RBC Insurance

Loss of Use / Dismemberment Notice of Claim

EMPLOYER INSTRUCTIONS

1. Send the Client's/Employee's Statement and the Attending Physician's Statement to the Insured.

   Complete the Employer's Statement.

2. Send these documents to:

   RBC Life Insurance Company at:
   P.O. Box 4435, Station A
   Toronto (Ontario) M5W 5Y8
   Tel 416-643-4700
   Toll Free 1-877-519-9501
   Fax 1-800-714-8861

These forms represent initial notice of claim. Omissions or errors may cause a delay. Additional documentation may be requested from RBC Insurance® upon review of these forms.

- Employer's Statement.
- Client's/Employee's Statement.
- The original enrolment form.

CLIENT/EMPLOYEE INSTRUCTIONS

1. Complete the Client's/Employee's Statement. Return this form to your Employer.

2. Complete and sign the Authorization section on the Attending Physician's Statement, and send this form to your treating physician for completion. The form can be returned directly to our office.

RBC Insurance

Loss of Use / Dismemberment Claim Form
Client's/Employee's Statement

To be completed by the Insured Employee, if different from the Client.

SECTION A

Name of Insured Employee: _____
Last First Middle

Date of Birth: _____ (DD/MM/YYYY) Relationship of Client to you: _____

Policy Number: _____

SECTION B

To be completed by the Client (Client is the Individual who has suffered the loss, which is the basis of this claim). A designated representative should complete this form if the Client is unable to do so or if the Client is a minor child.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Male ☐ Female Social Insurance No. ☐☐☐-☐☐☐-☐☐☐

Name: _____
Last First Middle

Date of Birth: _____ (DD/MM/YYYY)

Address: _____
Apt. Street City Province Postal Code

Telephone No. (H): (____) _____

Date of Hire: _____ (DD/MM/YYYY)

Occupation: _____

Length of time in this occupation: _____

INFORMATION ABOUT YOUR CLAIM

1. What is the basis of your claim?
   - ☐ Accidental Dismemberment. Describe loss: _____
   - ☐ Loss of: ☐ sight ☐ hearing ☐ speech
   - ☐ Loss of use of: _____
   - ☐ Paralysis
   - ☐ Permanent & Total Disability
   - ☐ Other: _____

2. If the claim is for Permanent & Total Disability:
   a) What was your last day worked? _____ (DD/MM/YYYY)
   b) What was the date that you were first unable to work? _____ (DD/MM/YYYY)

3. a) What was the date of the Accident: _____ (DD/MM/YYYY) Time _____AM/PM
   b) Did the Accident occur at ☐ home ☐ work ☐ elsewhere?
   c) How did the accident occur?

_____

_____

(If due to an MVA, attach a copy of the accident report and correspondence received from the auto carrier)

TREATMENT

1. Date of first treatment by a physician for this condition: _____(DD/MM/YYYY)

2. If hospitalized:

Name of Hospital(s)	Date admitted (DD/MM/YYYY)	Date discharged (DD/MM/YYYY)

3. List all other treating physicians: _____

_____

(OVER)

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, counselor, 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) (Please complete only if your benefit is taxable)

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

_____
Name of Witness (Please Print)

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RBC Insurance

Loss of Use / Dismemberment Claim Form
Employer's Statement

EMPLOYER INFORMATION

Name of Employer:
Address (Street/City/Province/Postal Code):

Telephone No.
( )

Name of Group Policyholder:
Address (Street/City/Province/Postal Code):

Telephone No.
( )

EMPLOYEE INFORMATION

Name (Last, First, Middle):

Social Insurance Number
☐☐☐-☐☐☐-☐☐☐

Date of Birth: _____
(DD/MM/YYYY)

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

Telephone No.
( )

Occupation/Duties:

Number of Hours Worked
Per Week: _____

Employment Status: ☐ Active ☐ Full-time ☐ Part-time
☐ Leave of Absence ☐ Terminated ☐ Medical Leave ☐ Other _____

Date Employed: _____ (DD/MM/YYYY)

Effective Date of Insurance: _____ (DD/MM/YYYY)

Last Date of Active Work: _____ (DD/MM/YYYY)

Claim is for: ☐ Employee ☐ Employee's Spouse ☐ Employee's Dependent Child

Identification of Injured Party (if other than employee):

Name (Last, First, Middle):

Date of Birth: _____
(DD/MM/YYYY)

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

Social Insurance Number
☐☐☐-☐☐☐-☐☐☐

Date of Accident: _____ (DD/MM/YYYY)

Any other insurance in force? _____
(Provide amounts and names of insurance carriers and policy numbers)

Is the condition due to an injury or sickness arising out of insured's employment? ☐ Yes ☐ No ☐ Unknown

Amount of Insurance in force $ _____

If based on earnings, rate of basic earnings $ _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually
(Attach verification of earnings i.e. payroll listing, paystub)

Type of Insurance	Policy No.	Amount	Effective Date	Beneficiary
Basic				
Voluntary				
Travel				

Have premiums terminated? ☐ Yes - give date _____(DD/MM/YYYY) ☐ No

SIGNATURE

Signature of Representative
X

Title of Authorized Representative

Telephone No.
( )

Group Policy No(s).

Division No.

Class No.

Date _____
(DD/MM/YYYY)

RBC Insurance

Loss of Use / Dismemberment Claim Form
Attending Physician's Statement

AUTHORIZATION

Patient Name _____ Age _____ Policy No(s). _____ Employer Name _____

I hereby authorize the release to RBC Insurance® and its reinsurers any information requested in respect to this claim.

X _____ _____
Signature of Client/Patient — Date (DD/MM/YYYY)
(If the claim is for a minor child, the signature is for the legal guardian)

Note: The Patient is responsible for securing completion of this form and any charge for its completion.

PATIENT INFORMATION

Name: _____
Last — First — Middle

Date of Birth: _____ _____ _____
(DD/MM/YYYY) — Height (in/cm) — Weight (lb/kg)

DIAGNOSIS

1. a) Diagnosis and brief description of the condition: _____

   b) Describe the onset of the condition: _____

   c) Was the loss due solely to an accident: ☐ Yes ☐ No

   If "Yes," provide: Date of accident: _____ (DD/MM/YYYY) First visit for this condition: _____ (DD/MM/YYYY)

   If "No," what disease or condition was a contributory cause? _____

   d) Objective findings: (include the name of tests, the date performed and the results) _____

2. Provide names of any other physicians who treated the insured for a contributory condition:

Name of Physician	Address	Date(s) seen

3. Is the condition due to an injury or sickness arising out of the insured's employment? ☐ Yes ☐ No ☐ Unknown

4. a) Is the loss total and irrecoverable? ☐ Yes ☐ No

   b) Is improvement possible with any assisting devices? ☐ Yes ☐ No

   Comments: _____

The following pages contain condition-specific questions, so complete only those applicable.

(OVER)

5. **For vision** (if applicable):

a) Date of latest eye examination before the accident: _____ (DD/MM/YYYY) first examination after the accident: _____ (DD/MM/YYYY)

b) Extent of visual acquity before and after the accident (Snellen Notation):
With corrective devices, before/after: O.D. _____ O.S. _____
Without corrective devices, before/after: O.D. _____ O.S. _____

c) Date corrected vision was irrecoverably reduced to 20/20 or less (Snellen Notation): O.S. _____ (DD/MM/YYYY)
O.S. _____ (DD/MM/YYYY)

d) Is there a visual field defect? ☐ Yes ☐ No If "Yes," give details and degree of remaining field:
O.D. _____ O.S. _____

e) Prognosis: Vision can be restored in whole or in part by: ☐ Lenses ☐ Treatment ☐ Surgery ☐ No restorable
If by surgery, do you recommend it? ☐ Yes ☐ No
If "No," why? _____

6. **For hearing** (if applicable):

a) Date of latest hearing examination before the accident: _____ (DD/MM/YYYY) first examination after the accident: _____ (DD/MM/YYYY)

b) Extent of hearing before and after the accident:
With corrective devices, before/after: Right Ear _____ Left Ear _____
Without corrective devices, before/after: Right Ear _____ Left Ear _____

c) Prognosis: Hearing can be restored in whole or in part by: ☐ Devices ☐ Treatment ☐ Surgery ☐ No restorable
If by surgery, do you recommend it? ☐ Yes ☐ No
If "No," why? _____

7. **For paralysis / loss of use** (if applicable):

a) Indicate: ☐ Quadraplegia ☐ Hemiplegia ☐ Paraplegia ☐ other: _____

b) Indicate whether this is complete or incomplete: _____

c) Indicate what caused the paralysis/loss of use: _____

d) Indicate when the loss occured: _____

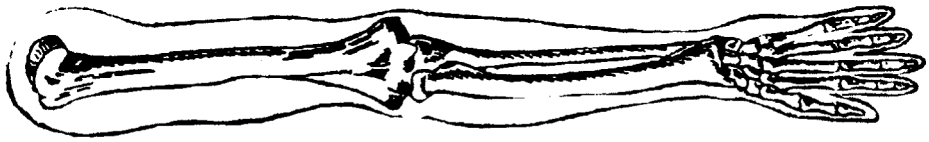
Attending Physician's Statement

8. **For loss of limb/fingers/toes/etc.** (if applicable):

a) Indicate exact point of severance

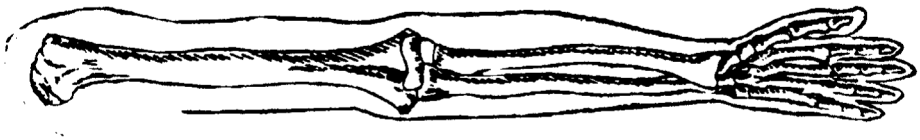
b) Date of severance

Left Upper



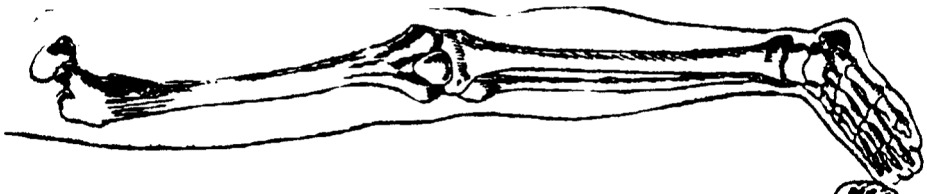
_____
(DD/MM/YYYY)

Right Upper



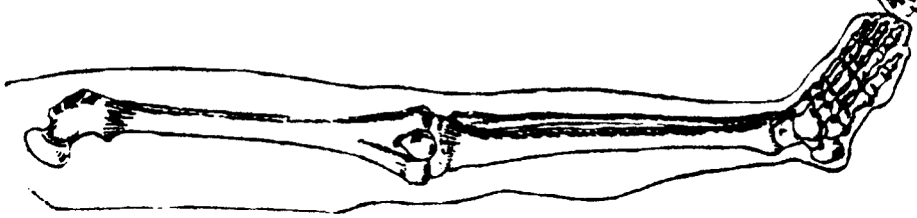
_____
(DD/MM/YYYY)

Left Lower



_____
(DD/MM/YYYY)

Right Lower



_____
(DD/MM/YYYY)

Remarks: Please provide comments and further details that you feel would be helpful _____

SIGNATURE

Signature of Representative

X _____ _____ _____
Signature | Date (DD/MM/YYYY) | Degree and Specialty

☐ Primary care ☐ Consultant

_____
Physician's Name

_____
Address (Street/City/Province/Postal Code)

(_____)_____ (_____)_____
Telephone No. | Fax No.

MAIL YOUR 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

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 your 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 *"Financial fraud prevention and privacy protection"* brochure, by calling us at the toll free number shown above or by visiting our web site at www.rbc.com/privacysecurity.