Instructions for Critical Illness Insurance Claim

1. **Section 1 – Certificate Information: :** Is to be completed by the Insured Person.

2. **Section 2 – Claimant's Statement:** Is to be completed by the Insured Person. Be sure to include your phone number and social insurance number for the claimant.

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 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**.**

6. **Supporting Documentation** - Please provide a copy of the Hospital Discharge Statement**.**

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

   - Birth Certificate
   - Canadian Drivers Licence
   - 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

Critical Illness Claim Form

Section 1: Certificate Information

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	**Critical Illness – Heart Attack**		

Section 2: Claimant's Statement

Name of Claimant:				
Claimant's Date of Birth: (m/d/y)				
Relationship to Insured Person:		**Is this Claimant a smoker?**	☐ Yes	☐ No
If "Yes" to smoker, please provide date of last use of tobacco product(s) (m/d/y)				
Please indicate type of tobacco product or use of any substance or product containing the following:				
Tobacco ☐	**Nicotine** ☐	**Marijuana** ☐		
Claimant's Address: (if different from primary insured)				
Claimant's Telephone Number: (if different from primary insured)				
Amount of Coverage	**$**			
Nature of Illness:				
Date Illness symptoms first appeared: (m/d/y)				

(Please see over)

Date admitted to hospital: (m/d/y)		**Date of release from hospital:** (m/d/y)	
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: _____

_____

_____

_____

_____

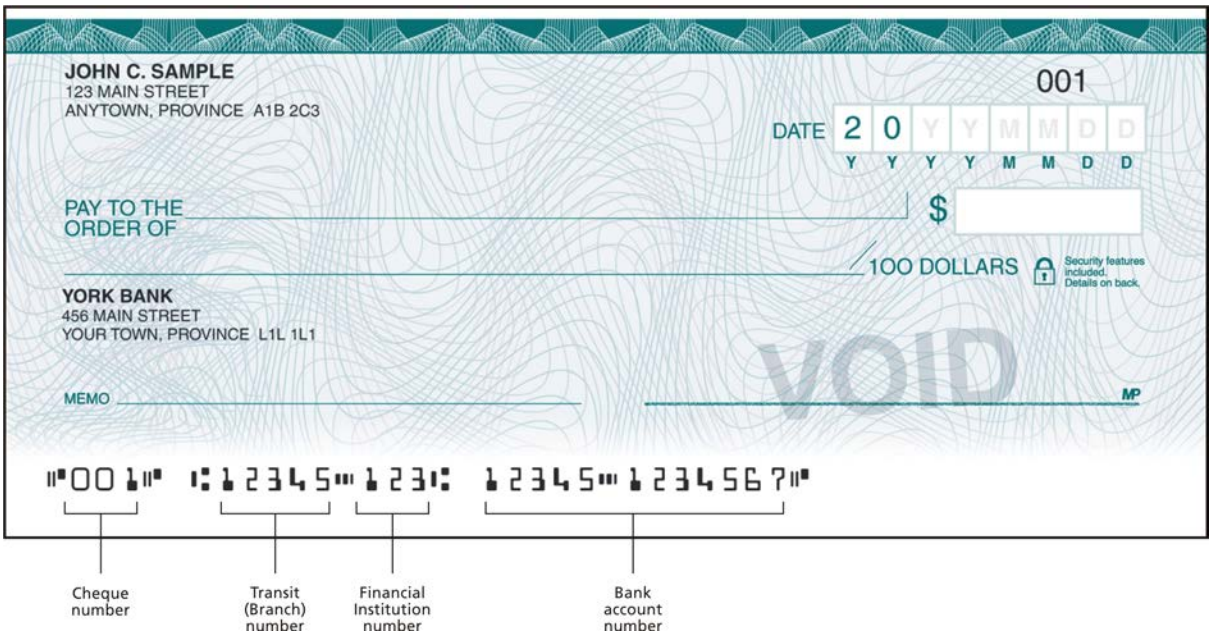
_____

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

In

(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
Critical Illness – Heart Attack (Myocardial Infarction)

(To be completed by the Specialist)

To 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. On what date did your patient first consult you for this condition?	**Date** → (m/d/y)
2. How long has the insured been your patient?	
3. When did the myocardial infarction occur?	**Date** → (m/d/y)
4. On what date was the diagnosis made?	**Date** → (m/d/y)
5. Please provide the name of the cardiologist who made the diagnosis of myocardial infarction. (if other than yourself)	
Name and Address of Family Physician	
6. Please provide the following details pertaining to the insured's myocardial infarction:	
a) Date of onset of **chest pain** (m/d/y):	
b) **ECG changes** in detail at time of event or provide tracings, if available:	
c) **Please provide** prior ECG tracings if applicable.	
d) **Cardiac enzyme levels**, include MB Band, at time of event:	

(Please see over)

Internal

7. What other investigations have been performed? If any, please provide the following:				
Investigation(s)	**Date** *(m/d/y)*	**Details**	**Copies of Reports**	
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No

8. When did your patient first suffer symptoms or episodes of cardiovascular disease? Please provide dates and details:	
Date *(m/d/y)*	**Details**

9. Please describe, including dates and symptoms, what disorder or risk factors has your patient had that may have contributed to his/her illness?	
Date *(m/d/y)*	**Description & Symptoms**

10. Is there a family history of cardiovascular disease or cerebrovascular disease? If yes, please provide details:	☐ *Yes*	☐ No
11. Please provide details of your patient's tobacco or nicotine use including amount per day and date last used.	**Amount per/day** **Date last used**	
12. Are you related to or in a business relationship with this patient?	☐ Yes	☐ No

Please provide copies of clinical notes and hospital reports for our Medical Consultant's review.

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:** ( ) _____