TD Insurance
Instructions for completing the claim package for Life Insurance

The Life Insurance –Claim Package contains two parts:

- **Part A: Life Claim Form**
- **Part B: Attending Physician's Statement – Proof of Death**

Note:

- **Medical and health information excludes genetic test.**
- **Please print all information using a pen.**
- **Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).**
- **Completion of both parts is required and any missing information may result in the delay of the processing of your claim.**
- **Checkboxes are provided below to assist you in completing the claim package.**
- **Within 10 business days of receiving your claim package, a claims analyst will send you a confirmation of receipt in writing.**
- **If you have any questions, please contact the TD Life Claims Department at 1-888-788.0839.**

Instructions for Claimant

Check if completed

☐ Please complete **Part A – Life Claim Form**

Section 1 – Policy Information

- This portion of the form has automatically been filled in by our systems. Please take a moment to ensure our data is correct.

Section 2 – Claimant's Statement

- To be completed by the claimant (beneficiary). If the estate is the beneficiary, the authorized representative must complete the statements. If the beneficiary is a minor, the guardian or other persons authorized by law to deal with the minor's property should complete the statement on behalf of the minor.
- Certified copies of Letters of Guardianship or Tutorship papers (in Quebec) are required. Social insurance number for the beneficiary is required for income tax purposes. If there are multiple beneficiaries, the Life Claim Form must be completed by each beneficiary.
- Provide a copy of the last Will and Testament if applicable

Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

- If your claim for benefits is $60,000 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.

Section 4 – Declaration, Authorization & Signature.

- **This section must** be completed by the claimant.

- **Part B** - Attending Physician's Statement - Proof of Death

Section 1 - Patient's Authorization - the Insured/patient's signature and date are required.

Section 2 - Attending Physician's Statement **must be completed and signed by a licensed medical practitioner.**

Note: Part B of this document can be detached and provided to the Attending Physician to complete and send separately to TD Insurance.

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

- **Attach a copy** of the Policy Schedule from your Policy of Insurance.
- **Send all completed documents** and any additional necessary documentation directly to TD Life Insurance, in the postage-paid envelope provided.
- Retain a copy of the completed claim package and additional documentation for your records.

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

Part A - Life Claim Form

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

Section 1: Policy Information

Policy	**#Policy Number**	**Issue Date**	**#Issue Date**
(#Deceased Person's Name)	**#NameofInsuredPerson**		
Name of Policy Owner (if different than policyholder)	**#Name of Policy Owner**		
Type of Claim	**#Life**		

Section 2: Claimant's Statement

Name of Deceased			
Sum Insured:	**$**		
☐ Smoker		☐ Non-Smoker	
If smoker, please provide date of last use of tobacco product(s)	**Date** (mm/dd/yy) →		
Please indicate type of tobacco product or use of any substance or product containing the following:			
Tobacco	□		
Nicotine	□		
Marijuana	□		
Date of Birth: (mm/dd/yy)		**Place of Birth:**	
Date of Death: (mm/dd/yy)		**Cause of Death:**	
Place of Death:			

1. In what capacity or by what title do you claim the insurance?
   - □ Executor or Administrator (please attach a copy of the Last Will & Testament)
   - □ Named Beneficiary

Name of Claimant:	
Social Insurance Number of Claimant:	
Claimant's Date of Birth: (mm/dd/yy)	
Claimant's Address:	

(Please see over)

Claimant's Telephone Number(s)	**Residence**	( )
	Business	( )
	Cellular	( )

2. Name and Address of Family Physician of the deceased: _____

_____

_____

Date Seen (mm/dd/yy)	**Reason**	**Result**

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

Physician, Hospital, Institution	**Address**	**Date of Consultation** (mm/dd/yy)	**Reason**

4. Additional Life Insurance in force with our company or any other Company:

Company	**Effective Date**	**Face Amount**

5. If death is due to an accident:

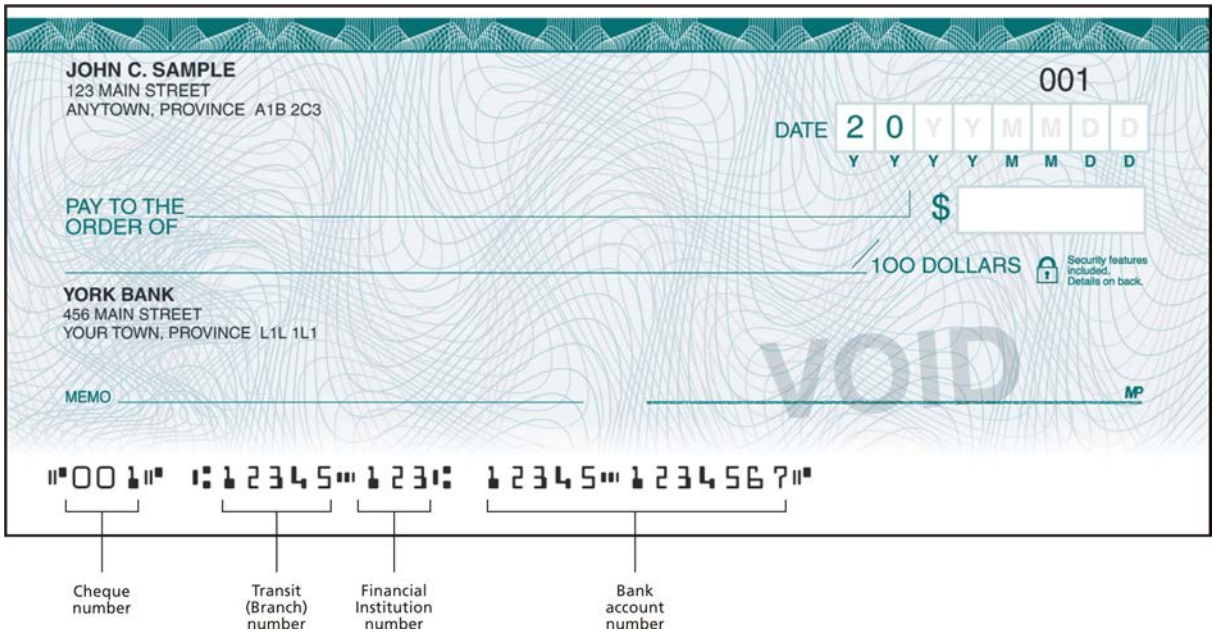
Date of Accident → (mm/dd/yy)				
Place of Accident:	☐Home	☐Work	☐Car	☐Aircraft
Details of Accident:				

Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

If your claim payment is $60,000 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) , hereby irrevocably direct and authorize TD Life (both as insurer and as administrator to deposit all claim benefits payable under the Insurance Contract (not to exceed $60,000), 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 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'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 (mm/dd/yy)

(Please see over)

Section 4: Declaration / Authorization / Signature

Insurer: TD Life insurance company

I declare that all the statements made in this claim 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 Privacy Agreement attached to your 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.

Claimant's Authorization: regarding the death of (the "Life Insured") _____
(Please print)

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 (if other than 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 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 relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured 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.

Signed at _____ Date _____ Relationship to deceased _____
(mm/dd/yy)

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
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Toronto, Ontario M5K 1A2

Part B - Attending Physician's Statement – Proof of Death

Section 1 - Patient's Authorization

Policy Number: #PolicyNumber

Patient's Name: _____ **Date of Birth :** _____
(Please print) (dd/mm/yy)

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

Date: _____ **Signature of Patient:** _____
((mm/dd/yy)

Section 2 - Attending Physician's Statement

(To be completed by Physician)

Physicians note:

This form has been specifically designed with the Physician in mind. Please complete the sections relating to your patient and stroke out non-applicable areas. In order to help the claimant, sufficient details of family and medical history, investigation, findings and treatment are essential.

The patient is responsible for securing this form and any charge which may be made for its completion.

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 Death and, to enable the assessment of the claim, we would be grateful for your cooperation on the completion of this form.

<table>
<tr><td>Name of Deceased:
(full legal name)
(Please print)</td><td colspan="3"></td></tr>
<tr><td>Date of Birth: (mm/dd/yy)</td><td></td><td rowspan="2">Place of Death:</td><td rowspan="2"></td></tr>
<tr><td>Date of Death: (mm/dd/yy)</td><td></td></tr>
<tr><td>Death Resulted From:</td><td colspan="3">☐ Natural Causes ☐ Suicide ☐ Homicide
☐ Accident ☐ Other</td></tr>
</table>

- Disease or condition directly leading to death: _____

  Duration: _____

- Antecedent Causes: _____

  Duration: _____

(Please see over)

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

If "Yes" to either question 5 or 6, by whom and with what result?

Name	Result

8.	Have you treated or advised the deceased during the last 5 years, prior to last illness?	☐ **Yes** ☐ **No**
9.	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 (mm/dd/yy)

Remarks: _____

_____

_____

_____

_____

Please mail this fully completed form to the address below:

TD Insurance
Claims Department
P.O. Box 1
TD Centre
Toronto, Ontario M5K 1A2
Tel: 1-877-417-2400

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

Date: _____ (mm/dd/yy) **Physician's Signature:** _____

Printed Name: _____ **Address:** _____

Speciality: _____

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