



**GROUP INSURANCE
EVIDENCE OF INSURABILITY FORM**

Please answer all applicable questions; all subsequent changes must be initialed by the Employee.
On completion, the form must be signed and dated to be accepted.

IMPORTANT:

The Employee must be a permanent resident of Canada with Canadian Citizenship or Permanent Resident status, and must be an eligible employee of the Policyholder in Active Employment as defined in the Group Insurance Policy on the date this Evidence of Insurability form is signed.

SECTION 1: EMPLOYER INFORMATION (to be completed by authorized Plan Administrator):

REASON FOR SUBMISSION OF EVIDENCE OF INSURABILITY BY EMPLOYEE:

- New Employee - Eligible for an amount exceeding Non-Evidence Maximum
- Current Employee – Eligible for increase over Non-Evidence Maximum
- Voluntary Life
- Late Application
- Add Dependant
- Other: _____

Name of Company: _____ Group Policy No: _____

Head Office Mailing Address: _____ City: _____ Prov: _____ Postal Code: _____

Company Phone No: (____) _____ Authorized Personnel: _____

Billing Type: Insurer-Billed Self-Billed TPA - Name of TPA: _____

SECTION 2: EMPLOYEE INFORMATION (to be completed by Employee):

Full Legal Name: First _____ Initial _____ Last _____

Date of Birth (must be age 18 to 64 to be eligible): _____ Gender: M F
(day/month/year)

Date of Hire: _____ Occupation: _____ Annual Earnings: \$ _____
(day/month/year)

Name and Address of Personal Physician: _____

Eligible Dependent Spouse (if Spousal Voluntary Life requested):

Full Legal Name: First _____ Initial _____ Last _____

Date of Birth (must be age 18 to 64 to be eligible): _____ Gender: M F
(day/month/year)

Name and Address of Personal Physician (if different from Employee) : _____

Eligible Dependent Child(ren) (if Dependent Voluntary Life requested):

First Name (Also indicate last name if different from Employee)	Gender	Date of Birth (day/month/year)	Height (indicate cm. or ft/ins.)	Weight (indicate kg. or lbs.)
1 _____	_____	_____	_____	_____
2 _____	_____	_____	_____	_____
3 _____	_____	_____	_____	_____

SECTION 3: AMOUNT OF INSURANCE

Employee

Group Basic Life: Current: \$ _____ Applying for: \$ _____

Group Voluntary Life: Current: \$ _____ Applying for: \$ _____

Long Term Disability: Current: \$ _____ Applying for: \$ _____

Group Voluntary Dependent Life

Eligible Spouse

Current: \$ _____
Applying for: \$ _____

Eligible Child(ren)

Current: \$ _____
Applying for: \$ _____

SECTION 5: DECLARATION

EMPLOYEE STATEMENT

I hereby declare that the above answers and statements that I have given in this Evidence of Insurability form are, to the best of my knowledge and belief, full, complete and true as of this date, and that any misstatements or failure to report information may be used as the basis for a rescission of my insurance. I understand and agree that they are material to the risk and form part of the Application and consideration for the insurance I am applying for. I further understand that if the insurance applied for becomes effective, it will be subject to the terms and conditions of the group policy.

Signature of Employee: _____ **Date:** _____

SPOUSE STATEMENT (if applicable):

I hereby declare that the above answers and statements that I have given in this Evidence of Insurability form are, to the best of my knowledge and belief, full, complete and true as of this date, and that any misstatements or failure to report information may be used as the basis for a rescission of my insurance. I understand and agree that they are material to the risk and form part of the Application and consideration for the insurance I am applying for. I further understand that if the insurance applied for becomes effective, it will be subject to the terms and conditions of the group policy.

Signature of Employee's Spouse: _____ **Date:** _____

SECTION 6: AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand and authorize RBC Life Insurance Company and its reinsurers (hereinafter collectively referred to as "RBC Life") to gather personal information concerning me and to disclose, as necessary, to third parties the fact that I am seeking insurance coverage from RBC Life.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to RBC Life any information, records or other data regarding me and my medical history or treatment, or my past and present income or employment, 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; and also any federal or provincial government department or organization, including the Workers' Compensation Board/Workplace Safety and Insurance Board and the federal or provincial income tax authorities; and also to any other organization, institution or person having information, records or data regarding me, my medical history or treatment or my past and present income and employment.

I understand that any information, records or data received by RBC Life pursuant to this authorization will be used for the purpose of determining eligibility for coverage under group insurance offered by my employer (underwriting), for the purpose of administering the group insurance policy(ies) arranged through my employer or for the evaluation of any claim for benefits.

To the extent reasonably necessary for this purpose, I authorize RBC Life to disclose any of the said information, records or data received to other insurance companies or any reinsurer; or to my employer and its insurance brokers or advisors or its benefit plan administrators; or to any other person or firm employed or engaged by RBC Life.

If this application is being made on behalf of my dependant(s), I am authorized to disclose information about them, for the purposes of underwriting, administration or adjudication of claims. I confirm that RBC Life is authorized to disclose information about this application to me, for the purposes of assessing this application and managing my group benefits plan.

A photocopy of this authorization, as executed by me, shall be as valid as the original and shall continue to have effect throughout the duration of my coverage under the group coverage offered by my employer.

Signature of Employee: _____ **Date :** _____

Signature of Employee's Spouse (if applying): _____ **Date :** _____

COLLECTION AND USE OF PERSONAL INFORMATION

Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about the employer and the employees (collectively “clients”) such as:

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

We may collect information from the employer or the employee, 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 and motor vehicle reports. Health information will not be shared with the employer without the consent of the employee.

Using personal information

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

- to verify the identity and investigate the background of the employer and employee;
- to issue and maintain insurance products and services that may be requested;
- to evaluate insurance risk and manage claims;
- to better understand the insurance situation of our clients;
- to determine eligibility for RBC insurance® products and services;
- to help us better understand the current and future needs of our clients;
- to communicate to our clients any benefit, feature and other information about RBC® products and services maintained with us;
- to help us better manage our business and the relationship with our clients; 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.

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 a client’s social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

Right to access of personal information

Our clients may obtain access to the information we hold about them 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, the employee 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

Our clients 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

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