



## Instructions for completing the Critical Accident Recovery Plan Insurance-Dismemberment claim package

The Critical Accident Recovery Plan - Dismemberment claim package contains three parts:

- **Part A:** Critical Accident Recovery Plan - Dismemberment Claim Form
- **Part B:** Attending Physician's Statements
- **Part C:** Additional supporting documentation

Notes:

- 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 TD Life Insurance Company at 1-888-788-0839.

Check if completed:

**Part A - Critical Accident Recovery Plan - Dismemberment Claim Form**

**Note:** All sections in **Part A** to be completed by the Insured Person. If you are not the Insured Person, you must be an authorized representative of the Insured.

- Section 1 – Certificate Information**
- Section 2 – Claimant's Statement.**
- 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**

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

**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 available.
- Accident Report**, if available.
- 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 Accident Recovery Plan - Dismemberment 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\*

<b>Certificate Number:</b>		<b>Issue Date:</b>	
<b>Insured Person's Name:</b>			
<b>Insured Person's Address:</b>			
<b>Date of Birth of Insured Person:</b> <i>(mm/dd/yyyy)</i>			
<b>Social Insurance Number of Insured Person:</b>			
<b>Type of Claim:</b>	<b>Dismemberment</b>		
<b>Amount of Coverage:</b>			

\*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**

<b>Name of Claimant:</b> <small>(if different from Insured Person)</small>			
<b>Claimant's Date of Birth:</b> <small>(if different from Insured Person)</small>			
<b>Relationship to Insured Person:</b>			
<b>Claimant's Address:</b> <small>(if different from Insured Person)</small>			
<b>Claimant's Contact Information:</b> <small>(if different from Insured Person)</small>	<b>Residence:</b>		
	<b>Cellular:</b>		
	<b>Email:</b>		
<b>Nature of Injury:</b>  <small>(Describe where &amp; how the injury occurred)</small>			
<b>Date Injury occurred:</b> <small>(mm/dd/yyyy)</small>			
<b>Date admitted to hospital:</b> <small>(mm/dd/yyyy)</small>		<b>Date discharged:</b> <small>(mm/dd/yyyy)</small>	
<b>Hospital Name:</b>			
<b>Hospital Address:</b>			
<b>Name of Family Physician:</b>			
<b>Address of Family Physician:</b>			
<b>How long have you been consulting this physician?</b>			
<b>If less than 2 years, please provide name and address of previous physician(s)</b>			
<b>Physician's name:</b>			
<b>Physician's address:</b>			

**Additional comments:**

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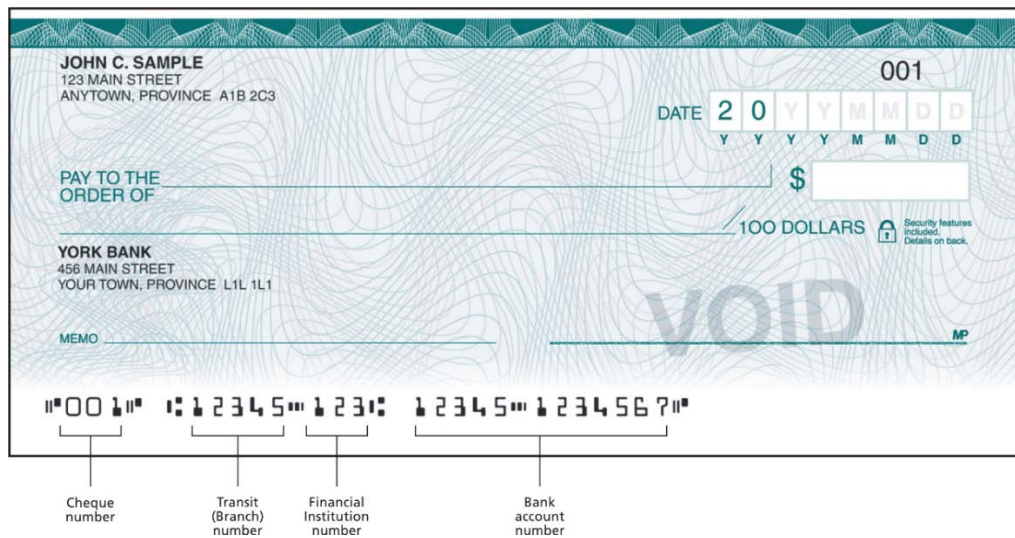
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### Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

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”) 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 certificate of insurance 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:

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**A photocopy/fax of this authorization is as valid as the original.**

**Section 2 - Attending Physician's Statement – Critical Accident Recovery Plan -  
Dismemberment (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 a **Critical Accident Recovery Plan – Dismemberment 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:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby authorize the release to my insurer any information requested in respect of this claim.				
<b>Date:</b> _____		<b>Signature of Patient:</b> _____		
<i><b>Any charges for the completion of this form are the responsibility of the claimant.</b></i>				
1. Date of Accident:	<b>Date</b> → (m/d/y)			
2. On what date did your patient first consult you regarding the injuries resulting from this accident?	<b>Date</b> → (m/d/y)			
3. Your diagnosis and complete description of injuries sustained:				
<b>4. Did the accident result in loss of:</b>				
<input type="checkbox"/> Right Arm?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below elbow)	
<input type="checkbox"/> Left Arm?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below elbow)	
<input type="checkbox"/> Right Leg?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below knee)	
<input type="checkbox"/> Left Leg?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below knee)	
<input type="checkbox"/> Right Hand?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below wrist)	
<input type="checkbox"/> Left Hand?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below wrist)	
<input type="checkbox"/> Right Foot?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below ankle)	
<input type="checkbox"/> Left Foot?	<b>Date</b> → (m/d/y)		Location of amputation (at, above or below ankle)	
<input type="checkbox"/> Right Index Finger?	<b>Date</b> → (m/d/y)		Complete and permanent severance of the digit	

<input type="checkbox"/> Left Index Finger?	<b>Date →</b> (m/d/y)		Complete and permanent severance of the digit
<input type="checkbox"/> Right Thumb?	<b>Date →</b> (m/d/y)		Complete and permanent severance of the digit
<input type="checkbox"/> Left Thumb?	<b>Date →</b> (m/d/y)		Complete and permanent severance of the digit
<b>5. Complete loss of vision.</b>			
a) If injury necessitated removal of eye, date of removal:		<b>Date →</b> (m/d/y)	
b) Vision in each eye prior to accident:		Right	
		Left	
c) Present vision in each eye:		Right	
		Left	
d) If use can be restored, please provide details:			
<b>6. Loss of hearing:</b>			
a) Is deafness a direct result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Has the deafness been verified by audiological testing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, what were the results?			
c) Is the loss irrecoverable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>7. Loss of speech:</b>			
a) Is speech loss a direct result of an accident	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Has the speech loss been assessed by a speech therapist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, what were the results?			
c) Is the loss irrecoverable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>8. Brain Damage:</b>			
a) Is brain damage a direct result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Has the brain damage been assessed by a specialist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c) What investigations were used to assess the severity of the injury?			
If so, what were the results?			

d) Does the patient require any of the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Specialized Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Specialized Feeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Institutionalization	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please give details			
e) Do you expect improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>9. Loss of use due to hemiplegia, paraplegia or quadriplegia.</b>			
a) Did the accident result in loss due to :	Paraplegia? <input type="checkbox"/>	Quadriplegia? <input type="checkbox"/>	
b) What was the extent of the injury to the spinal cord?			
c) Which, if any, tests were used to make the determination of the extent of injury.			
d) Is the loss irrecoverable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
e) Please provide any additional details that may be applicable:			
<b>10. Were the injuries or impairment sustained due solely to the above accident?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If not, please provide details of any condition or disease, which in your opinion may have served as a contributory cause.			
<b>11. Coma:</b>			
a) Is the coma a direct result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Please provide us with copies of all consultation/investigation reports			
c) Is he/she on life support?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
d) Do you expect improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>12. Burns:</b>			
a) Was the burn a direct result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Please indicate the degree of burn	1 <sup>st</sup> degree <input type="checkbox"/>	2 <sup>nd</sup> degree <input type="checkbox"/>	3 <sup>rd</sup> degree <input type="checkbox"/>



c) Location of burn?		
d) Treatment provided?		
<b>13. Did the patient require admission to hospital as an in-patient?</b>  If Yes, provide date of hospital admission  and date of hospital discharge.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Date → (m/d/y)	
	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

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**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.**