TD Insurance

Instructions for completing the claim package for TD Protection Plan Disability Insurance (Loan/Mortgage)

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 Protection Plan Disability Insurance Claim Package contains two parts:

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

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 Disability 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 Disability 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.

☐ You are required to maintain your loan or mortgage payments until you have received confirmation that your Claim has been approved.

☐ 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 Disability 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 ☐ Loan

Branch/Transit Number: _____

Loan/Mortgage 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 the Claimant: _____
(Last Name) (First Name and Initial)

Address: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Telephone Number: _____ Alternate Telephone Number: _____

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

Details of Employment and Disability ('you' and 'your' refer to the Insured, if other than the claimant)

Your occupation and job title: _____

Job Description: _____

Number of hours worked each week prior to your disability: _____

Name, address and telephone number of your employer

a) at time of application _____

_____

b) immediately prior to your disability _____

1. When did your health first become affected? _____

2. From what date has your disability prevented you from working? _____

		From	To
3.	Were you confined to bed? ☐ Yes ☐ No If "Yes", give dates		
b)	Were you confined to your home? ☐ Yes ☐ No If "Yes", give dates		
c)	Were you a patient at a hospital or sanitarium or drug/alcohol rehabilitation centre? ☐ Yes ☐ No If "Yes", give dates		

4. a) Describe your present **condition**, its **cause** and **history** to date. If injured, indicate the nature of the accident. Please also advise when and where the accident occurred and how it came about.

_____

_____

b) 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.

5. a) Does your health completely prevent you from working now? ☐ Yes ☐ No

b) If not working, when do you anticipate returning to: 1) your own job?_____ 2) another job? _____

c) If now working 1) Briefly state your duties _____ _____

2) When did you return to work? _____

3) Are you now working on a gradual basis? ☐ Yes ☐ No

If Yes, please confirm the number of hours per week _____

d) Do you have another claim in regards to this loss? ☐ Yes ☐ No If Yes, with who? _____

6. a) Name and address of Family Physician. Number of Years: _____

_____

_____

b) Names of all Physicians who have attended you during this disability.

Name	Address	Dates From	Dates To

Please list your present medications:

Name of Medication	Dosage (mg)	How Often?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

☐ Left ☐ Right

7. a) What is your level of education in Canada?

_____

b) If educated outside Canada, what is the Canadian equivalent?

_____

c) Have you attended any trade schools or received other special training?

_____

d) List and give details of all previous occupations.

_____

_____

e) What are your hobbies and/or other special interests ?

_____

_____

f) In your opinion, how do your limitations and symptoms prevent you from performing your usual job duties ?

_____

_____

_____

g) Have you discussed returning to work or rehabilitation with your doctor? ☐ Yes ☐ No
If "Yes", what is his/her opinion?

_____

h) Have you contacted Employment Insurance Canada Rehabilitation Services on the possibilities of vocational retraining? If yes, what is the name and address of the counselor in charge of your case, and what vocational plans have been made? ☐ Yes ☐ No

_____

_____

Disability Insurance Claim Authorization

Insurer: The Canada Life Assurance Company ("Canada 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: _____
(Print Last name, First name and initial)

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 - Disability

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 Statement (Completed by Physician)

This form has been 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 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.

I am the: ☐ Family Physician ☐ Consulting Specialist ☐ Other (please specify): _____

Please complete to the best of your knowledge

Diagnosis

Primary:

_____

_____

Secondary and/or Complications:

_____

_____

_____

If Childbirth - Expected or Actual Delivery Date (mm/dd/yyyy): _____

Is this condition due to:

Occupational Illness/injury: ☐ Yes ☐ No Auto accident: ☐ Yes ☐ No

If yes, date of event: _____ If yes, date of event: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Have you completed any other disability claim forms recently for this patient? ☐ Yes ☐ No
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.):

_____

Date of first visit to you pertaining to this condition: _____
(mm/dd/yyyy)

First date of work absence due to condition: _____
(mm/dd/yyyy)

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in Section 1):

_____

_____

_____

_____

_____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other (describe): _____

Date of last visit: _____
(mm/dd/yyyy)

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: _____ Treatment Provider: _____
(mm/dd/yyyy)

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No

If so, please explain: _____

_____

Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No Is future hospitalization planned? ☐ Yes ☐ No

	Date of admittance (mm/dd/yyyy)	Date of discharge (mm/dd/yyyy)	Institution Name
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (mm/dd/yyyy)	Description
1.	_____	_____
2.	_____	_____

Investigations

Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Are tests/investigations pending? ☐ Yes ☐ No

	Date (mm/dd/yyyy)	Description
1.	_____	_____
2.	_____	_____

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future? ☐ Yes ☐ No

Name of Specialist	Specialty	Date (mm/dd/yyyy)
1. _____	_____	_____
2. _____	_____	_____

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

_____

_____

_____

_____

_____

_____

_____

How have the patient's symptoms evolved to date? ☐ Improved ☐ No Change ☐ Retrogressed

Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:

_____

_____

_____

_____

_____

_____

_____

Has any license held by the patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No

If yes, as of when?_____ Type of license: _____
(mm/dd/yyyy)

Do you have concerns about the patient's ability to manage his/her own affairs? ☐ Yes ☐ No

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals? ☐ Yes ☐ No
Please elaborate:

_____

_____

_____

_____

Prognosis
Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work
What return-to-work goals have been discussed with the patient? Please elaborate:

Attach any specialist report, if available

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.

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.