TD Insurance
Instructions for completing the claim package for Credit Protection Life Insurance (Mortgage, Line of Credit, Loan)

This insurance benefit is underwritten by The Canada Life Assurance Company ("Canada Life"), and TD Life Insurance Company ("TD Life") is the authorized administrator. TD Life will be managing this claim on behalf of Canada Life.

The Credit Protection Life Insurance Claim Package contains three parts:

- **Part A: Claim for Credit Protection Life Insurance**
- **Part B: Claimant's Statement for Credit Protection Life Insurance**
- **Part C: Attending Physician's Statement - Proof of Death**

Note:

- **Please print all information using a pen.**
- **Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).**
- **Completion of all three 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 1-888-983-7070.**

Instructions for Claimant

Check if completed

❑ Please visit your local TD Canada Trust branch to have a branch representative complete **Part A -** Claim for Credit Protection Life Insurance.

❑ Please complete **Part B -** Claimant's Statement for Credit Protection Life Insurance.

- Be sure to print your first and last name, date and sign all entries and include your telephone number.
- Note: you **must** be the Next-of-Kin, Executor or Administrator of the Estate in order to complete this section.

❑ Please ensure that both sections of **Part C** - Attending Physician's Statement - Proof of Death are completed.

Section 1 - Claimant's Authorization - signature and date are required.

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

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

❑ Retain a photocopy of the completed claim package for your records.

❑ Please attach a copy of the Last Will & Testament or Letters of Administration.

❑ Return the original forms to:

TD Insurance
Claims Department
P.O. Box 1
TD Centre
Toronto, Ontario M5K 1A2

OR

You may bring the original forms back to your TD Canada Trust branch in a sealed envelope to be sent to TD Life.

Instructions for Branch

❑ Please complete **Part A -** Claim for Credit Protection Life Insurance.

❑ Be sure to enter the branch transit number, address, telephone number and name of contact person, should it be necessary for the TD Life Claims Department to contact you.

❑ The claimant may mail the claims package directly to TD Life or, if they wish, they may ask you to send the forms to us in the **TD Insurance green vinyl bag**.

PART A - Claim for Credit Protection Life Insurance

Statement of Claim (To be completed by your TD Canada Trust representative)

Product:

- ☐ Mortgage
- ☐ Line of Credit
- ☐ Loan

Branch/Transit Number: ____________________

Mortgage/Line of Credit/Loan number: ____________________

Please provide details of any other credit insured mortgages, lines of credit or loans held by the Insured at TD Canada Trust.

____

____

Name of the Insured: ____________________
(Last Name) (First Name and Initial)

Address of the Insured: ____________________
(Number) (Street)

____
(City) (Province) (Postal Code)

Insured Date of Birth: ____________________
(Month, Day, Year)

Date of Death: ____________________
(Month, Day, Year)

Current Principal Balance	Date of Last Regular Payment (Month, Day, Year)	Insurance Effective Date (Month, Day, Year)
Date Funds Advanced (Month, Day, Year)	Initial Loan/Mortgage Amount, or Line of Credit Limit	Refinancing Details ☐ Yes ☐ No

Branch Comments

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____

____

Branch Contact: ____________________
(Last Name) (First Name)

Signature: ____________________

Title: ____________________

Date: ____________________
(Month, Day, Year)

Telephone Number: ( ) ______ - ______

PART B - Claimant's Statement for Credit Protection Life Insurance

Statement of Claim (Completed by Claimant)

Section 1 - Statement of Next-of-Kin, Executor of the Estate or Administrator of the Estate

❑ Ms. ❑ Mrs. ❑ Mr.

Name of the Deceased: ____
(Last Name) (First Name and Initial)

Last Known address of the Deceased: ____
(Number) (Street)

____
(City) (Province) (Postal Code)

Deceased Date of Birth: ____________________ Date of Death: ____________________
(Month, Day, Year) (Month, Day, Year)

Name and Address of the Family Physician of the Deceased:

____

____

How long was the Deceased a patient of this Family Physician: ____________________

Other physicians consulted during the last 24 months, hospitals and institutions attended.

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

Other Life Insurance in force with this or other Companies.

Company	Effective Date	Face Amount

In what capacity or by what title do you claim the insurance? (Check all that may apply):

❑ Next of Kin ❑ Administrator of the Estate ❑ Executor of the Estate

❑ Ms. ❑ Mrs. ❑ Mr.

Name of Claimant: ____
(Print Last Name, First Name and Initial)

Relationship to the Deceased: ____________________ Date of Birth: ____________________
(Month, Day, Year)

Address: ____
(Number) (Street)

____
(City) (Province) (Postal Code)

Telephone Number (____) ____-______ Alternate Telephone Number (____) ____-______

Signature: ______________________________ Date: ____________________
(Month, Day, Year)

This claim form can be used for otherwise valid claims under discontinued policies.

Life Insurance Claim Authorization

Insurer: The Canada Life Assurance Company ("Canada Life")

Claimant's Authorization and Declaration regarding the death of ______________________________
(the "Life Insured")

- 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 rescinded by the Insurer.
- 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 Deceased, 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.
- I further authorize the Insurer or its administrator to release information relating to this claim (however, not including medical information) to The Toronto-Dominion Bank to allow the bank to manage the credit facility related to this insurance.
- In providing this authorization to collect personal information about the Deceased relating to this claim, I the undersigned do hereby certify that I have authority 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.

Claimant: ______________________________
(Print Last Name, First Name and Initial)

Signature of Claimant: ______________________________ Date: ______________________________
(Month, Day, Year)

Relationship of Claimant to Deceased: ______________________________

Executor/Administrator of the Estate / Next-of-Kin: ______________________________
(Print Last Name, First Name and Initial)

Signature of Executor/Administrator of the Estate / Next-of-Kin: ______________________________

Date: ______________________________
(Month, Day, Year)

Address of Executor/Administrator of the Estate / Next-of-Kin: ______________________________

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A photocopy/fax of this authorization shall be as valid as the original.

PART C - Attending Physician's Statement - Proof of Death

Section 1 - Claimant's Declaration

❑ Ms. ❑ Mrs. ❑ Mr.

Deceased Name (Please Print): ______________________________
(Last Name, First Name and Initial)

Deceased Date of Birth: ____________________
(Month, Day, Year)

I hereby authorize the release of any information requested in respect of this claim, to the Insurer, Canada Life Assurance Company and its authorized claims administrator, TD Life Insurance Company.

Date: ________________ Signature of Executor/Administrator/Next-of-Kin: ______________________________
(Month, Day, Year)

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 Claimant, sufficient details of family and medical history, investigation, findings and treatment are essential.

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

Full Name of Deceased ______________________________

Date of Birth, or Age at Death ______________________

Date of Death ________________________

Place of Death ______________________________

Cause of Death (Enter one cause for each of (a), (b) and (c))

Interval Between Onset and Death

Disease or condition directly leading to death.

(a) ______________________________

____

(a)

Antecedent causes (Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last)

Due to (b) ______________________________

____

(b)

Due to (c) ______________________________

____

(c)

Date of diagnosis of illness leading to death ____________________

If death was due to an accident, suicide or homicide, state which and provide a brief description of the circumstances

____

____

Date of first attendance in final illness ____________________ Date of last attendance in final illness ____________________

Name and Address of Family Physician

____

____

____

(continued)

Did the deceased, to your knowledge, receive treatment from you or any other physician, or were they in any other hospital or institution? ❑ Yes ❑ No

(If "Yes", please provide the following information)

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

Attach any specialist report, if available.

You may mail this form directly to the Administrator below:

TD Insurance
Claims Department
P.O. Box 1
TD Centre
Toronto, Ontario M5K 1A2
Tel: 1-888-983-7070

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

Physician's Signature: ______________________ Date: ______________________
(Month, Day, Year)

Specialty: ______________________

Print Name: ______________________

Address: ______________________

Telephone Number: (   ) _______ - _________ Fax Number: (   ) _______ - _________

Thank you for taking the time to complete this form.