# TD Insurance Instructions for completing the Life Insurance –claim package

The Lif	e Insurance claim package contains three parts:		
П	Part A: Life Claim Form		
	Part B: Attending Physician's Statement		
	Part C: Additional Supporting Documentation		
Note:	Part C. Additional Supporting Documentation		
	Description and disclusional and analysis of the foreign of the property of the property of the foreign of the		
	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.		
П	If you have any questions, please contact TD Life Insurance Company at 1-888-788.0839.		
	if you have any questions, pieuse contact 15 Life insurance company at 1-000-700.0005.		
Check if	completed:		
	Part A – Life Insurance Claim Form		
Note: A	All sections in Part A to be completed by the Claimant (named beneficiary), unless otherwise specified. If the estate		
is the b	eneficiary, the authorized representative must complete the form. If the beneficiary is a minor, the guardian or other		
	s authorized by law to deal with the minor's property should complete the form on behalf of the minor. If there are		
	e beneficiaries, each beneficiary must complete the form.		
manapic	bononoidines, each beneficiary must complete the form.		
	Section 1 – Policy Information		
	Section 2 – Insured Person's Statement		
	Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)		
	<ul> <li>If you choose to have the payment for these benefits deposited directly to your bank account, please</li> </ul>		
	complete section 3 and attach a void cheque.		
	Section 4 – Declaration, Authorization & Signature		
	Part B – Attending Physician's Statement – Proof of Death		
Note: F			
	Part B of this document can be detached and provided to the Attending Physician to complete and send separately to		
ID Life	Insurance Company.		
	Section 1 – Claimant's Authorization		
	<ul> <li>The Claimant's signature and date are required.</li> </ul>		
	Section 2 - Attending Physician's Statement		
	Must be completed and signed by a licensed medical practitioner.		
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Part C – Additional Supporting Documentation			
	Proof of Age of Insured Person – Please provide a copy of one of the following:		
	<ul> <li>Birth Certificate</li> </ul>		
	o Canadian Driver's License		
	<ul> <li>Permanent Residence Card</li> </ul>		
	o Canadian Passport		
	Canadian Citizenship Card		
	O Ganadian Onizononip Gara		
	If Estate is the hanoficiany provide a copy of the Last Will and Testament form		
	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		

Please note that beneficiary(s) must also provide 2 Additional Supporting Documentation which provides your name, address and date of birth, Support documentation may include 2 of the following:

- CRA Tax documents: Notice of Assessment
- o Canadian Driver's License
- o Canadian Passport
- o Canadian Citizenship Card
- o Birth Certificate
- Marriage Certificate or government-issued proof of marriage document (long-form which includes date of birth)
- o T4 statement
- o Record of Employment
- o Canadian Pension Plan (CPP) statement of contributions



#### Part A - Life Insurance Claim Form

In this form "Insured Person" means the person who is insured under this policy.

"Claimant" means the person who is making the claim.

**Section 1: Policy Information** 

Life Insurance is insured by TD Life Insurance Company\*

Policy Number	
Issue Date	
Name of Insured Person (full legal name) (please print)	
Policy Owner Name (if different than Insured Person)	
Type of Claim	Life

## **Section 2: Claimant's Statement**

In what capacity or by what title do	you claim the insuranc	e?		
<ul><li>Executor or Administrator (</li><li>Named Beneficiary</li></ul>	Please attach a copy o	of the Last Will & Te	estament)	
Insured Person's Name:				
Insured Person's Address:				
Insured Person's Social Insuran (Required for income tax purposes				
Insured Person's Date of Birth:	•			
Insured Person's Place of Birth:				
Insured Person's Date of Death:	(mm/dd/yyyy)			
Cause of Death:				
Place of Death:				
Sum Insured: (\$)				
Was the Insured Person a smok If Yes, please provide the last d (mm/dd/yyyy)				
Please indicate type of tobacco of any substance or product cor following: Tobacco; Nicotine; Ma	ntaining the			
Claimant's Name:				
Claimant's Social Insurance Nui (Required for income tax purposes				
Claimant Address:				
Claimant Contact Information: Residential or Cellular Phone N	umber			
Business Contact Number:				
Claimant Email Address:				
Name of Insured Person's Famil				
Address of Insured Person's Fa Physician:	mily			
Date of Consultations	Pos	ison		Result
(mm/dd/yyyy)	1/60			Nosuit

Other Physicians consulted, including any hospitals or institutions during the last 5 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		(mm/dd/yyyy)	Face Amount
If the death is due to an accident	:		
Date of Accident: (mm/dd/yyyy	y)		
Place of Accident:			
<ul><li>Home</li><li>Work</li></ul>			
• Car			
Aircraft			
Details of accident:			
Details of accident.			

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

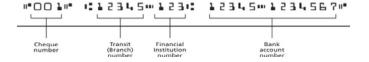
We are pleased to offer you the ease and convenience of depositing your benefit directly into your designated account. This will ensure that you receive your claim payment as guickly and efficiently as possible.

To proceed with direct deposit of your benefit, please complete, sign and date the authorization below. You also need to either attach a void cheque that clearly identifies the Bank Account (the "Account") into which you wish the payment to be deposited OR, enter this information in the space provided under Account Information below. 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 Your account information can be verified by contacting your financial institution or by referencing the numbers at the bottom of your cheque:

Branch Transit Number: This is the 5-digit number that identifies your home banking branch

Financial Institution Number: Every Canadian Financial Institution has its own 3-digit number. For example, TD Canada Trust is 004

Bank Account Number: This is a unique 7-digit number that is used to refer to your personal account.



#### **Account Information**

Branch Transit Number F	inancial Institution Number	Bank Account Number
Davile Address		
Bank Address		
TD Life (both as insurer and through electronic funds transpood and sufficient authorise for the purpose of paying the payment upon its deposit in belongs to a third party, it is me or are used to pay down unable to verify the accura	issued by TD Life Insurance Co ad as administrator to deposit all ansfer (direct deposit) to the acc ty for so doing. I consent to the his claim by this method. I fully r in the above-described Account. shall not be TD Life responsibility on any indebtedness for which the	rint name) as the Beneficiary under the Insurance Policy Impany (TD Life), hereby irrevocably direct and authorize claim benefits payable under the Insurance Contract, count number as noted above and this shall serve as your collection, use and disclosure of my personal information elease TD Life from any and all liability in regard to such If such account is a joint account with any other person or should any funds be withdrawn by any person other than its account is responsible. I understand that TD Life is m responsible in the event that an incorrect account e.
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, I agree that we may collect, use and disclose your Information as described in the Privacy Policy attached to my Insurance Policy including for, but not limited to, the purposes of identifying me, providing ongoing service, processing my claims, understanding my 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:	
Relationship to the Insured Person:	
Claimant's Name:(Please print)	
Claimant's Signature:	Date: (mm/dd/yyyy)

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



### 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**

Life Insurance insured by TD Life Insurance Company\*

Policy Number	
Insured Person's Name (please print)	
Date of Birth (mm/dd/yyyy)	
I hereby authorize the release of any information	requested in respect of this claim to TD Life
Insurance Company.	
, •	
Signature of Claimant	Date (mm/dd/yyyy)

# Section 2 - Attending Physician's Statement (Completed by Physician)

physician's administrative workload. Please comp	e Physician in mind. By being comprehensive, it will hopefully reduce the applete the sections relating to your patient and strike out non-applicable etails of family and medical history, investigation, findings and treatment
<ul><li>□ This form may be mailed directly to TD Life Insura</li><li>□ The above named is insured with TD Life Insurar</li></ul>	ance Company or given to the Claimant at the physician's discretion. Ince Company against the happening of certain contingent events Submitted in connection with a Life benefit and, to enable the assessment
of the claim, we would appreciate for your coope	eration on the completion of this form.
Patient's Name: (Please print)	
Patient's Date of Birth: (mm/dd/yyyy)	
Patient's Date of Death: (mm/dd/yyyy)	
Place of Death:	
Death resulted from: Natural Causes; Suicide; Homicide; Accident; Other	
Disease or condition directly related to death:	
o Duration:	
Antecedent Causes:	
o Duration:	
1. Date of first attendance of final illness: (n	mm/dd/yyyy)
2. Date of last attendance of final illness: (m	nm/dd/yyyy)
3. Was your patient a smoker? (Yes/No) If Yes, when was the last date used? (mm/dd/	
4. If accident, suicide, homicide, describe b	oriefly:
5. Was death solely due to this accident? (Y	Yes/No)
6. Was there an inquest?	
<ol><li>Was there an autopsy? (Yes/No) If Yes, pl attach a copy.</li></ol>	lease
If "Yes" to either question 6 or 7, by whom and result?	d with what
Full name	
• Result	
8. Have you treated or advised your patient	
<ul><li>last 5 years, prior to last illness? (Yes/No</li><li>9. Did your patient, to your knowledge, received</li></ul>	
treatment during the last 5 years from ar Physician or in any Hospital or Institution	ny other
If "Yes" to either question 8 or 9, please provide	
following details:	

<ul> <li>Address</li> <li>Nature of illness or injury</li> <li>Date (mm/dd/yyyy)</li> </ul>	
Remarks:	
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 t	o the best of my knowledge and belief.
Physician's Name: Physic (Please print)	ian's Signature:
Physician's Specialty:	
Date:Address:	
Telephone Number: Fax Number:	

Thank you for taking the time to complete this form.