



REFUSAL OF COVERAGE FORM

1122 International Boulevard, P.O. Box 5044, Burlington, Ontario L7R 4C1 • 905.319.9501

EMPLOYER SECTION (to be completed by Employer)					
NAME OF EMPLOYER		POLICY NUMBER(S)		BILLING DIVISION	CLASS NO.
OCCUPATION / TITLE		DATE EMPLOYED FULL-TIME MM DD YYYY		EARNINGS \$ _____ <input type="checkbox"/> Hr. <input type="checkbox"/> Wk. <input type="checkbox"/> Mth. <input type="checkbox"/> Yr.	NUMBER OF HOURS WORKED PER WEEK
EMPLOYEE SECTION (to be completed by Employee)					
EMPLOYEE NAME			DATE OF BIRTH		PROVINCE OF RESIDENCE
LAST	FIRST	INITIAL	MM	DD	YYYY
					LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH
					SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<p>I fully understand that I am only able to refuse coverage for which I pay a portion of the premium. As such, I have decided to refuse coverage applicable to my Employer's non-mandatory Plan, as shown:</p> <p style="text-align: center;"> <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability </p> <p>I understand that if I and/or my dependents apply for the refused coverages at a later date, I will be required to furnish, AT MY OWN EXPENSE, EVIDENCE OF INSURABILITY for myself and my dependents which is satisfactory to RBC Life Insurance Company before becoming insured.</p>					
Employee's Signature			Date (mm / dd / yyyy)		
13026 (Rev. 05/04)					

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