TD Insurance
Instructions for completing the claim package for Business Credit Living Benefit Insurance - Critical Illness/Stroke (Group Policy # 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 Business Credit Living Benefit Insurance - Critical Illness Insurance Stroke Claim Package contains two parts:

Part A: Claimant's Statement for Business Credit Living Benefit Insurance - Critical Illness / Stroke.
Part B: Attending Physician's Statement of Critical Illness - Stroke.

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 Business Credit Living Benefit Insurance - Critical Illness / Stroke

☐ 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 Critical Illness - Stroke are completed.

Section 1 - Patient'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 B of this document can be detached and provided to the Attending Physician to complete and send separately to TD Life Insurance Company - Claims Department.

☐ 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

*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. All trade-marks are the property of their respective owners.

PART A

Claimant's Statement for Business Credit Living Benefit Insurance - Critical Illness/Stroke

Statement of Claim (Completed by Insured/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 - Claimant's Statement

Name of Business: _____

Address of Business: _____

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)

Telephone Number: _____ Alternate Telephone Number: _____

1. Claim and related details ('you' and 'your' refer to the Insured, if other than Claimant)

a) Please provide details of your Critical Illness:

_____

b) On what date was your condition diagnosed or surgery performed?

_____

c) (i) On what date did symptoms first commence?

_____

(ii) Please describe these symptoms.

_____

d) On what date did you first consult a medical practitioner in connection with your illness?
Please provide the physician's name, address and telephone number:

_____

_____

e) Have you undergone any tests or investigations related to the diagnosis? ☐ Yes ☐ No
If yes, please provide details and dates.

_____

f) Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No
If yes, please provide details and dates.

_____

2. Medical Consultations

a) (i) Please provide the name, address and phone number of your personal physician.

(ii) How long had he/she been your personal physician?

b) Please list the names, addresses and phone numbers of physicians seen in the past 5 years, other than those listed in (a) (i) above.

c) List the names and locations of all hospitals and/or institutions where you were treated in the past 5 years (include admission and discharge dates).

d) Please provide the names, addresses and phone numbers of any other physicians or specialists who have been consulted in connection with your illness.

e) What treatment have you received and are you currently receiving in connection with your condition?

Type of treatment	Institution/Physician	Dates	
		From	To

f) Have you ever smoked:

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)

3. General

a) Have you or any of your immediate family (mother, father, brother(s), sister(s)) had cancer, (including leukemia, lymphoma and Hodgkin's disease), a tumor, stroke/TIA, heart disease, heart attack or diabetes before the age of 60? ☐ Yes ☐ No

b) If yes, list relationship, condition, age at which illness was first diagnosed, and date of diagnosis.

Relationship	Condition	Age at which illness was first diagnosed	Date of diagnosis (Month, Day, Year)

c) Please provide any further information which you think might be helpful in support of your claim.

Business Credit Living Benefit Insurance - Critical Illness / Stroke
Claimant's Authorization and Declaration

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

- 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 (not including medical information) to The Toronto-Dominion Bank ("TD Bank") to allow TD 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 [am authorized to sign on their behalf] and 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: _____
(Month, Day, Year)

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

PART B

Attending Physician's Statement of Critical Illness - Stroke

Section 1 - Patient's Authorization

Patient's Name (Please Print): _____

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

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

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 patient is responsible for the securing of 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.

The above named is insured with **The Canada Life Assurance Company** against the happening of certain contingent events associated with their health. A claim has been submitted in connection with **Stroke** and, to enable the assessment of the claim, we would be grateful for your cooperation on the completion of this form.

1. a) On what date did your patient first consult you for this condition?

   b) How long has the Insured been your patient?

2. a) Was a diagnosis of a Stroke made? ☐ Yes ☐ No

   b) How long has the Insured been your patient?

   c) Please describe the cause of the Stroke (if known).

   d) When did your patient first suffer symptoms or episodes of cerebrovascular disease? What were these symptoms?

   e) Please describe the residual neurological deficits.

   Are there neurological deficits? ☐ Yes ☐ No

   if yes, Please provide information on each neurological deficit:

Deficit	Persisting (Y/N)	Resolved(Y/N)	Date resolved (if applicable)

   f) How long have the neurological deficits persisted?

g) By whom was the diagnosis made (if other than yourself)?

h) Please provide a copy of the CT scan if available.

3. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke.

4. Is there any immediate family history of cancer (including leukemia, lymphoma and Hodgkin's disease), a tumor, stroke/TIA, heart disease, heart attack or diabetes before the age of 60? ☐ Yes ☐ No

If yes, list relationship, condition, age at which illness was first diagnosed, and date of diagnosis.

Relationship	Condition	Date of diagnosis (Month, Day, Year)

5. Please provide details of your patient's tobacco, nicotine or Marijuana use including amount per day and date last used.

6. List all risk factors and the date each was first diagnosed:

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 Administrator 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