TD Insurance

Instructions for completing the Accident Disability Insurance –claim package

The Accident Disability claim package contains three parts:

- **Part A:** Accident Disability Claim Form
- **Part B:** Attending Physician's Statement
- **Part C:** Additional Supporting Documentation

Note:

- **Request for medical records excludes any genetic test results. Please do not provide any genetic test results**.
- **Please print all information using a pen.**
- **Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).**
- **Completion of all parts is required, and any missing information may result in a delay of the processing of your claim.**
- **Checkboxes are provided below to assist you in completing the claim package.**
- **A claims analyst will send you a confirmation of receipt in writing within 10 business days of receiving your claim package.**
- **If you have any questions, please contact TD Life Insurance Company at 1-888-788.0839.**

Check if completed:

☐ Part A – Accident Disability Claim Form

Note: All sections in **Part A** to be completed by the Insured Person. If you are not the Insured Person, you must be an authorized representative of the insured.

- ☐ **Section 1 – Certificate Information**
- ☐ **Section 2 – Insured Person's Statement**
- ☐ **Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**
  - If you choose to have the payment for these benefits deposited directly to your bank account please complete section 3 and attach a void cheque.
- ☐ **Section 4 – Declaration, Authorization & Signature**

☐ Part B – Attending Physician's Statement

Note: Part B of this document can be detached and provided to the Attending Physician to complete and send separately to TD Life Insurance Company.

- ☐ **Section 1 – Insured Person's Authorization**
  - The Insured Person's signature and date are required.
- ☐ **Section 2** - **Attending Physician's Statement**
  - Must be completed and signed by a licensed medical practitioner.

(Please see over)

□ Part C – Additional Supporting Documentation

□ **Hospital Discharge Statement –** Please provide a copy, if applicable.

□ **Proof of Age of Insured Person –** Please provide a copy of **one** of the following:

- Birth Certificate
- Canadian Driver's License
- Permanent Residence Card
- Canadian Passport
- Canadian Citizenship Card

TD Insurance
TD Life Insurance Company
P.O. Box 1
TD Centre
Toronto ON M5K 1A2

Part A - Accident Disability Claim Form

In this form "Insured Person" means the person who is insured under this policy.
"Claimant" means the person who is making the claim.

Section 1: Certificate Information

Accident Disability insured by TD Life Insurance Company*

Certificate Number:		**Issue Date:**	
Name of Insured Person (full legal name) *(Please print)*			
Address of Insured Person			
Date of Birth of Insured Person (mm/dd/yyyy)			
Insured Person's Contact Information:	**Residence:**		
	Cellular:		
Type of Claim:	**Accident Disability**		

*TD Life Insurance Company is the authorized administrator for this insurance. For more details on insurer and/or administrator information, please refer to the Insurance Certificate.

Section 2: Insured Person's Statement

Name of Claimant: (if different from Insured Person)					
Claimant's Date of Birth: (if different from Insured Person)					
Relationship to Insured Person					
Claimant's Address: (if different from Insured Person)					
Claimant's Contact Information: (if different from Insured Person)	**Residence:**				
	Cellular:				
Occupation and Job Title					
Name of Employer:					
Address of Employer:					
Phone Number of Employer:					
Job Description					
What is your annual income? (please provide proof of income)	$				
Number of hours worked each week prior to your disability		**Last date worked** (mm/dd/yyyy)			
From what date has your disability prevented you from working? (mm/dd/yyyy)					
What date did your symptoms first appear? (mm/dd/yyyy)					
Please provide details of your disability:					
Are you confined to a bed?	□ Yes □ No	**If "Yes" provide dates (mm/dd/yy)**	From	To	
Are you confined to your home?	□ Yes □ No	**If "Yes" provide dates (mm/dd/yy)**	From	To	

(Continued)

Are you a patient at a hospital, sanitarium or drug/alcohol rehabilitation center?	□ Yes □ No	**If "Yes" provide name, address of hospital**	
Does your health completely prevent you from working now?	□ Yes □ No		
If not currently working, when do you anticipate returning to:	Your own job:	Another job:	
If currently working, describe your duties if different from your regular duties			
	What date did you return to work? (mm/dd/yyyy)		
Have you returned to work on a gradual basis? □ **Yes** □ **No**	**If "Yes" please confirm the number of hours you work per week**		
Do you have another claim filed for this accident?	□ Yes □ No	If "Yes" with who?	
Name of Family Physician:			
Address of Family Physician:			
How long have you been consulting this physician?			
If less than 2 years, please provide name and address of previous physician(s)			
Physician's name:			
Physician's address:			
Please provide the name and address of all the doctors you've seen for this disability:			

Name	**Address**	**Dates** **To**	**From**
Name	**Address**	**Dates** **To**	**From**

(Please see over)

Name	Address	Dates From To

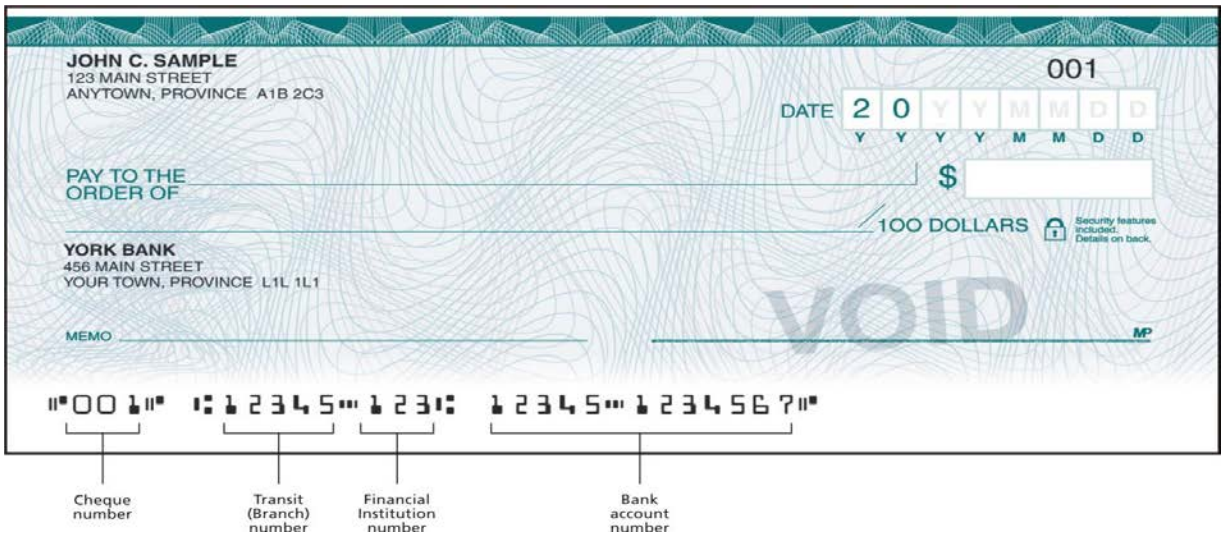
List of your present medications			Please provide:
Name of Medication	Dosage (mg)	How Often?	
1. _____	_____	_____	Height: _____
2. _____	_____	_____	Weight: _____
3. _____	_____	_____	Dominant Hand: ☐ Left ☐ Right
4._____	_____	_____	
5. _____	_____	_____	

Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

At your request, we can deposit your benefit directly to your designated account. This will ensure that you receive your claim payment as quickly and efficiently as possible

Do you wish to proceed with this option? □ Yes □ No

If yes, please attach a void cheque that clearly identifies the Bank Account (the "Account") into which you wish the payment to be deposited into or, enter this information in the space provided under Account information and sign and date this form at the bottom. Please note that if you are not a TD Canada Trust account holder and are not attaching a void cheque, we require your financial institution's address in order to deposit your benefit into your designated account.



Account information:

For help filling out your account information, please see sample cheque above.

Transit Number **Financial Institution Number** **Bank account number**

Bank Address

I_____(Please print name) as the Insured Person under the Insurance Certificate (the "Insurance Contract"), issued by TD Life Insurance Company (TD Life), hereby irrevocably direct and authorize TD Life (both as insurer and as administrator to deposit all claim benefits payable under the Insurance Contract, through electronic funds transfer (direct deposit) to the account number as noted above and this shall serve as your good and sufficient authority for so doing. I consent to the collection, use and disclosure of my personal information for the purpose of paying this claim by this method. I fully release TD Life from any and all liability in regard to such payment upon its deposit in the above described Account. If such account is a joint account with any other person or belongs to a third party, it shall not be TD Life responsibility should any funds be withdrawn by any person other than me or are used to pay down any indebtedness for which this account is responsible. I understand that TD Life is unable to verify the accuracy of an account number so I am responsible in the event that an incorrect account number is provided. I will ensure the information is accurate.

Signature Date (mm/dd/yyyy)

Section 4: Declaration / Authorization / Signature

Insurer: TD Life Insurance Company

- 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 void.
- By signing below, you agree that we may collect, use and disclose your Information as described in the Privacy Agreement attached to your Insurance Policy including for, but not limited to, the purposes of identifying you, providing ongoing service, processing your claims, understanding your financial needs, protecting us both from fraud and error and complying with legal and regulatory requirements.
- 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 Person, 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.
- In providing this authorization to collect personal information about the Insured Person relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured Person 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.

Insured Person's Name:_____ Date: _____
(Please print) (mm/dd/yyyy)

Insured Person's Signature:

_____

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

TD Insurance
TD Life Insurance Company
P.O. Box 1
TD Centre
Toronto ON M5K 1A2

Part B - Attending Physician's Statement – Accident Disability Insurance Plan

Notes:

- The Insured Person 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.

Section 1 - Insured Person's Authorization

Certificate Number: _____

Accidental Disability insured by TD Life Insurance Company*

Insured Person's Name _____ **Date of Birth**:_____
(Please print) (mm/dd/yyyy)

I hereby authorize the release of any information requested in respect of this claim, to TD Life Insurance Company.

Date: _____ **Signature of Insured Person**:_____
(mm/dd/yyyy)

*TD Life Insurance Company is the authorized administrator for this insurance. For more details on insurer and/or administrator information, please refer to the Insurance Certificate.

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 Insured Person, sufficient details of family and medical history, investigation, findings and treatment are essential.
- This form may be mailed directly to TD Life Insurance Company or given to the patient at the physician's discretion.
- The above named is insured with TD Life Insurance Company against the occurrence of unforeseen events connected with their health. A claim has been submitted in connection with **Accident Disability** coverage and, to enable the assessment of the claim, we would appreciate your cooperation on the completion of this form.

Patient's Name: (Please print)	
Patient's Date of Birth: (mm/dd/yyyy)	

1. Diagnosis

Primary:			
Secondary and/or Complications:			
Objective findings (including results of current X-Rays, ECGs, or any other special tests. Please attach copies of any test results.			
Other contributing factors/complications:			
Is this condition due to:			
Occupational Illness/Injury ☐ Yes ☐ No	If yes, provide date of event: (mm/dd/yyyy)	Auto or other accident: ☐ Yes ☐ No	If yes, provide date of event: (mm/dd/yyyy)
Have you recently completed any other disability claim forms for this patient?	☐ Yes ☐ No		
If yes, indicate requestor: (other insurance company, CPP, QPP, WISB, etc.)			
Date of first visit to you pertaining to this condition: (mm/dd/yyyy)			
First date of work absence due to conditions: (mm/dd/yyyy)			

(Continued)

2. Treatment

State any special programs, therapies, medications:				
Frequency of visits:	☐ Weekly ☐ Monthly ☐ Other (describe):		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, please provide the following: Date: (mm/dd/yyyy)	Treatment Provider:	
Is the patient following the recommended treatment program?	☐ Yes ☐ No	Please elaborate:		
Response to treatment to date:	☐ Complete ☐ Partial ☐ None ☐ Too soon to tell			
Are there any plans to change or augment the treatment program?	☐ Yes ☐ No	If yes, please explain:		

3. 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.		

(Please see over)

If surgery(s) was or will be performed, please provide the following:	
Date (mm/dd/yyyy)	Description of surgery(s)
1.	
2.	

4. Investigations

Please attach copies all relevant:		
▪ Test results/investigations (If test results are not attached, we will assume that tests were not performed) ▪ Consultation reports		
Are there any tests/investigations still pending?	☐ Yes ☐ No	
If yes, please update below:		
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	
If yes, please update below:		
Name of Specialist	Specialty	Date (mm/dd/yyyy)
1.		
2.		
3.		

5. Clinical Findings and Observations

Describe the patient's symptoms, including history, severity and frequency:_____

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

6. Restrictions and Limitations

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

_____

_____

_____

_____

_____

_____

_____

_____

Has any license held by the patient been restricted or revoked because of this condition?	☐ Yes ☐ No
If yes, as of when? Date: _____ (mm/dd/yyyy)	If yes, what type of license:
Are there concerns about the patient's ability to manage their own affairs?	☐ Yes ☐ No

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

Please elaborate:

_____

_____

_____

_____

(Please see over)

7. Prognosis

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

_____

_____

_____

_____

8. Return-to-Work

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

_____

_____

_____

_____

_____

Attach any specialist report, pathology or test results, 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: 1-888-788-0839
Fax: 416-308-1223 / 1-877-838-2163

These statements are true and complete to the best of my knowledge and belief.

Date: _____ **Physician's Signature:** _____
(mm/dd/yyyy)

Physician's Name: _____ **Address:** _____
(Please print)

Specialty: _____

Telephone Number: **(** **)** _____ **Fax Number:** **(** **)** _____