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 the Insurer, **Sun Life Assurance Company of Canada** and its authorized claims administrator, TD Life Insurance Company.

Date ____________________ Signature of Patient: ______________________________
(Month, Day, Year)

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 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.

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

1. a) On what date did your patient first consult you for this condition?

____

b) How long has the Insured been your patient?

____

2. a) Was a diagnosis of a Stroke made? ☐ No ☐ Yes

b) On what date did the Stroke occur?

____

c) Please describe the cause of the Stroke (if known).

____

d) When did your patient first suffer symptoms or episodes of cerebrovascular disease? What were these symptoms?

____

d) Please describe the residual neurological deficits.
Are there neurological deficits? ☐ Yes ☐ No

If yes, please provide information on each neurological deficit:

____

Deficit	Persisting (Y/N)	Resolved(Y/N)	Date resolved (if applicable)

e) How long have the neurological deficits persisted?

____

f) By whom was the diagnosis made (if other than yourself)?

____

g) Please provide a copy of the CT scan if available.

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

4. Is there any immediate family history of cancer (including leukemia, lymphoma and Hodgkin's disease), a tumor, stroke/TIA, heart disease, heart attack or diabetes before the age of 60? ☐ Yes ☐ No

If yes, list condition, date of diagnosis and nature of illness.

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

5. Please provide detail of your patient's tobacco or nicotine use including amount per day and date last used (List all risk factors and the date each was first diagnosed):

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.