TD Insurance
Instructions for completing the claim package for TD Protection Plan Accidental Dismemberment Insurance

This insurance benefit is underwritten and administered by TD Life Insurance Company ("TD Life").

The TD Protection Plan Accidental Dismemberment Insurance Claim Package contains two parts:

- **Part A: Claimant's Statement for TD Protection Plan Accidental Dismemberment Insurance.**
- **Part B: Attending Physician's Statement of Accidental Dismemberment.**

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 Protection Plan Accidental Dismemberment 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 of Accidental Dismemberment 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

PART A - Claimant's Statement for TD Protection Plan Accidental Dismemberment 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.

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.

Section 1 - Claimant's Statement

Name of Insured: _____

Address of Insured: _____

Insured Date of Birth: _____

If you are not the Insured, please complete the Claimant details below and confirm what is your relationship to the Insured?

Name of Claimant: _____ (Last Name) _____ (First Name and Initial)

Address: _____ (Number) _____ (Street)

_____ (City) _____ (Province) _____ (Postal Code)

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

Telephone Number: _____ Alternate Telephone Number: _____

Name and Address of Family Physician:

Details of Accident ("you and your refer to the Insured, if other than the claimant")

1. Date of Accident: _____

2. Complete details of accident: where and how did it happen? Please provide an accident report if available.

3. If you were involved in a motor vehicle accident and you were the driver, please attach a copy of the police report and motor vehicle accident report.

4. Which covered loss are you claiming?
   - ☐ loss of limb
   - ☐ paralysis
   - ☐ loss of sight

5. List of all physicians you have seen since your accident.

Physician	Address	Dates	Any hospitalizations; provide dates of admission/discharge	
			From	To

(Please use a separate sheet for additional comments)

Accidental Dismemberment Insurance Claim Authorization

Insurer: TD Life Insurance Company ("TD Life")

Claimant's Authorization and Declaration:

- 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 Insured (if other than the Claimant), 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.

If I am not the Insured:

- In providing this authorization to collect personal information about the Insured relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured 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 _____

Claimant's Signature _____ Date _____

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

PART B - Attending Physician's Statement - Accidental Dismemberment

Section 1 - Patient's Authorization

Patient's Name (Please Print): _____

Patient's Date of Birth: _____
(Month, Day, Year)

I hereby authorize the release of any information requested in respect of this claim, to the Insurer 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.

Date: _____ Signature of Patient: _____
(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

1. Date of accident _____ (Month, Day, Year)
Date you were first consulted regarding the injuries resulting from this accident _____ (Month, Day, Year)

2. Your diagnosis and complete description of injuries sustained.

_____

_____

_____

3. Did the accident result in loss of

☐ Right arm? Date _____ (Month, Day, Year) Location of amputation (at, above or below elbow) _____

☐ Left arm? Date _____ (Month, Day, Year) Location of amputation (at, above or below elbow) _____

☐ Right leg? Date _____ (Month, Day, Year) Location of amputation (at, above or below knee) _____

☐ Left leg? Date _____ (Month, Day, Year) Location of amputation (at, above or below knee) _____

☐ Right hand? Date _____ (Month, Day, Year) Location of amputation (at, above or below wrist) _____

☐ Left hand? Date _____ (Month, Day, Year) Location of amputation (at, above or below wrist) _____

☐ Right foot? Date _____ (Month, Day, Year) Location of amputation (at, above or below ankle) _____

☐ Left foot? Date _____ (Month, Day, Year) Location of amputation (at, above or below ankle) _____

4. Complete loss of vision.

a) If injury necessitated removal of eye, date of removal _____ (Month, Day, Year)

b) Vision in each eye prior to accident Right _____ Left _____

c) Present vision, if any, in each eye Right _____ Left _____

d) If use can be restored, provide details.

_____

_____

_____

_____

_____

_____

5. Loss of use due to paraplegia or quadriplegia.

a) Did the accident result in loss due to

☐ Paraplegia? ☐ Quadriplegia? ☐ Hemiplegia?

b) What was the extent of injury to the spinal cord?

c) Which, if any, tests were used to make the determination of the extent of injury.

d) Is loss irrecoverable? ☐ Yes ☐ No

e) Please provide any additional details that may be applicable.

6. Were the injuries or impairment sustained due solely to the above accident? ☐ Yes ☐ No
If not, please provide details of any condition or disease which in your opinion may have served as a contributory cause.

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 or fax this form to the Insurer below:

TD Insurance
Claims Department
P.O. Box 1
TD Centre
Toronto, Ontario M5K 1A2
Tel: 1-888-983-7070
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 Signature: _____ Date: _____ (Month, Day, Year)

Specialty: _____

Print Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Thank you for taking the time to complete this form.