TD Insurance

Instructions for completing the Critical Illness Recovery Insurance - Stroke claim package

The Critical Illness Recovery Plan – Stroke claim package contains three parts:

- **Part A:** Critical Illness Recovery Plan – Stroke Claim Form
- **Part B:** Attending Physician's Statement - Critical Illness - Stroke
- **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 the 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 the TD Life Claims Department at **1-888-788-0839**.

Check if completed:

☐ **Part A - Critical Illness Recovery Plan – Stroke Claim Form**

Note: All sections in **Part A** to be completed by the Insured Person with the critical illness or an authorized representative of the Insured Person with the critical illness.

☐ **Section 1 – Policy Information**
☐ **Section 2 – Insured Person's Statement**
☐ **Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**
☐ **Section 4 – Declaration, Authorization & Signature**

☐ **Part B - Attending Physician's Statement - Stroke**

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.

☐ **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 - Critical Illness Recovery Plan - Stroke Claim Form

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

Section 1: Policy Information

Critical Illness Recovery Plan insured by TD Life Insurance Company*

Policy Number:		**Issue Date:**	
Insured Person's Name: (full legal name) (Please print)			
Policy Owner: (If different than Insured Person)			
Type of Claim :	**Critical Illness – Stroke**		
Amount of Coverage:			

*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 Policy.

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Section 2: Insured Person's Statement

Insured Person's Name:			
Insured Person's Address:			
Insured Person's Date of Birth: (mm/dd/yyyy)			
Insured Person's Contact Information	**Residence:**		
	Cellular:		
	Email:		
Is the Insured Person a smoker?	☐ **Yes** ☐ **No**		
If "Yes" to smoker, please provide date of last use of tobacco product(s) (mm/dd/yyyy)			
Please indicate type of tobacco product or use of any substance or product containing the following:			
Tobacco ☐	**Nicotine** ☐	**Marijuana** ☐	
Nature of Illness:			
Date illness or symptoms first appeared: (mm/dd/yyyy)			
On what date did the Insured Person first consult a doctor in connection with their illness? (mm/dd/yyyy)			
Has the insured Person undergone any tests or investigation related to this diagnosis? **If yes, please provide dates and details.**	☐ **Yes** ☐ **No**		
Has the Insured Person previously suffered from or received treatment for a similar or related condition? **If yes, please provide dates and details.**	☐ **Yes** ☐ **No**		
Please describe any residual neurological deficits			

Have any immediate family (mother, father, brothers, sisters) had heart disease, stroke, diabetes, cancer or tumour or kidney disease prior to age 60? **If yes, please list relationship, nature of illness, date of diagnosis and relationship.**	☐ **Yes** ☐ **No**		
Date admitted to hospital: (mm/dd/yyyy)		**Date of release from hospital:** (mm/dd/yyyy)	
Hospital Name:			
Hospital Address:			
Name of Family Physician:			
Address of Family Physician:			
How long has the Insured Person 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:

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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.

JOHN C. SAMPLE
123 MAIN STREET
ANYTOWN, PROVINCE A1B 2C3

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DATE 2 0 Y Y M M D D
Y Y Y Y M M D D

PAY TO THE ORDER OF $

/100 DOLLARS Security features included. Details on back.

YORK BANK
456 MAIN STREET
YOUR TOWN, PROVINCE L1L 1L1

MEMO

VOID

⑈001⑈ ⑆12345⑉123⑆ 12345⑉1234567⑈

Cheque number | Transit (Branch) number | Financial Institution number | Bank account number

Account information:
For help filling out your account information, please see sample cheque above.

Transit Number ______ **Financial Institution Number** ______ **Bank account number** ______

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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 (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/yyyy)

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 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.
- 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 (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 Person 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.

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 Critical Illness 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 for Critical Illness – Stroke

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: ___________________________

Critical Illness Recovery Plan insured by TD Life Insurance Company*

Insured Person's Name: ___________________________ **Date of Birth:** ____________________
(Please Print) (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: _____________________ **Insured Person's Signature**: ______________________________
(mm/dd/yyyy)

*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.

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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 **Stroke** and, to enable the assessment of the claim, we would appreciate for your cooperation on the completion of this form.

Patient's Name: (Please print)	
Patient's Date of Birth: (mm/dd/yyyy)	
1. On what date did your patient first consult you for this condition?	**Date →** (mm/dd/yyyy)
2. How long has the insured been your patient? (years/months)	
a) Name & Address of Family Physician:	
3. Was a diagnosis of Cerebrovascular Accident made?	☐ **Yes** ☐ **No**
4. On what date did the CVA occur?	**Date →** (mm/dd/yyyy)
5. Please describe the cause of the CVA (if known).	
6. Please describe the residual neurological deficits.	
7. How long have the neurological deficits persisted?	
8. By whom was the diagnosis made (if other than yourself)?	
a) **On what date was the patient advised of the diagnosis? By Whom?**	

9. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke or CVA.	
Name of Physician/Hospital	**Address**
Has your patient suffered from a previous stroke:	☐ **Yes** ☐ **No**
If yes, please provide the date and details:	**Date →** (mm/dd/yyyy)
10. Have any immediate family (mother, father, brothers, sisters) had heart disease, stroke, diabetes, cancer or tumour or kidney disease prior to age 60? **If yes, please provide details:**	☐ **Yes** ☐ **No**
11. Is your patient a smoker?	☐ **Yes** ☐ **No**
12. If yes, please provide the year the patient started smoking and the last date used	**Year Patient started →**
	Date Last Used → (mm/dd/yyyy)
13. Are you related to or in a business relationship with this patient?	☐ **Yes** ☐ **No**

Please provide:

a) Copies of clinical notes and hospital reports for our Medical Director's review.

b) The neurologist's recent assessment results.

c) Please provide any other information to would be helpful in the assessment of your patients claim.____

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

You may mail or fax this form to:

TD Life Insurance Company
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

(Please see over)

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

Physician's Name: ________________________ **Physician's Signature:** _______________________

Physician's Speciality:

____

Date: ________________________ **Address:** ____

Telephone Number: (   ) _____________________ **Fax Number: (   )** _______________________

Thank you for taking the time to complete this form.