RBC Insurance®

Long Term Care Supplement to:

Application Number: ____________________

Proposed Insured (If joint application, complete separate applications for each life)

1. Name: Last name ____ First name ____ Initial ____

Type of Long Term Care Insurance

2.

		Amount	Benefit Period	Waiting Period
Facility Care Benefit	☐	$ ______	______	______
Home Care (only available with Facility Care)	☐	$ ______	______	______
Future Purchase Option	☐	$ ______	______	______
COLA	☐		______	______
Other	☐	$ ______	______	______

Special Instructions ____________________

3. Do you now have any pending insurance application or in force coverage for Long Term Care? Yes ☐ No ☐

If yes, please complete the following information:

Product Type	Company	Benefit amount	Coverage in force	Are you replacing?
		$	$	Yes ☐ No ☐
		$	$	Yes ☐ No ☐

To be completed by the Proposed Insured

4. Do you have a Power of Attorney/Mandate for personal care? Yes ☐ No ☐
5. Is your Attorney currently exercising this Power of Attorney/Mandate? Yes ☐ No ☐
6. Are you presently
   a) confined to a hospital or nursing home? Yes ☐ No ☐
   b) bedridden, wheelchair confined or in need of at home nursing or health aid services? Yes ☐ No ☐
   c) receiving physical, speech or inhalation therapy or kidney dialysis? Yes ☐ No ☐
7. Are you presently being treated, or within the past five years been treated or advised to be treated, for
   a) multiple sclerosis, leukaemia, liver cirrhosis or paralysis? Yes ☐ No ☐
   b) senility, dementia, brain disease or disorder, Alzheimer, Parkinson or Lou Gehrig Disease? Yes ☐ No ☐
   c) a lung disorder which requires the use of oxygen or a mechanical device to help you breathe? Yes ☐ No ☐
   d) AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex (ARC) or had a positive test for antibodies to the Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐
8. Have you
   a) been advised to have joint replacement or other surgery which has not been done? Yes ☐ No ☐
   b) been advised you need hospitalization, nursing home care, home health care or kidney dialysis? Yes ☐ No ☐
   c) had or been advised to have an amputation because of a medical condition? Yes ☐ No ☐
9. Do you currently need, or within the past five years have you required, another person's help in performing any activities of daily living such as bathing, dressing, toileting, eating, transferring from bed to chair, or controlling bladder or bowel functions? Yes ☐ No ☐

IF YOU HAVE ANSWERED "YES" TO ANY OF QUESTIONS 5 – 9, YOU ARE *NOT* ELIGIBLE FOR COVERAGE.

IF YOU HAVE ANSWERED "NO" TO QUESTIONS 5 – 9, PLEASE CONTINUE.

10. During the last five years, have you ever had or been told you had or received advice or treatment for any of the following

a) transient ischemic attack, stroke or weakness? Yes ☐ No ☐

b) diabetes mellitus, pancreatic disease, kidney disease or kidney failure? Yes ☐ No ☐

c) drug addiction or intravenous drug use or alcoholism? Yes ☐ No ☐

11. Have you within the past five years used or are you currently using medical equipment such as a walker, wheelchair, cane, hearing device, colostomy, urinary catheter or pads to treat bladder or bowel incontinence? Yes ☐ No ☐

12. Have you ever been declined, rated or restricted for long term care insurance? Yes ☐ No ☐

13. Please give the name, address and phone number of the Health Care Professional with the most complete record of your health history.

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14. Please give the name, address and phone number of most recently seen Health Care Professional, date last consulted, reason for your visit, diagnosis or specified treatment, if any.

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15. **PLEASE PROVIDE DETAILS FOR ALL "YES" ANSWERS FOR QUESTIONS 10 TO 12.**

Question #	Condition/Impairment	Onset Date	Duration	Treatment or Type of Assistance	Health Care Professional's Name and Address

I declare to the best of my knowledge that all statements and answers recorded on this Supplemental Long Term Care (LTC) application are complete and true. I understand that this Supplement LTC Application will form part of the contract of insurance as outlined under the Declarations, Agreements and Consents section of the Application for Life Insurance to RBC Insurance Company to which this Supplemental LTC Application is appended.

I understand that no Interim Insurance coverage is available for Long Term Care.

Dated at ____________________ this __________ day of ____________________ year __________

____
Signature of Proposed Insured

____
Signature of Applicant

____
Witness

____
Witness

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