Instructions for Injury Insurance 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)**

4. 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.

5. **Section 4 – Authorization & Signature** must be completed by the claimant.

6. **Attending Physician's Statement –** Please have a physician complete this form. If the form is completed by a physician, other than that of the primary insured's family physician, please provide the name, address and phone number of the primary insured's family physician.

7. **Supporting Documentation -** Please provide a copy of all that apply :

   - Accident Report
   - Newspaper Clippings
   - Hospital Admittance Statement
   - Police Report
   - Employer Accident Report
   - Hospital Discharge Statement

8. **Proof of Age of Insured Person as wells as Claimant -** Please provide a certified copy or original of at least one of the following:

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

9. **Please attach a copy** of the"Coverage Schedule" of your Certificate of Insurance.

10. **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

11. **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

Illness & Injury Claim Form

Section 1: Policy/Certificate Information

Policy/Certificate	#	**Issue Date**	
Name of Insured Person (full legal name) *(Please print)*			
Address of Insured Person			
Date of Birth of Insured Person (m/d/y)			
Social Insurance Number of Insured Person			
Type of Claim	**Dismemberment**		

Section 2: Claimant's Statement

Name of Claimant:			
Claimant's Date of Birth: (m/d/y)			
Relationship to Primary Insured:			
Claimant's Address: (if different from primary insured)			
Claimant's Telephone Number: (if different from primary insured)			
Amount of Coverage	**$**		
Nature of Injury: **(Describe where & how injury happened.)**			
Date Injury occurred: (m/d/y)			
Date admitted to hospital: (m/d/y)		**Date discharged from hospital:** (m/d/y)	

(Please see over)

Hospital Name:	
Hospital Address:	
Name of Family Physician:	
Address of Family Physician:	
How long have you been consulting this physician?	
If less than 2 years, please provide name & address of previous physician (s).	
Other Physician's name	
Other Physician's Address	

Additional Comments: _____

_____

_____

_____

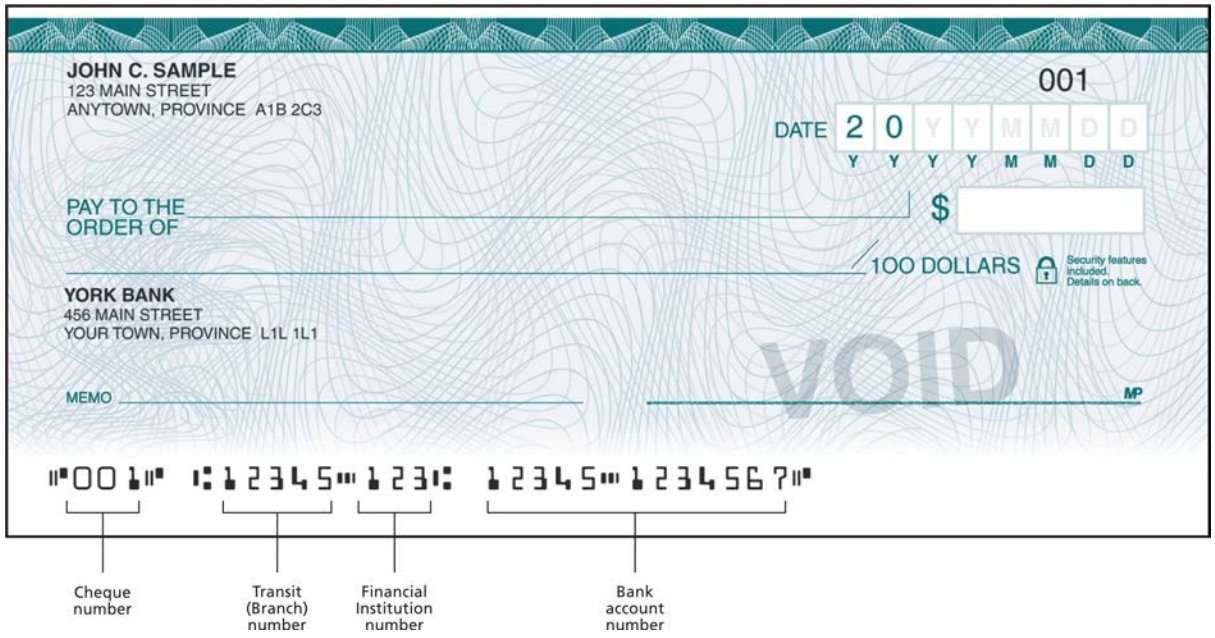
_____

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

Internal

(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 – Hospital Benefit

(To be completed by the Family Physician)

Physicians:

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 cross out non-applicable areas. In order to help the claimant, sufficient details of 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.

Patient's Name: _____ **Date of Birth:** _____

I hereby authorize the release to my insurer any information requested in respect of this claim.

Date: _____ **Signature of Patient:** _____

Any charges for the completion of this form are the responsibility of the claimant.

1. Nature of injury (describe complications, if any):		
2. When did accident happen?	**Date** → (m/d/y)	
a) Was this hospital confinement solely a result of an accident?	☐ Yes	☐ No
b) If Yes, please provide details:		
c) Name and Address of Family Physician (if other than yourself):		
3. When did patient first consult you for this condition?	**Date** → (m/d/y)	
a) Was the patient referred to you?	☐ Yes	☐ No
b) If Yes, by whom:		
4. Has the patient ever had same or similar condition:	☐ Yes	☐ No
a) If Yes, state when and describe:		
5. Was hospitalization as an inpatient required?	☐ Yes	☐ No
a) If Yes, please indicate dates of hospitalisation and attach a copy of the	**Admission Date** → (m/d/y)	

hospital dmission and discharge reports.	**Discharge Date** → (m/d/y)

(Please see over)

6. List surgical procedure(s), if any (describe fully):		
Date Performed:	**Date** → (m/d/y)	
If performed in a hospital, was it:	☐ In-Patient	☐ Out-Patient
Please provide name & address of hospital:		
7. Is further operative procedure(s) anticipated:	☐ Yes	☐ No

Remarks: _____

_____

_____

_____

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

Date: _____ **Physician's Signature:** _____

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

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

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

Attending Physician's Statement – Critical Accident

(To be completed by the Family Physician)

Physicians

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 cross out non-applicable areas. In order to help the claimant, sufficient details of 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.

Patient's Name: _____ **Date of Birth:** _____

I hereby authorize the release to my insurer any information requested in respect of this claim.

Date: _____ **Signature of Patient:** _____

Any charges for the completion of this form are the responsibility of the claimant.

1. Date of Accident:	**Date** → (m/d/y)
2. On what date did your patient first consult you regarding the injuries resulting from this accident?	**Date** → (m/d/y)
3. Your diagnosis and compete description of injuries sustained:	

4. Did the accident result in loss of:

☐ Right Arm?	**Date →** **(m/d/y)**		Location of amputation (at, above or below elbow)	
☐ Left Arm?	**Date →** **(m/d/y)**		Location of amputation (at, above or below elbow)	
☐ Right Leg?	**Date →** **(m/d/y)**		Location of amputation (at, above or below knee)	
☐ Left Leg?	**Date →** **(m/d/y)**		Location of amputation (at, above or below knee)	
☐ Right Hand?	**Date →** **(m/d/y)**		Location of amputation (at, above or below wrist)	
☐ Left Hand?	**Date →** **(m/d/y)**		Location of amputation (at, above or below wrist)	
☐ Right Foot?	**Date →** **(m/d/y)**		Location of amputation (at, above or below ankle)	
☐ Left Foot?	**Date →** **(m/d/y)**		Location of amputation (at, above or below ankle)	
☐ Right Index Finger?	**Date →** **(m/d/y)**		Complete and permanent severance of the digit	
☐ Left Index Finger?	**Date →** **(m/d/y)**		Complete and permanent severance of the digit	
☐ Right Thumb?	**Date →** **(m/d/y)**		Complete and permanent severance of the digit	

☐ Left Thumb?	**Date →** **(m/d/y)**		Complete and permanent severance of the digit

(Please see over)

5. Complete loss of vision.		
a) If injury necessitated removal of eye, date of removal:	**Date** → (m/d/y)	
b) Vision in each eye prior to accident: Right		
Left		
c) Present vision in each eye: Right		
Left		
d) If use can be restored, please provide details:		
6. Loss of hearing:		
a) Is deafness a direct result of an accident?	☐ Yes	☐ No
b) Has the deafness been verified by audiological testing?	☐ Yes	☐ No
If yes, what were the results?		
c) Is the loss irrecoverable?	☐ Yes	☐ No
7. Loss of speech:		
a) Is speech loss a direct result of an accident	☐ Yes	☐ No
b) Has the speech loss been assessed by a speech therapist?	☐ Yes	☐ No
If yes, what were the results?		
c) Is the loss irrecoverable?	☐ Yes	☐ No
8. Brain Damage:		
a) Is brain damage a direct result of an accident?	☐ Yes	☐ No
b) Has the brain damage been assessed by a specialist?	☐ Yes	☐ No
c) What investigations were used to assess the severity of the injury?		
If so, what were the results?		
d) Does the patient require any of the following:	☐ Yes	☐ No
Specialized Care	☐ Yes	☐ No
Specialized Feeding	☐ Yes	☐ No
Rehabilitation	☐ Yes	☐ No
Institutionalization	☐ Yes	☐ No
If yes, please give details		

e) Do you expect improvement?	☐ Yes	☐ No

9. Loss of use due to hemiplegia, paraplegia or quadriplegia.		
a) Did the accident result in loss due to :	Paraplegia? ☐	Quadriplegia? ☐
b) What was the extent of the injury to the spinal cord?		
c) Which, if any, tests were used to make the determination of the extent of injury.		
d) Is the loss irrecoverable?	☐ Yes	☐ No
e) Please provide any additional details that may be applicable:		
10. Were the injuries or impairment sustained due solely to the above accident?	☐ Yes	☐ No
If not, please provide details of any condition or disease, which in your opinion may have served as a contributory cause.		

11. Coma:			
a) Is the coma a direct result of an accident?	☐ Yes	☐ No	
b) Please provide us with copies of all consultation/investigation reports			
c) Is he/she on life support?	☐ Yes	☐ No	
d) Do you expect improvement?	☐ Yes	☐ No	
12. Burns:			
a) Was the burn a direct result of an accident?	☐ Yes	☐ No	
b) Please indicate the degree of burn	1st degree ☐	2nd degree ☐	3rd degree ☐
c) Location of burn?			
d) Treatment provided?			
13. Did the patient require admission to hospital as an in-patient ?	☐ Yes	☐ No	
If Yes, provide date of hospital admission	Date → (m/d/y)		
and date of hospital discharge.	Date → (m/d/y)		

(Please see over)

Physician's Remarks: _____

_____

_____

_____

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

Date: _____ **Physician's Signature:** _____

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

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