TD Insurance

Instructions for completing the Guaranteed Acceptance Life Insurance – Compassionate Advance Living Benefit claim package

The Guaranteed Acceptance Life Insurance - Compassionate Advance Living Benefit claim package contains three parts:

- **Part A:** Guaranteed Acceptance Life Insurance - Compassionate Advance Living Benefit Claim Form
- **Part B:** Attending Physician's Statement **–** Guaranteed Acceptance Life Insurance - Compassionate Advance Living Benefit
- **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 – Guaranteed Acceptance Life Insurance – Compassionate Advance Living Benefit Claim Form**

Note: All sections in **Part A** to be completed by the Insured Person.

☐ **Section 1 – Policy 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 - Guaranteed Acceptance Life Insurance - Compassionate Advance Living Benefit**

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.

(continued)

□ 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 - Guaranteed Acceptance Life Insurance - Compassionate Advance Living Benefit Claim Form

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

Section 1: Policy Information

Guaranteed Acceptance Life Insurance insured by TD Life Insurance Company*

Policy Number:		**Issue Date:**	
Insured Person's Name:			
Policy Owner Name: (if different than Insured Person)			
Type of Claim:	Compassionate Advance Living Benefit		

*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/Policy.

Section 2: Insured Person's Statement

Insured Person's Name:			
Insured Person's Address:			
Insured Person's Date of Birth: (mm/dd/yyyy)		**Date of Diagnosis:** (mm/dd/yyyy)	
Insured Person's Contact Information:	**Residence:**		
	Cellular:		
	Email:		
Name and Address of Insured Person's Family Physician:			
How long has this doctor been the Insured Person's Family Physician:			
☐ Smoker		☐ Non-Smoker	
If a smoker, please provide the last date used		**Date** (mm/dd/yyyy)	
Please indicate type of tobacco product or use of any substance or product containing the following:			
☐ Tobacco ☐ Nicotine ☐ Marijuana			

Other doctors consulted during the last 12 months, hospitals and institutions attended.

Physician, Hospital, Institution	Address	Nature of Illness or Injury	Dates

1. Please provide details of your illness:

_____

_____

_____

2. a) Are you confined to bed? ☐ Yes No ☐

   b) Are you confined to your home? ☐ Yes No ☐

   c) Are you a patient at a hospital? ☐ Yes No ☐

   If the answer to 2(c) is Yes, please provide name and address of hospital:

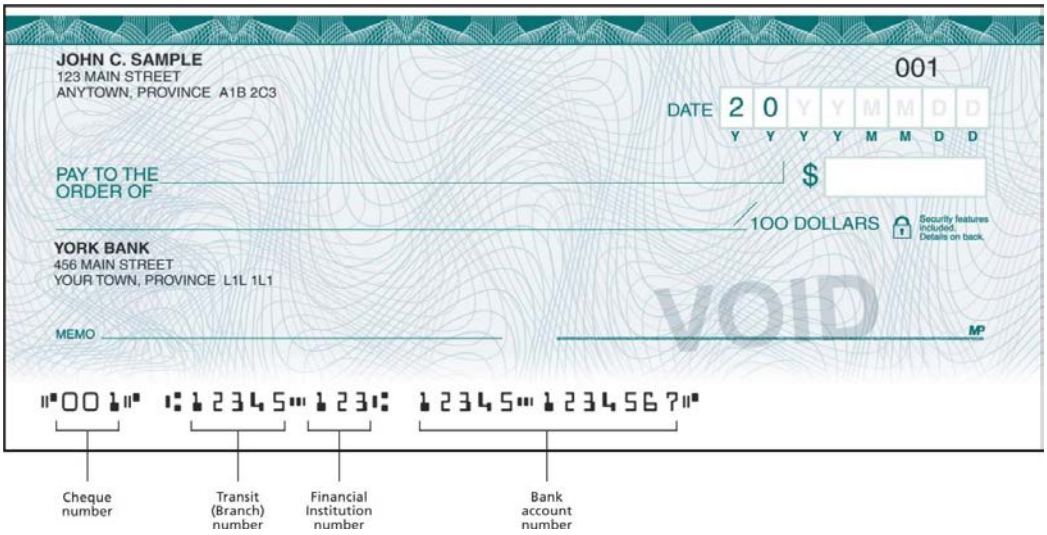
   _____

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 Policy (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

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

By signing below you— the Insured Person—also agree to the following unless you check the box below to indicate that you do not agree:

- If you do not qualify to claim for the Compassionate Advance Living Benefit, we may explain this to the Policy Owner. If other information negatively affects our claim decision, we may tell the Policy Owner whether the relevant information relates to your family history, medical information or lifestyle.

I do not agree to the disclosure of my personal information to the Policy Owner.

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

Guaranteed Acceptance Life Insurance - Compassionate Advance Living Benefit

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

Policy Number: _____

Guaranteed Acceptance Life Insurance is insured by TD Life Insurance Company*

Insured Person's Name: _____
(Please print)

Date of Birth:_____
(mm/dd/yyyy)

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

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

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*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/Policy.

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 happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **Compassionate Advance Living Benefit** and, to enable the assessment of the claim, we would appreciate for your cooperation on the completion of this form.

_____

1. Diagnosis

a) Primary: _____ Symptoms: _____

b) Secondary: _____ Symptoms: _____

c) Objective findings (including results of current X-rays, ECGs or any other special tests).
Please attach copies of any test results.

_____

_____

d) Other contributing factors/complications:

_____

2. History

a) Symptoms began: _____

(mm/dd/yyyy)

b) Date of diagnosis: _____

(mm/dd/yyyy)

c) Date patient advised of diagnosis: _____

(mm/dd/yyyy)

d) What treatment and/or medication have been prescribed?

_____

_____

How often do you see the patient?

_____

e) Has your patient ever had the same or similar condition? Yes No Unknown

If "Yes", state when and describe:

_____

_____

_____

_____

(Continued)

3. Clinical Findings and Investigations

Has your patient been referred to any other physicians or specialists? Yes No
If "Yes", complete the following chart:

Physician's Name and Specialty	Date of Examination	Summary of Findings

4. Prognosis

What is your patient's prognosis?

_____

_____

Based on your knowledge of your patient's condition and your experience, what is your estimation of your patient's life expectancy?

Are any further treatment options being considered?

_____

_____

If yes, when will this treatment commence?

_____

_____

What is the expected outcome?

_____

_____

Attach any specialist report, pathology or test results, if available.

Please mail or fax this form to:

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

_____

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

Physician's Name: _____ Physician's Signature: _____
(Please print)

Physician's Specialty: _____

Date: _____ Address: _____

Telephone Number: ( ) _____Fax Number: ( ) _____

Thank you for taking the time to complete this form.