

D. GENERAL

3. Has any blood relative suffered from a similar or related condition? Yes No If "Yes," please indicate:
- | <u>Relationship</u> | <u>Nature of Illness</u> | <u>Age when Illness First Diagnosed</u> |
|---------------------|--------------------------|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
4. Are you insured for benefits related to this condition from another company? Yes No If "Yes," please indicate:
- | <u>Name of Insurer</u> | <u>Type of Benefit</u> | <u>Amount of Benefit</u> | <u>Has a Claim been submitted?</u> |
|------------------------|------------------------|--------------------------|------------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
5. Do you smoke or use tobacco products? Yes No
If "Yes," indicate amount per day: _____ How long have you used tobacco products? _____
If "No," did you previously use tobacco products? Yes No On what date did you quit? (MM/DD/YYYY) _____
6. Please provide any further information that you think might be relevant to your claim. _____

E. FRAUD NOTICE *Any person who knowingly files a claim containing any false or misleading information is subject to criminal and civil penalties.*

I, _____, (print name) _____, verify that the above statements are true and complete to the best of my knowledge and belief.

Date _____ (MM/DD/YYYY) Signature of Claimant _____

F. AUTHORIZATION

I understand and authorize the Company (the Company refers to RBC Life Insurance Company, and its participating reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me. 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 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.

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, 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 or workers' compensation; and also any federal or provincial government department or organization, including the workers' compensation 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 evaluating my claim for benefits, my ability to return to work or for the purpose of administering the policy under which my claim is made. 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 firm (including physicians, health care practitioners, rehabilitation workers, vocational evaluators) employed or engaged by the Company.

I also authorize the Company to use my Social Insurance Number for my insurance file identification, any tax reporting purposes, and all other matters relating to my insurance claim or entitlement to benefits.

This authorization does not have any expiry date. It will remain valid for as long as I am claiming benefits or service from the Company. A photocopy of this authorization, as executed by me, will be as valid as the original.

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

Name of Claimant (Please Print)

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

MAIL YOUR COMPLETED FORM TO:

RBC Insurance Customer Care Centre

30 Adelaide Street East, Suite 500, Toronto, ON M5C 3H3 or fax to: 1-800-714-8861

If you have any questions, call toll free 1-877-519-9501 or 416-643-4700