TD Insurance

Instructions for completing the Accidental Death/Common Carrier claim package

The Accidental Death/ Common Carrier claim package contains three parts:
- **Part A:** Accidental Death/ Common Carrier Claim Form
- **Part B:** Attending Physician's Statement – Proof of Death
- **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 – Accidental Death/ Common Carrier Claim Form

Note: All sections in **Part A** to be completed by the Claimant (named beneficiary), unless otherwise specified. If the estate is the beneficiary, the authorized representative must complete the form. If the beneficiary is a minor, the guardian or other persons authorized by law to deal with the minor's property should complete the form on behalf of the minor. If there are multiple beneficiaries, each beneficiary must complete the form.

☐ **Section 1 – Certificate Information**
☐ **Section 2 – Claimant's Statement**
☐ **Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**
If you are the named beneficiary and 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.
If you are the authorized representative or if the amount of your claim for benefits is greater than $60,000, we will issue a cheque once your claim is processed.
☐ **Section 4 – Declaration, Authorization & Signature**

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

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 – Claimant's Authorization**
- The Claimant's signature and date are required.

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

(Please see over)

☐ Part C – Additional Supporting Documentation

- ☐ **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
- ☐ **If Estate is the beneficiary**, provide a copy of the **Last Will and Testament form**
- ☐ **If the beneficiary is a minor,** provide certified copies **of Letters of Guardianship** or **Tutorship papers** (in Quebec)
- ☐ **If claiming Common Carrier benefits**, please provide a copy of the **Insured Person's ticket, accident report that was filed with the carrier** and any other information pertaining to the accident.
- ☐ **A copy of the Police report, coroner's report**, if available.

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

Part A – Accidental Death/ Common Carrier Claim Form

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

Section 1: Certificate Information

Insured by TD Life Insurance Company*

Certificate Number:		Issue Date:	
Insured Person's Name:			
Insured Person's Address:			
Type of Claim:	Accidental Death/Common Carrier		
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 Certificate of Insurance.

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Section 2: Claimant's Statement

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

Insured Person's Name:			
Insured Person's Address:			
Insured Person's Social Insurance Number: (Required for income tax purposes)			
Insured Person's Date of Birth: (mm/dd/yyyy)		**Place of Birth:**	
Insured Person's Date of Accident:		**Place of Death:**	
Insured Person's Date of Death:		**Cause of Death:**	
Details of accident:			
Please indicate type of Common Carrier:			
Airline (Provide copy of tickets, name of Airline and flight number)		**Train** (Provide copy of tickets, rail carrier, destination and route)	
Public Transport (Provide copy of ticket and route number, if applicable)		**Water Vessels** (Provide copy of tickets and name of carrier)	
Taxi (Provide copy of receipt)		**Other** (indicate type)	
Sum Insured:	$		
☐ Smoker		☐ Non-Smoker	
If a smoker, please provide the last date used:		**Date (mm/dm/yyyy)** →	
Please indicate type of tobacco product or use of any substance or product containing the following:			
Tobacco	☐		
Nicotine	☐		
Marijuana	☐		
Claimant's Name:			

Claimant's Social Insurance Number: (Required for income tax purposes)		
Claimant's Date of Birth: (mm/dd/yyyy)		
Claimant's Address:		
Claimant's Contact Information:	**Residence:**	
	Business:	
	Cellular:	
	Email:	

Name and Address of Family Physician of the Insured Person:____________________________________

____

Date of Consultations (mm/dd/yyyy)	Reason	Result

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

Physician, Hospital, Institution	Address	Date of Consultations (mm/dd/yyyy)	Reason

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

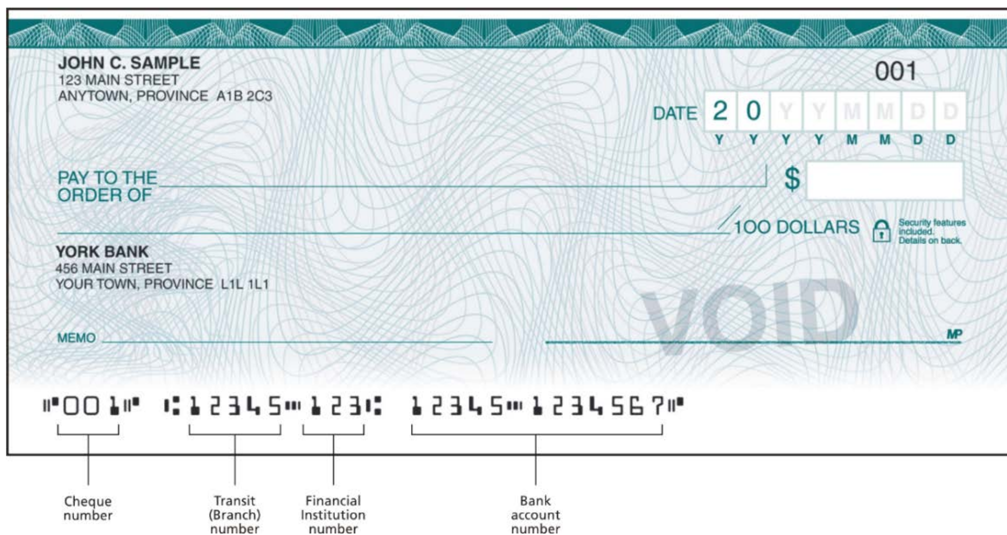
Company	Effective Date (mm/dd/yyyy)	Face Amount

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") 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 Certificate of Insurance (the "Insurance Contract") issued by TD Life Insurance Company (TD Life) , hereby irrevocably direct and authorize TD Life 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 regarding 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 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'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 – Proof of Death

Notes:

- The Claimant 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 - Claimant's Authorization

Policy Number: ___________________________________

Life Insurance insured by TD Life Insurance Company*

Insured Person's Name:_______________________________ Date of Birth:__________________
(Please print) (mm/dd/yyyy)

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

Date___________________________ Claimant's signature: ____________________________

*TD Life Insurance Company is the authorized administrator for this insurance. For more details on insurer and/or administrator information, please refer to the Certificate of Insurance.

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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 an **Accidental Death/Common Carrier benefit** and, to enable the assessment of the claim, we would be grateful for your cooperation on the completion of this form.

Patient's Name: (Please print)	
Patient's Date of Birth: (mm/dd/yyyy)	**Place of Death:**
Patient's Date of Death: (mm/dd/yyyy)	
Death Resulted From:	☐ Natural Causes ☐ Suicide ☐ Homicide ☐ Accident ☐ Other

Disease or condition directly leading to death: ______________________________

Duration: ____

Antecedent Cause____

Duration:____

1. Date of first attendance in final illness:	**Date** (mm/dd/yyyy) ☐	
2. Date of last attendance in final illness:	**Date** (mm/dd/yyyy) ☐	
3. Was your patient a smoker?	☐ **Yes**	☐ **No**
If Yes, what is the date last used?	**Date** (mm/dd/yyyy) ☐	
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 6 or 7, 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** (m/d/y)

Remarks:____

____

____

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

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 Speciality:
____

Date: _________________________ **Address:**____
(mm/dd/yy)

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

Thank you for taking the time to complete this form.