Instructions for Hospital Cash Insurance Claim

1. **Section 1 – Certificate Information:** Is to be completed by the claimant or the insured if the claim is for a minor.

2. **Section 2 – Claimant's Statement:** Is to be completed by the claimant or the insured if the claim is for a minor. Be sure to include your phone 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.
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.

5. **Supporting Documentation –** Please provide a copy of all that apply:
   - Accident Report
   - Police Report
   - Newspaper Clippings
   - Employer Accident Report
   - Hospital Admittance Statement
   - Hospital Discharge Statement

6. **Proof of Age of Insured as well as Claimant:** Please provide a copy of at least one of the following:
   - Birth Certificate
   - Canadian Passport
   - Canadian Drivers Licence
   - Canadian Citizenship Card

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

8. **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

Hospital Cash Claim Form

Section 1: Certificate Information

Certificate	#	**Issue Date**	
Name of Insured Person (full legal name) *(Please print)*			
Address of Insured Person			
Type of Claim	**Hospital Benefit**		

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:			
Amount of Coverage	$		
Nature of Illness or Injury: (If ailment due to injury, state where, & how it happened.)			
Date Injury occurred or, date Illness symptoms first appeared:	**Date** → (m/d/y)		
Date admitted to hospital: (m/d/y)		**Date discharged from hospital:** (m/d/y)	
Name of Hospital:			
Address of Hospital:			

(Please see over)

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)	
Other Physician's name	
Other Physician's Address	

Additional Comments: _____

_____

_____

_____

_____

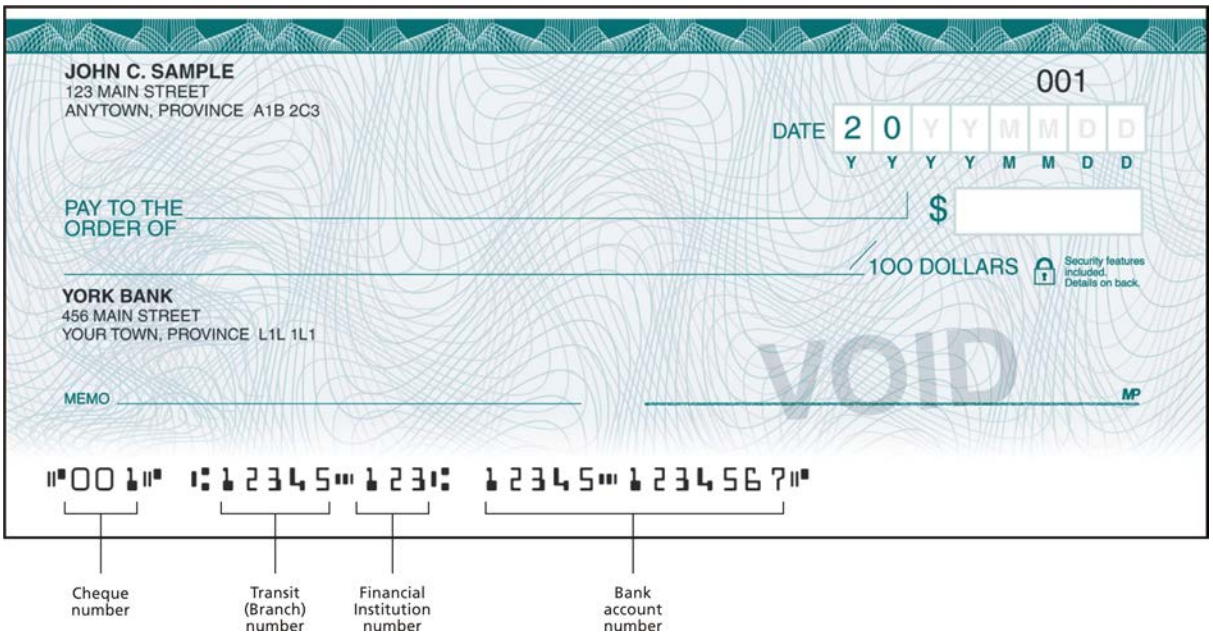
_____

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

(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)

To Physicians – Please note

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 sickness or injury (describe complications, if any):		
2. When did symptoms first appear or accident happen?	**Date** → (m/d/y)	
a) Was this hospital confinement a result of?	☐ **Accident**	☐ **Sickness**
b) 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 illness?	☐ Yes	☐ No
a) If Yes, state when and describe:		

(Please see over)

5. Was hospitalization, as an inpatient required?	☐ Yes	☐ No
If yes, please indicate dates of hospitalization and attach a copy of the hospital admission and discharge summary.	**Admission Date** → (m/d/y)	
	Discharge Date → (m/d/y)	
6. List surgical procedure(s), if any (describe fully):		
Date (s) 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:** **( )** _____