RBC Insurance®

REFUSAL OF COVERAGE FORM

PO BOX 1800 STN B, MISSISSAUGA ON L4Y 3W6 • **1-888-604-3434**

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 $ _____ ❑ Hr. ❑ Wk. ❑ Mth. ❑ Yr.	NUMBER OF HOURS WORKED PER WEEK	

EMPLOYEE SECTION ***(to be completed by Employee)***

EMPLOYEE NAME LAST FIRST INITIAL	DATE OF BIRTH MM DD YYYY	PROVINCE OF RESIDENCE	
		LANGUAGE ❑ ENGLISH ❑ FRENCH	SEX ❑ MALE ❑ FEMALE

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:

- ❑ Short Term Disability
- ❑ Long Term Disability
- ❑ Basic Life
- ❑ Basic AD&D

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.

Employee's Signature _____ Date (mm / dd / yyyy) _____

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