TD Insurance
Instructions for completing the Waiver of Premium Benefit Claim Form

The Waiver of Premium Benefit claim package contains three parts:

- ☐ **Part A:** Waiver of Premium Benefit claim form
- ☐ **Part B:** Attending Physician's Statement - Stroke
- ☐ **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 – Waiver of Premium 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 – Declaration, Authorization & Signature**
- ☐ **Section 4 – Claimant's Supplementary Statement**

Part B – Employer Questionnaire and Attending Physician's Statement

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 – Job Description and Physical Demands Questionnaire**
  - To be completed by the Insured person's employer.
- ☐ **Section 2 - Insured Person's Authorization**
  - The Insured Person's signature and date are required
- ☐ **Section 3 - Attending Physician's Statement**
  - Must be completed and signed by a licensed medical practitioner.

Part C – Additional Supporting Documentation

- ☐ **Hospital Discharge Statement** – Please provide a copy, if available.
- ☐ **Hospital Admittance Statement**
- ☐ **Accident report, employer report and/or police report** – Please provide a copy, if available.
- ☐ **Proof of income** – please provide a copy if available.
- ☐ **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

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

Part A – Waiver of Premium Benefit 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

Critical Illness Recovery Plan insured by TD Life Insurance Company*

Policy Number	
Issue Date	
Name of Insured Person (please print full legal name)	
Address of Insured Person	
Date of Birth of Insured Person (mm/dd/yyyy)	
Insured Person's Contact Information: (Residential/Cellular Phone Number)	
Type of Claim	Disability Waiver of Premium

*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.

Section 2: Insured Person's Statement

Name of Claimant: (if different from Insured Person)	
Claimant's Date of Birth: (if different from Insured Person)	
Relationship to Insured Person:	
Claimant's Address: (if different from Insured Person)	
Claimant's Contact Details: (Residence/Cellular Phone Number)	
Is the claimant a smoker? If a smoker, please provide the last date used.	☐ Smoker ☐ Non-Smoker Date:
Please indicate type of tobacco product or use of any substance or product containing the following:	☐ Tobacco ☐ Nicotine ☐ Marijuana
Amount of coverage: ($)	
Nature of Illness/injury:	
Date Illness/Injury symptoms first appeared: (mm/dd/yyyy)	
Date admitted to hospital: (mm/dd/yyyy)	
Date discharged from hospital: (mm/dd/yyyy)	
Hospital Name:	
Hospital Address:	
Name of Family Physician:	
Address of Family Physician:	
If less than 2 years, please provide name & address of previous physician(s).	

Do you have other insurance policies? If yes, complete below:

Insurance Policy	Effective Date	Face amount

Section 3: 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

By signing below you—the insured person—also agree to the following unless you check the box below to indicate that you do not agree:

- If you do not qualify to claim for the Critical Illness Benefit, we may explain this to the Policy Owner. If other information negatively affects our claims decision, we may tell the Policy Owner whether the relevant information relates to your family history, medical information, or lifestyle.

☐ I do not agree to the disclosure of my personal information to the Policy Owner.

Insured Person's Name:_____ Date:_____

(Please print) (mm/dd/yyyy)

Insured Person’s Signature:_____

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

Section 4 - Claimant's Supplementary Statement - Waiver of Premium Benefit Claim

Employer's Name:	
Employer's Address:	
Employer's Telephone:	
Description of Duties:	
Self Employed:	☐ Yes ☐ No
Annual Salary: ($)	
Date last worked due to disability: (mm/dd/yyyy)	
On what date will you be able to return to work? (mm/dd/yyyy)	
Please provide the following if applicable: • **WCB/CSST/CPP Claim Number** • **Name and Telephone Number of Case Worker**	

Training and Education

What is your level of education in Canada? **Year of completion:**	
Diploma(s) and/or Degree(s) completed: **Include Year of completion.**	**1.** **2.**
If educated outside Canada, what is the Canadian equivalent?	
Have you attended any trade schools, received other special training, or completed professional certificates?	☐ Yes ☐ No

Occupational History

Please list details (the most recent first) below:

Company Name	**Occupation**	**Date of Employment** (mm/dd/yy)

(continued)

What are your hobbies and/or other special interests?
In your opinion, how do your limitations and symptoms prevent you from performing your usual job duties?

Do you expect to return to your previous occupation?	☐ Yes ☐ No
Do you expect to return to any occupation?	☐ Yes ☐ No
Have you discussed returning to work or rehabilitation with your doctor? **If yes, what is his/her opinion?**	☐ Yes ☐ No Details:
Have you contacted Manpower or the Provincial Ministry of Community and Social Services or your other insurers on the possibilities of vocational retraining? **If yes, what is the name and address of the counsellor in charge of your case and what vocational plans have been made?**	☐ Yes ☐ No Details:

Declaration

I declare that the statements made are true, complete and correctly recorded. I understand that concealment, misrepresentation or false declaration concerning this statement could cause any insurance to be void.

Signature of Claimant_____ **Date**_____

Part B - Section 1 - Job Description and Physical Demands Questionnaire -To be completed by your employer

Would you please forward a brief description of this employee's job immediately before he/she became disabled and/or attached his job description. This will assist in our evaluation the of disability relative to the job requirements.

Job Title:	
Briefly Describe Duties:	
Does the job require the use of machinery or special equipment?	☐ Yes ☐ No
Indicate the total number of hours regularly worked per week:	
Indicate the number of hours spent each day in: **Walking:** **Standing:** **Sitting:**	

Other job activities – please check all that apply:

☐ Balancing	☐ Climbing	☐ Lifting	☐ Working around others
☐ Bending	☐ Crawling	☐ Reaching	☐ Working with others
☐ Carrying	☐ Kneeling	☐ Running	☐ Other

If other, please explain: _____

If job requires lifting or carrying, state:

The approximate weight to be lifted or carried	Lifted from what height?	To what height?

If reaching or bending was indicated above, please describe:
If climbing was indicated above, does this job require climbing stairs, ladders or other?
Are light or modified duties available? Please provide details:
☐ Yes:
☐ No:

Are occupational hazards present, please check all that apply:

☐ Cold	☐ Electrical Hazards	☐ Odours	☐ Toxic Conditions
☐ Dangerous Machinery	☐ Heat	☐ Poor Ventilation	☐ Wet Quarters
☐ Dust	☐ Noise	☐ Sudden Temperature Change	☐ Other

If other, please explain: _____

Senses needed to perform duties, please answer yes or no to the following:

Vision:		
Near	☐ Yes	☐ No
Far	☐ Yes	☐ No
Depth Perception	☐ Yes	☐ No
Peripheral Vision	☐ Yes	☐ No
Hearing:		
Ordinary Conversation	☐ Yes	☐ No
Other	☐ Yes	☐ No
Speech:		
Ordinary Conversation	☐ Yes	☐ No
Loud Talking	☐ Yes	☐ No
Touch:		
Finger Dexterity	☐ Yes	☐ No
Other	☐ Yes	☐ No

If other, please explain:

Hearing: _____

Touch: _____

Please describe the level of concentration required for this job:
Would you consider this job mentally or physically demanding or both, describe:
Last date worked?
Comments:

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

Employer: _____

Signature: _____ **Date:** _____

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Toronto ON M5K 1A2

Part B – Attending Physician's Statement

Waiver of Premium

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

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 to my insurer any information requested in respect of this claim to TD Life Insurance Company.

Signature of Insured Person: _____

Date_____

(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.

Section 3 - 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 Claimant at the physician's discretion.
- The above named is insured with TD Life Insurance Company against the occurrence of unforeseen events connected with their health. A disability claim has been submitted in connection with your patient's insurance coverage and, to enable the assessment of the claim, we would appreciate your cooperation on the completion of this form.

Patient's Name: (Please print)	
Patient's Date of Birth: (mm/dd/yyyy)	
Is your patient a smoker? **If yes, please provide the year the patient started smoking and the last date used**	☐ Yes ☐ No Date started: Date last used:
Please indicate type of tobacco product or use of any substance or product containing the following:	☐ Tobacco ☐ Nicotine ☐ Marijuana
Date symptoms first appeared, or accident happened: (mm/dd/yyyy)	
Date patient ceased work because of current condition: (mm/dd/yyyy)	
Date of first visit for current condition: (mm/dd/yyyy)	
Date of latest visit: (mm/dd/yyyy)	
Has patient ever had same or similar condition?	☐ Yes ☐ No ☐ Unknown
Is condition due to injury or sickness arising out of patient's employment?	☐ Yes ☐ No ☐ Unknown
Is condition considered chronic? **If yes, what precipitated absence from work?**	☐ Yes ☐ No Details:
Names and specialties of other treating consulting physicians:	

Diagnosis

Primary Diagnosis: Were there any precipitating factors?	
Additional conditions or complications which might affect duration of absence from work.	
Subjective symptoms, including severity and frequency.	
Objective signs (including results of current X-rays, EKG's, or laboratory data and any relevant clinical findings)	

Physical Impairment

☐ **Class 1**	(no limitation – capable of physical activity, 0 – 10%)
☐ **Class 2**	(slight limitation – capable of light manual activity, 15 – 30 %)
☐ **Class 3**	(moderate limitation – capable of clerical/administrative activity, 35 – 55 %)
☐ **Class 4**	(marked limitation, 60 – 70%)
☐ **Class 5**	(severe limitation – incapable of sedentary activity, 75 – 100%)

Is patient capable of:

☐ Lifting hrs.	☐ Sitting hrs.	☐ Standing hrs.	☐ Walking hrs.
☐ Bending	☐ Squatting	☐ Climbing	

Is patient:

☐ Ambulatory	☐ Ambulatory with assistive devices? (please specify)	☐ Bed confined	☐ House confined	☐ Hospital confined

Mental / Nervous Impairment (if applicable)

How does patient's mental or nervous impairment affect ability to work?	
Has there been any psychiatric referral? (If yes, please attach copies of consultation reports)	☐ Yes ☐ No

Cardiac (if applicable)

☐ **Class 1** No limitation	☐ **Class 2** Slight limitation	☐ **Class 3** Moderate limitation	☐ **Class 4** Marked limitation	☐ **Class 5** Complete limitation

Blood pressure (last visit)	**Systolic:**	**Diastolic:**

Treatment

Nature of treatment (including surgery, and medications prescribed, if any)	
Frequency of visits:	☐ Weekly ☐ Monthly ☐ Other (please specify) :
Other treatment (therapy), please specify and provide Therapist's name and address:	
To your knowledge is patient following recommended treatment program? Please provide details:	☐ Yes ☐ No
Please describe response to treatment program?	

Progress - Has patient:

☐ Recovered	☐ Improved	☐ Not Improved	☐ Retrogressed

Prognosis

Do you think that the patient will be able to return to work? **If Yes, state approximate date. (m/d/y)** **If No, what precisely is preventing the patient from returning to work?**	☐ Yes ☐ No Date or details:
In your opinion, can the patient return to modified work?	☐ Yes ☐ No

Rehabilitation

Is the patient a suitable candidate for further medical rehabilitation services (ie. Cardiopulmonary program, speech therapy, etc.)? **If Yes, please specify:**	☐ Yes ☐ No Details:
Would vocational counselling and/or retaining be recommended? **If Yes, please specify:**	☐ Yes ☐ No Details:
Is the patient suitable for trial employment? **If Yes, stated date** (mm/dd/yyyy)	☐ Yes ☐ No Date:

Please provide copies of clinical notes and hospital reports for our Medical Director's review. The neurologist's recent assessment results. Please provide any other information to would be helpful in the assessment of your patients claim. 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.