TD Insurance

Instructions for completing the claim package for TD Business Credit Protection Life Insurance (Group Contract # 60241)

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 TD Business Credit Protection Life Insurance Claim Package contains two parts:

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

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.**
- **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 complete **Part A -** Claimant's Statement for TD Business Credit Protection Life Insurance.

- Be sure to print your first and last name, date and sign all entries and include your telephone number.
- If you are not the Insured, you must be an authorized representative of the Insured.

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

Section 1 - Patient's Authorization - the Insured/patient's signature and date are required.
Section 2 - Attending Physician's Statement **must be completed and signed by a licensed medical practitioner .**

Note: Part B 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.

☐ 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.

*TD Life Insurance Company is the authorized administrator for this insurance. All customer inquiries should be directed to 1-888-983-7070. The Canada Life Assurance Company is located at 330 University Avenue, Toronto ON M5G 1R8, toll-free number: 1-800-380-4572. For more details on insurer and/or administrator information, please refer to the Certificate of Insurance.

PART A - Claimant's Statement for TD Business Credit Protection Life Insurance

Statement of Claim (Completed by Claimant)

The completion of the below product details is **mandatory** in order to process this claim. If you do not have the product details, please contact your TD Canada Trust branch before submitting the claim forms.

Branch/Transit Number: _____

Master Loan Number: _____

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

_____

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

Name of the Deceased (Insured): _____
(Last Name) (First Name and Initial)

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

_____
(City) (Province) (Postal Code)

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

Name and Address of the Deceased's Family Physician:

_____

_____

Other physicians consulted during the last 5 years, hospitals and institutions attended.

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

Did the Deceased ever smoke

Cigarettes? ☐ Yes Start date _____ (Month, Day, Year) ☐ No If quit,when? _____ (Month, Day, Year)

Marijuana? ☐ Yes Start date _____ (Month, Day, Year) ☐ No If quit,when? _____ (Month, Day, Year)

Other Tobacco products? ☐ Yes Start date _____ (Month, Day, Year) ☐ No If quit,when? _____ (Month, Day, Year)

Other Life Insurance in force with this or other Companies.

Company	Effective Date	Face Amount

Name of Next-of-Kin, Executor or Administrator of the Estate: _____
(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: _____

Date: _____ Signature: _____
(Month, Day, Year)

Name of Business Owner (if different from Next-of-Kin): _____ Date of Birth: _____
(Month, Day, Year)

Name of Business: _____

Business Address: _____
(Number) (Street) (City) (Province) (Postal Code)

Telephone Number: _____

Date: _____ Signature: _____
(Month, Day, Year)

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

Life Claim Authorization

Insurer: The Canada Life Assurance Company

Claimant's authorization: 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.

Date : _____ Relationship of Claimant to Deceased: _____
(Month, Day, Year)

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

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

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

Address of Executor/Administrator/ Next-of-Kin: _____

_____

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

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

Section 1 - Claimant's Declaration

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, The Canada Life Assurance Company and its authorized claims administrator, TD Life Insurance Company.

I understand that I can revoke this consent at any time but that without it my claim may not be assessed.

Signature of Next-of-Kin, or Executor or Administrator of the Estate: _____

Date: _____
(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.

Note: Before you submit the form, please ensure you complete the Declaration section, including your signature.

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

Full Name of the 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))** Disease or condition directly leading to death (a) _____ Antecedent causes (Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last) Due to (b) _____ Due to (c) _____	Interval between Onset and Death (a) (b) (c)

Was the deceased totally and continuously disabled to date of death? ☐ Yes ☐ No

If "Yes", please state on which date such continuous disability began _____
(Month, Day, Year)

Did the deceased smoke cigarettes, marijuana or other tobacco products? ☐ Yes ☐ No

If "Yes", for how long? _____ years and daily amount _____

If quit, when? _____

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 (Month, Day, Year)	Date of last attendance in final illness (Month, Day, Year)

Name and address of Family Physician

Did the deceased, to your knowledge, receive treatment during the last 5 years from you or any other physician, or in any hospital or institution? ☐ Yes ☐ No

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

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

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the Insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. I understand that I can revoke this consent at any time but that without it my patient's claim may not be assessed. By providing the information I consent to such unedited release of any information contained herein.

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.