Instructions for Accidental Death Claim/Common Carrier Claim

1. **Section 1 – Certificate Information:** Is to be completed by the claimant or the Insured Person if the claim is for a minor.
2. **Section 2 – Claimant's Statement:** Is to be completed by the claimant or the Insured Person if the claim is for a minor. Be sure to include your phone number and the Insured Person's social insurance number.
3. **Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**
   If your claim for benefits is $25,000 or less, you may choose to have the payment for these benefits deposited directly to your Bank account. Please complete section 3 and attach a void cheque if you wish to take advantage of this payment option.
4. **Section 4 – Authorization & Signature** must be completed by the claimant.
5. **Attending Physician's Statement –** Please have your physician complete this form. If the form is completed by a physician, other than the primary insured's family physician, please provide the name, address and phone number of the primary insured's family physician.
6. **Supporting Documentation –** Please provide a copy of all that apply:
   - Provincial Death Certificate or Funeral Director's Statement
   - Coroner's Report
   - Police Report
   - Autopsy Report
   - Newspaper Clippings

If claiming Common Carrier benefits, please provide a copy of the Insured Person's ticket, accident report that was filed with the carrier and any other information pertaining to the accident.

7. **Proof of Age of the Insured Person as well as the Claimant** - Please provide a copy of at least one of the following:
   - Birth Certificate
   - Canadian Passport
   - Canadian Drivers Licence
   - Canadian Citizenship Card
8. **Please attach a copy of the "Coverage Schedule" of your Certificate of Insurance.**
9. **Send all completed documents** and any additional necessary documentation directly to TD Life Insurance Company, in the postage-paid envelope provided. Should you need to use a larger envelope, please address the envelope as follows:

TD Life Insurance Company
Attn: Claims Department
P.O. Box 1, TD Centre
Toronto, Ontario
M5K 1A2

10. **Keep a copy** of the completed claim forms for your records.

Again, should you have any question(s) about how to complete these forms, please contact us at: 1-888-788-0839.

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

Accidental Death/Common Carrier Claim Form

Section 1: Certificate Information

Certificate	#	**Issue Date**	
Name of Insured Person (full legal name)			

Section 2: Claimant's Statement

Name of Deceased Policyholder:			
Sum Insured:	$		
☐ Smoker		☐ Non-Smoker	
If smoker, please provide date of last use of tobacco product(s)		**Date** (m/d/y) →	
Please indicate type of tobacco product or use of any substance or product containing the following: Tobacco ☐ Nicotine ☐ Marijuana ☐			
Date of Birth: (m/d/y)		**Place of Birth:**	
Date of Accident: (m/d/y)		**Place of Death:**	
Date of Death: (m/d/y)		**Cause of Death:**	
Details of Accident:			
Please indicate type of Common Carrier:			
Airline (Provide copy of tickets, name of Airline and flight number)	☐		
Train (Provide copy of tickets, rail carrier, destination and route)	☐		
Public Transport (Provide copy of ticket and route number, if applicable)	☐		
Water Vessels (Provide copy of tickets and name of carrier)	☐		
Taxi (Provide copy of receipt)	☐		
Other (indicate type)	☐		
In what capacity or by what title do you claim the insurance? ☐ Executor or Administrator ☐ Named Beneficiary			
Name of Claimant:			
Claimant's Social Insurance Number:			
Claimant's Date of Birth: (m/d/y)			
Claimant's Address:			
Claimant's Telephone Number(s)	**Residence**	( )	
	Business	( )	

	Cellular	**(　　　　)**

(Please see over)

Name and Address of Family Physician of the deceased:		
Date Seen (m/d/y)	**Reason**	**Result**

Other physicians consulted, including any hospitals or institutions during the last five years.

Physician, Hospital, Institution	Address	Date of Consultation (m/d/y)	Reason

Additional life insurance in force with our company or any other company:

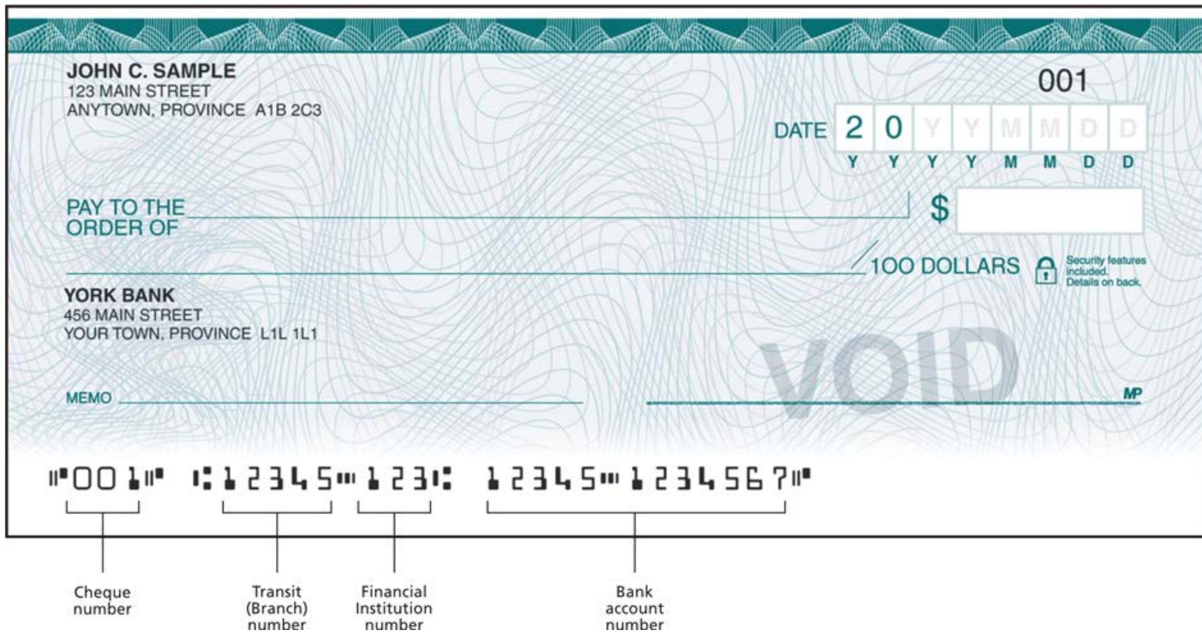
Company	Effective Date	Face Amount

Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

If your claim payment is $25,000 or less, 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 owner or a beneficiary under a Certificate or Policy of Insurance (the "Insurance Contract") issued by TD Life Insurance Company (TD Life) and/or Sun Life Assurance Company (Sun Life) if applicable, hereby irrevocably direct and authorize TD Life (both as insurer and as administrator for Sun Life Assurance Company if applicable) to deposit all claim benefits payable under the Insurance Contract (not to exceed $25,000), 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 and Sun 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 or Sun Life's responsibility should any funds are 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

(Please see over)

Section 4: Declaration / Authorization / Signature

Claimant's Declaration:

I declare that the statements made are true, complete and correctly recorded. I understand that concealment, misrepresentation or false declaration concerning this statement could cause any insurance to be void.

Claimant's 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 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 insurer, TD Life Insurance Company, 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. This consent shall be valid during the continuation of such claim. I also authorize the insurer, TD Life Insurance Company, its reinsurers and their respective agents to exchange and or transmit information concerning this claim to the organizations listed above as is necessary to evaluate this claim.

Signed at ______________________________ Date ______________________________
(m/d/y)

Claimant's name: ____
(Please print)

Claimant's signature: ____

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

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

Attending Physician's Statement – Proof of Death

(*Charges for the completion of this form are the responsibility of the claimant*)

Name of Deceased: (full legal name)					
Date of Birth: (m/d/y)		**Place of Death:**			
Date of Death: (m/d/y)					
Death Resulted From:	☐ **Natural Causes**	☐ **Suicide**	☐ **Homicide**	☐ **Accident**	☐ **Other**

- Disease or condition directly leading to death: ____________________

  Duration: ____________________
- Antecedent Causes: ____________________

  Duration: ____________________

1. Date of first attendance in final illness:	**Date (m/d/y)** →	
2. Date of last attendance in final illness:	**Date (m/d/y)** →	
3. Did the Deceased smoke or use tobacco products?	☐ **Yes**	☐ **No**
4. If Yes, when did he/she last smoke or use tobacco products?	**Date (m/d/y)** →	
5. If accident, suicide or homicide, describe briefly:		
6. Was death solely due to this accident?	☐ **Yes**	☐ **No**
7. Was there an inquest?	☐ **Yes**	☐ **No**
8. Was there an autopsy? If Yes, please attach a copy.	☐ **Yes**	☐ **No**

If "Yes" to either question 7 or 8, by whom and with what result?

Name	**Result**

(Please see over)

	☐ Yes	☐ No
9. Have you treated or advised the deceased during the last 5 years, prior to last illness?	☐ Yes	☐ No
10. Did the deceased to your knowledge, receive treatment during the last 5 years from any other Physician or in any Hospital or Institution?	☐ Yes	☐ No

If "Yes" to either question 8 or 9, please provide the following details:

Name	**Address**	**Nature of Illness or Injury**	**Date** (m/d/y)

Physician's Remarks: ____

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

Date: _________________________________ Physician's Signature:________________________________

Printed Name: ____

Address: ____

Telephone Number: (   ) ______________________ Fax Number: (   ) ______________________