



TD Insurance
Instructions for completing the Term Life Insurance –
Living Benefit claim package

The Term Life - Living Benefit claim package contains three parts:

- **Part A:** Term Life Insurance - Living Benefit Claim Form
- **Part B:** Attending Physician's Statement
- **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 – Term Life Insurance –Living Benefit 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 – Policy Information**
- Section 2 – Insured Person's Statement**
- Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**

If you choose to have the payment for these benefits deposited directly to your Bank account, please complete section 3 and attach a void cheque.

- Section 4 – Declaration, Authorization & Signature**

Part B - Attending Physician's Statement - Term Life Insurance - Living Benefit

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.

(continued)

Part C – 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 – Term Life Insurance - Living Benefit 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: Policy Information

Term Life Insurance insured by TD Life Insurance Company*

Policy Number:		Issue Date:	
Insured Person's Name:			
Policy Owner Name: (if different than Insured Person)			
Type of Claim:	Living Benefit		

*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)		Date of Diagnosis: (mm/dd/yyyy)	
Insured Person's Contact Information:	Residence:		
	Cellular:		
	Email:		
Name and Address of Insured Person's Family Physician:			
How long has this doctor been the Insured Person's Family Physician:			
<input type="checkbox"/> Smoker	<input type="checkbox"/> Non-Smoker		
If a smoker, please provide the last date used	Date (mm/dd/yyyy)		
Please indicate type of tobacco product or use of any substance or product containing the following:			
<input type="checkbox"/> Tobacco <input type="checkbox"/> Nicotine <input type="checkbox"/> Marijuana			

Other doctors consulted during the last 12 months, hospitals and institutions attended.

Physician, Hospital, Institution	Address	Nature of Illness or Injury	Dates

1. Please provide details of your illness:

2. a) Are you confined to bed? Yes No
 b) Are you confined to your home? Yes No
 c) Are you a patient at a hospital? Yes No

If the answer to 2(c) is Yes, please provide name and address of hospital:

3. a) Does your health completely prevent you from working now? Yes No

b) If not working, when do you anticipate returning to:

1) your own job? _____

2) another job? _____

c) If currently working:

a) Briefly state your duties _____

b) When did you return to work? _____

c) Are you now working on a gradual basis? Yes No

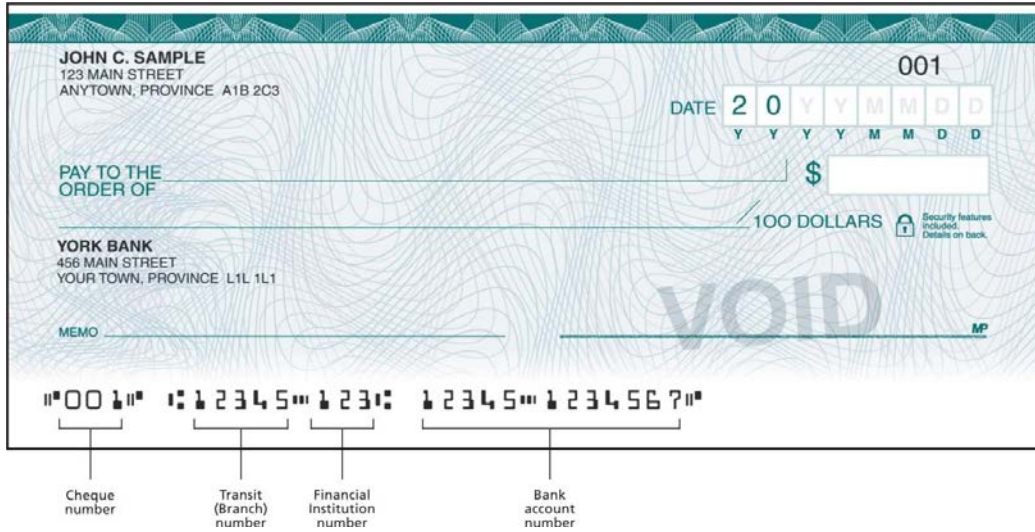
If Yes, please confirm the number of hours per week: _____

Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

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 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, 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 responsibility should any funds be 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

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: _____



TD Insurance

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

Part B - Attending Physician's Statement
Term Life Insurance - Living Benefit

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: _____

Term Life Insurance is insured by TD Life Insurance Company*

Insured Person's Name: _____
(Please print)

Date of Birth: _____
(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: _____ Signature of Insured Person: _____
(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 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 **Term Life - Living Benefit** and, to enable the assessment of the claim, we would appreciate for your cooperation on the completion of this form.

1. Diagnosis

a) Primary: _____ Symptoms: _____

b) Secondary: _____ Symptoms: _____

c) Objective findings (including results of current X-rays, ECGs or any other special tests).
Please attach copies of any test results.

d) Other contributing factors/complications:

2. History

a) Symptoms began: _____

(mm/dd/yyyy)

b) Date of diagnosis: _____

(mm/dd/yyyy)

c) Date patient advised of diagnosis: _____

(mm/dd/yyyy)

d) What treatment and/or medication have been prescribed?

How often do you see the patient?

e) Has your patient ever had the same or similar condition? Yes No Unknown

If "Yes", state when and describe:

(Continued)

3. Clinical Findings and Investigations

Has your patient been referred to any other physicians or specialists? Yes No

If "Yes", complete the following chart:

Physician's Name and Specialty	Date of Examination	Summary of Findings

4. Prognosis

What is your patient's prognosis?

Based on your knowledge of your patient's condition and your experience, what is your estimation of your patient's life expectancy?

Are any further treatment options being considered?

If yes, when will this treatment commence?

What is the expected outcome?

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

Please mail or fax this form to:

TD Insurance

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 Specialty: _____

Date: _____ Address: _____

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

Thank you for taking the time to complete this form.