RBC Insurance®

Group Disability Claim Form

Client's Name: _____

Policy No(s): _____

Employer Name: _____

IMPORTANT GUIDELINES

- Print legibly in ink, preferably black for photocopy purposes. DO NOT use ditto marks.
- DO NOT make erasures or use liquid paper. Stroke out an error and have the applicant initial it.

COMPLETING THE FORM:

We want to make sure your claim is processed accurately and quickly. To make the process as timely as possible, we have designed this Disability Claim form to collect as much necessary information as possible from you at the beginning of the process. The information we have requested will help us determine the benefits you receive according to your contract with us.

Please use the following guidelines to complete the form:

- Use an ink pen when completing all sections and print clearly
- Attach additional pages where necessary and clearly mark the following on each page: **Your name, the section, page and question number that the supplementary information refers to**

PLEASE NOTE THAT YOUR PHYSICIAN WILL NEED TO COMPLETE AN "ATTENDING PHYSICIAN'S STATEMENT" ACCORDING TO YOUR DIAGNOSIS. PLEASE CALL US TO OBTAIN THE APPROPRIATE FORM OR VISIT OUR WEBSITE AT WWW.RBC.COM

THE COMPLETED FORMS MUST REACH RBC LIFE INSURANCE COMPANY WITHIN 90 DAYS OF THE CLAIMED DISABILITY DATE.

If you require assistance, or have questions concerning the form, please call the Life & Health Claims Department at (416) 643-4700 or 1 877 519-9501.

MAIL THE COMPLETED FORM TO:
RBC Life Insurance Company, Life and Health Claims Department
P.O. Box 4435, Station A, Toronto ON, M5W 5Y8, or fax to: 1 800 714-8861

COLLECTION AND USE OF PERSONAL INFORMATION

Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about you such as:

- information establishing your identity (for example, name, address, phone number, date of birth, etc.) and your personal background;
- information related to or arising from your relationship with and through us;
- information you provide through the application and claim process for any of our insurance products and services; and
- information for the provision of products and services.

We may collect information from you, either directly or through representatives. We may collect and confirm this information during the course of our relationship. We may also obtain this information from a variety of sources including hospitals, doctors and other health care providers, the MIB, Inc., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

Using personal information

This information may be used from time to time for the following purposes:

- to verify your identity and investigate your personal background;
- to issue and maintain insurance products and services you may request;
- to evaluate insurance risk and manage claims;
- to better understand your insurance situation;
- to determine your eligibility for insurance products and services we offer;
- to help us better understand the current and future needs of our clients;
- to communicate to you any benefit, feature and other information about products and services you have with us;
- to help us better manage our business and your relationship with us; and
- as required or permitted by law.

For these purposes, we may make this information available to our employees, our agents and service providers, and third parties, who are required to maintain the confidentiality of this information. If you are insured under a group insurance policy obtained through your employer, we may also share your information with your employer when necessary for the services we provide to you. Your health information will not be shared with your employer without your consent.

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, Inc. and financial institutions.

We may also use this information and share it with RBC® companies (i) to manage our risks and operations and those of RBC companies and (ii) to comply with valid requests for information about you from regulators, government agencies, public bodies or other entities who have a right to issue such requests.

If we have your social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

Your right to access your personal information

You may obtain access to the information we hold about you at any time and review its content and accuracy, and have it amended as appropriate; however, access may be restricted as permitted or required by law. To request access to such information or to ask questions about our privacy policies, you may do so now or at any time in the future by contacting us at:

RBC Life Insurance Company
P.O. Box 515, Station A,
Mississauga, Ontario
L5A 4M3
Telephone: 1 800 663-0417
Facsimile: (905) 813-4816

Our privacy policies

You may obtain more information about our privacy policies by asking for a copy of our "Straight Talk®" brochure about privacy, by calling us at the toll free number shown above or by visiting our web site at www.rbc.com/privacy.

Please list all of your RBC Life Policy Numbers:

_____

_____

_____

CLIENT'S STATEMENT OF DISABILITY

PERSONAL INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other ☐ Male ☐ Female ☐

Name: Last First Middle

Name commonly used *(if different from your first name)* Date of birth (DD/MM/YYYY)

Address (Apt. / Street / City / Province / Postal Code)

Indicate mailing address (if different from above)

Home Tel. No.: (_____) _____ Bus. Tel. No.: (_____) _____ Mobile Tel. No.: (_____)_____

Email Address: _____ Provincial Health Card No.: _____

CLAIM DETAILS

ACCIDENT	SICKNESS
Date of accident: (DD/MM/YYYY)	Provide nature and details of sickness:
Type of accident: Work ☐ Auto ☐ Other ☐	
Describe how accident happened:	
	Have you ever had a similar sickness? Yes ☐ No ☐
What injuries did you receive?	If "Yes," give date(s):
	What are your disabling symptoms?
When did your symptoms first appear? (DD/MM/YYYY)	
Have you had previous injuries of a similar nature?	
Yes ☐ No ☐ If "Yes," give date(s):	When did your symptoms first appear? (DD/MM/YYYY)

My last day at work (unable to perform any work) was: _____ (DD/MM/YYYY)

First day that my condition forced me to work less time: _____ (DD/MM/YYYY)

First day that my condition forced me to stop working completely: _____ (DD/MM/YYYY)

Date I returned/am returning to work: _____ (DD/MM/YYYY) _____ (DD/MM/YYYY)
Full-time date Part-time date

1. a) What prevents you from returning to work or working full time? _____

   _____

   b) How does your current condition affect your daily living? Please provide details: _____

   _____

2. Have you discussed a return-to-work plan with your attending physician? Yes ☐ No ☐

   If "Yes," do you believe that your occupational duties will need to be modified in some way when you return to work? Yes ☐ No ☐

   If "Yes," please explain: _____

   _____

TREATMENT

1. List all physicians/health care providers you have consulted for any reason in the last two years. This should include your current family physician, consulting physicians, physiotherapists, chiropractors, psychologists, counselors and therapists (list any additional health care providers on a separate page):

_____

Physician/Health Care Provider

_____(____)_____|_____

Address (Street / City / Province / Postal Code) Telephone No. Date(s) Seen (DD/MM/YYYY)

_____

Physician/Provider Specialty

_____(____)_____|_____

Address (Street / City / Province / Postal Code) Telephone No. Date(s) Seen (DD/MM/YYYY)

2. Hospital where you received treatment or attended as an out-patient for any reason (List any additional hospitals on a separate page):

_____|_____

Hospital/Facility Reason for Visit

_____

Address (Street / City / Province / Postal Code)

_____|_____

Date Admitted (DD/MM/YYYY) Date Discharged (DD/MM/YYYY)

3. Pharmacy where you have had prescriptions filled in the last two years:

_____

Name of Pharmacy

_____(____)_____

Address (Street / City / Province / Postal Code) Telephone No.

_____|_____

Who Prescribed? Date Prescribed (DD/MM/YYYY)

OCCUPATION

1. a) What is the name of your employer? _____

   b) Date of hire: _____ (DD/MM/YYYY)

2. a) What was your occupation immediately prior to this claim? _____

   b) Briefly describe this position: _____

   _____

   c) Describe the essential duties of this job: _____

   _____

   d) Describe the non-essential duties of this job: _____

   _____

3. How many hours per week did you work immediately prior to this claim? _____ hrs./wk.

4. Are you employed in more than one occupation? Yes ☐ No ☐ If "Yes," please include all occupations and employers:

   _____

   _____

   _____

SALARY

1. Please indicate your salary or wage prior to this claim: $_____ per _____ (i.e. Hour, Year)
2. How was your salary or wage received? Weekly ☐ Bi-weekly ☐ Monthly ☐ Other ☐
3. Please indicate any remuneration received in addition to your regular salary or wage during your most recent 12 months of employment (i.e. commissions, bonuses, overtime, etc.):

_____ $ _____
Type Amount

_____ $ _____
Type Amount

FUNDS FROM OTHER SOURCES

☐ Salary Continuation
☐ Short Term Disability
☐ Employment Insurance
☐ Mortgage Creditor Insurance
☐ Canada/Quebec Pension Plan
☐ Automobile Insurance
☐ Retirement Pension Plan
☐ Other
☐ Individual Disability
☐ Workers' Compensation
☐ Association Group Plan

Please provide details for each income source:

Company name or type of government plan: _____

Claim No._____ Date claim filed (DD/MM/YYYY) _____

Amount of this benefit $_____ Weekly ☐ Bi-weekly ☐ Monthly ☐

Name of contact _____ Telephone (_____) _____

Company name or type of government plan: _____

Claim No. _____ Date claim filed (DD/MM/YYYY) _____

Amount of this benefit $_____ Weekly ☐ Bi-weekly ☐ Monthly ☐

Name of contact _____ Telephone (_____) _____

Company name or type of government plan: _____

Claim No. _____ Date claim filed (DD/MM/YYYY) _____

Amount of this benefit $_____ Weekly ☐ Bi-weekly ☐ Monthly ☐

Name of contact _____ Telephone (_____) _____

DOCUMENTS REQUIRED

Please enclose the following documents with this Statement:

☐ Copy of all police reports or incident reports *(if your injury was the result of an accident or police-reported incident)*
☐ Any correspondence from all motor vehicle and other insurance carriers
☐ Any correspondence from alternate sources of income *(i.e. STD, EI, WCB/WSIB, CPP/QPP etc.)*
☐ Proof of income
☐ Attending Physician's Statement

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RBC Insurance®

CLIENT'S AUTHORIZATION STATEMENT

FRAUD NOTICE

Any person who knowingly files a Client's Statement containing false or misleading information is subject to criminal and civil penalties.

I, _____ , declare that the above statements are true and complete
(Print Name)
to the best of my knowledge and belief.

Date _____ Signature of Client _____
(DD/MM/YYYY)

AUTHORIZATION

I understand and authorize the Company (the company refers to and includes each of RBC Life Insurance Company and RBC Insurance Services Inc., and their reinsurers) to conduct such investigation as is necessary, to gather personal information concerning me and to disclose as necessary to third parties the fact that I am making a claim to the Company for benefits. I understand that the Company will create and maintain files, which contain personal information concerning me. I also understand that access to personal information concerning me will be limited to, the employees of, and other persons engaged by, the Company, in the performance of their duties, or the persons to whom I have granted access, in writing, or to any other person or organization authorized by law.

I further understand that, except when the Company can and does lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information in the possession of the Company, upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and have any errors in the personal information noted and corrected by formulating a written request to the Company mailed to the employee who is handling my claim.

I acknowledge and agree that if I choose to use, or instruct the Company to use, any electronic communication that is not encrypted, including without limitation, any fax or email communication, that (i) security, privacy and confidentiality cannot be ensured, (ii) such communication is not reliable and may not be received by the intended recipient in a timely manner or at all, (iii) such communication could be subject to interception, loss or alteration, and (iv) I assume full responsibility for the risks in connection with such communication and the Company will not be responsible or liable in any way in connection with such communication, including without limitation, any unauthorized access to or interception, loss or alteration of such communication.

Your Authorization to Disclose Personal Information

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to the Company any information, records or other data regarding me, my medical history or treatment, or my past and present income, employment, education or training, which they have in their possession or control.

Persons to whom this Authorization Applies: Any physician, nurse, counsellor, psychologist, pharmacist, physiotherapist, chiropractor or other rehabilitation professional or other health care practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of health care or treatment; and also the provincial health insurance plan, any insurance company or other financial institution or insurance broker or administrator; and also my employer or former employers and any of their agents performing services relating to any employee benefits or workers' compensation; and also any federal or provincial government department or organization, including the Workers' Compensation Board/ Workplace Safety and Insurance Board, the CPP/QPP disability/retirement authorities, and the federal or provincial income tax authorities; and also to any other person, agency, credit bureau or institution having information, records or data regarding me, my medical history or treatment, or my past and present income, employment, education or training.

I understand that any information, records or data received by the Company pursuant to this authorization, both medical and non-medical, will be used for the purpose of determining coverage under the policy, evaluating my claim for benefits, my ability to return to work and/or for the purpose of assisting with the co-ordination of my return to work, for the purpose of administering the group and/or individual plans of insurance (including life, accidental death and dismemberment and disability policies of insurance) arranged through my employer with the Company or another insurer, for the purpose of providing ongoing claim status information to my employer at the time the claim was incurred, for the recovery of any overpayment of benefits incurred by me, if necessary, or for the purposes of fulfilling its (or RBC Financial Group's) legal obligations with respect to audits, anti-money laundering, terrorist financing, fraud investigation or other criminal activities. To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to other insurance companies or any reinsurer; or to my employer and their insurance brokers or advisors or their benefit plan administrators; or to my physicians or health care providers; or to any other person or organization (including physicians, health care practitioners, rehabilitation workers, vocational evaluators) employed or engaged by the Company.

I also authorize the Company to collect, use and disclose, as necessary and relevant, my personal information from any prior claim(s) and/or for any subsequent claim(s).

I also authorize the Company to use my Social Insurance Number for any tax reporting purposes and CPP/QPP purposes and to request information from federal and provincial tax authorities and for identification purposes when required by policyholders on group LTD/GSI policies.

This authorization does not have any expiry date. It will remain valid for as long as I am claiming eligibility for benefits or services from the Company and while the Company pursues the recovery of any overpayment of benefits incurred by me, if necessary, whether or not benefits are being paid, and whether or not either party takes the position that there has been a breach of contract. A photocopy of this authorization, as executed by me, will be as valid as the original.

X _____ Date _____
Signature of Client (DD/MM/YYYY)

_____ Social Insurance Number: ☐☐☐–☐☐☐–☐☐☐
Name of Client (Please Print)

X _____ Date _____
Signature of Witness (DD/MM/YYYY)

_____
Name of Witness (Please Print)

MAIL THE COMPLETED FORM TO:
RBC Life Insurance Company, Life and Health Claims Department
P.O. Box 4435, Station A, Toronto ON, M5W 5Y8, **or fax to:** 1 800 714-8861
If you have any questions, call toll free 1 877 519-9501 or 416 643-4700