RBC Insurance

DISABILITY CLAIM FORM CLIENT'S STATEMENT

☐ Accident Weekly Income/Association: Policy No.: _____

☐ Short Term Disability: Policy No.: _____

☐ STD Advice to Pay: Policy No.: _____

YOUR INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____ Date of Birth _____ (DD/MM/YYYY) ☐ Male ☐ Female

Name: Last First Middle

Address (Apt./Street/City/Province/Postal Code)

Home Telephone Number ( ) | Cell/Mobile Number ( )

YOUR CLAIM DETAILS

1. a) What was your last day worked? _____(DD/MM/YYYY)
   b) What was the date you were first unable to work? _____(DD/MM/YYYY)
   c) On the last day worked, did you work a full day? ☐ Yes ☐ No
   If "No", elaborate: _____
   d) What was the reason for stopping work?
2. Describe your current symptoms that prevent you from working (include when symptoms first appeared):
3. Is your condition the result of an Injury? ☐ Yes ☐ No
   If "Yes", did the Injury occur at ☐ home ☐ work ☐ elsewhere
4. How did the injury occur? _____
5. Date of Injury: _____ (DD/MM/YYYY) Time: _____AM/PM
6. Date you returned to work or are scheduled to return: _____ _____
   Full-time date (DD/MM/YYYY) Part-time date (DD/MM/YYYY)

YOUR OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

1. Have you filed a disability claim and/or are you in receipt of income from any other sources? (e.g. WCB/WSIB, disability, auto insurance, employment income) ☐ Yes ☐ No If "Yes", complete the chart below:

Source of Income	Yes/No	Policy No.	Amount per week/month	Date Filed	Status	Begins/Began	Ends/Ended
Employment Insurance							
Worker's Compensation Board (WCB/WSIB) benefits							
Automobile Insurance							
CPP/QPP							
Other (Specify): _____							

(Provide copies of all correspondence received, including Accident Report)

YOUR TREATMENT

1. Date of first treatment by a physician for this condition: _____(DD/MM/YYYY)
2. If hospitalized: Date admitted:_____ (DD/MM/YYYY) Date discharged: _____(DD/MM/YYYY)
3. List all health care providers you have consulted for any reason in the past two years. This should include your current family physician, consulting physicians, physiotherapists, chiropractors, psychologists, counsellors and therapists. Begin with the most recent. List any additional health care providers on a separate page.

Physician/Provider: **Specialty:**

Address (Street / City / Province / Postal Code)

Telephone Number ( ) Fax Number ( ) Date(s) Seen (DD/MM/YYYY)

Treatment

Physician/Provider: **Specialty:**

Address (Street / City / Province / Postal Code)

Telephone Number ( ) Fax Number ( ) Date(s) Seen (DD/MM/YYYY)

Treatment

Physician/Provider: **Specialty:**

Address (Street / City / Province / Postal Code)

Telephone Number ( ) Fax Number ( ) Date(s) Seen (DD/MM/YYYY)

Treatment

RBC Insurance

CLIENT'S AUTHORIZATION STATEMENT

FRAUD NOTICE

Any person who knowingly files a Client's Statement containing false or misleading information is subject to criminal and civil penalties.

I, _____ , declare that the above statements are true and complete
(Print Name)
to the best of my knowledge and belief.

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

AUTHORIZATION

I understand and authorize the Company (the company refers to and includes each of RBC Life Insurance Company and RBC Insurance Services Inc., and their reinsurers) to conduct such investigation as is necessary, to gather personal information concerning me and to disclose as necessary to third parties the fact that I am making a claim to the Company for benefits. 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 or organization 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.

I acknowledge and agree that if I choose to use, or instruct the Company to use, any electronic communication that is not encrypted, including without limitation, any fax or email communication, that (i) security, privacy and confidentiality cannot be ensured, (ii) such communication is not reliable and may not be received by the intended recipient in a timely manner or at all, (iii) such communication could be subject to interception, loss or alteration, and (iv) I assume full responsibility for the risks in connection with such communication and the Company will not be responsible or liable in any way in connection with such communication, including without limitation, any unauthorized access to or interception, loss or alteration of such communication.

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/ Workplace Safety and Insurance 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 determining coverage under the policy, evaluating my claim for benefits, my ability to return to work and/or for the purpose of assisting with the co-ordination of my return to work, for the purpose of administering the group and/or individual plans of insurance (including life, accidental death and dismemberment and disability policies of insurance) arranged through my employer with the Company or another insurer, for the purpose of providing ongoing claim status information to my employer at the time the claim was incurred, for the recovery of any overpayment of benefits incurred by me, if necessary, or for the purposes of fulfilling its (or RBC Financial Group's) legal obligations with respect to audits, anti-money laundering, terrorist financing, fraud investigation or other criminal activities. 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 organization (including physicians, health care practitioners, rehabilitation workers, vocational evaluators) employed or engaged by the Company.

I also authorize the Company to collect, use and disclose, as necessary and relevant, my personal information from any prior claim(s) and/or for any subsequent claim(s).

I also authorize the Company to use my Social Insurance Number for any tax reporting purposes and CPP/QPP purposes and to request information from federal and provincial tax authorities and for identification purposes when required by policyholders on group LTD/GSI policies.

This authorization does not have any expiry date. It will remain valid for as long as I am claiming eligibility for benefits or services from the Company and while the Company pursues the recovery of any overpayment of benefits incurred by me, if necessary, whether or not benefits are being paid, and whether or not either party takes the position that there has been a breach of contract. A photocopy of this authorization, as executed by me, will be as valid as the original.

X _____ Date _____
Signature of Client (DD/MM/YYYY)

_____ Social Insurance Number: ☐☐☐-☐☐☐-☐☐☐
Name of Client (Please Print) (Please complete only if your benefit is taxable)

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

_____
Name of Witness (Please Print)

MAIL THE COMPLETED FORM TO:

RBC Life Insurance Company, Life and Health Claims Department
P.O. Box 4435, Station A, Toronto ON, M5W 5Y8; or fax to 1-800-714-8861
If you have any questions, call toll free 1-877-519-9501 or 416-643-4700

VPS 82089

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RBC Insurance

EMPLOYER/CARRIER STATEMENT

Company Name	If an affiliate, subsidiary, branch or employer member, give name
Address (Street / City / Province / Postal Code)	Telephone Number ( )
Contact Name	Telephone Number ( ) / Fax Number ( )
Email Address of Contact	
Name of Employee / Insured	Employee's / Insured's Date of Birth (DD/MM/YYYY) / Member ID Number
Employee's / Insured's Address (Street / City / Province / Postal Code)	
Employee's / Insured's Job Title / Date of Hire (DD/MM/YYYY) / Effective Date of Insurance Coverage (DD/MM/YYYY)	
Employee's / Insured's Occupation at time of disability and duration in this position	☐ Regular ☐ Part-time ☐ Other (specify)
List occupational duties and/or attach a job description	

What are the regular hours worked excluding overtime? From _____ AM/PM To _____AM/PM

Please indicate one complete average work week or shift cycle by showing the number of hours worked per day:

	S	M	T	W	T	F	S
Hours							

Indicate "0" for days off

Does this cycle repeat? ☐ Yes ☐ No

Average number of hours worked per week: _____

Has the Employee's / Insured's been laid off?	☐ Yes	☐ No	If "Yes", when?_____ (DD/MM/YYYY)
Has the Employee's / Insured's been recalled?	☐ Yes	☐ No	If "Yes", when?_____ (DD/MM/YYYY)
Has the employee's / insured's been terminated?	☐ Yes	☐ No	If "Yes", when?_____ (DD/MM/YYYY)

Date last at work (DD/MM/YYYY)	Date of return to work or expected return to work Full-time (DD/MM/YYYY)_____ Part-time (DD/MM/YYYY) _____
Regular salary at time absence began (prior to disability): $ _____ (Attach verification of earnings) ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually	E.I. Insurable Earnings at date last worked: $ _____

Do you have a return-to-work program to assist early rehabilitation? ☐ Yes ☐ No If "Yes", explain:

Describe the work accommodations that are possible for this position:

(If accident is the result of an occupational injury, please provide a copy of the accident report)

SIGNATURE

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

X _____ Date _____
Signature of Benefits Representative (DD/MM/YYYY)

_____ (_____) _____
Job Title Telephone No.

_____ (_____) _____
Email Address Fax No.

MAIL THE COMPLETED FORM TO:

RBC Life Insurance Company, Life and Health Claims Department
P.O. Box 4435, Station A, Toronto ON, M5W 5Y8; or fax to 1-800-714-8861
If you have any questions, call toll free 1-877-519-9501 or 416-643-4700

RBC Insurance

ATTENDING PHYSICIAN'S STATEMENT – SHORT TERM DISABILITY CLAIM

PLAN MEMBER / EMPLOYEE INFORMATION AND CONSENT (To be completed by Plan Member)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other_____	☐ Male ☐ Female	Date of Birth: _____ (DD/MM/YYYY)
Plan Member/Employee Name: Last	First:	Middle:

Address: (Apt. / Street / City / Province / Postal Code)

Home Tel No.: ( )	Mobile Tel No.: ( )	Height:	Weight:
Employer's Name:		Plan Contract No.:	Plan Member Certificate No.:

Last Date Worked: _____ (DD/MM/YYYY)	**Date Returned to Work or Expected Return to Work Date:** _____ (DD/MM/YYYY)

I hereby authorize the release of medical and health information in my file to RBC Life Insurance Company and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form.

Plan Member/Employee Signature _____ Date of Consent (DD/MM/YYYY) _____

ATTENDING PHYSICIAN'S STATEMENT

Notice to Physician:

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete pages 1 and 2 in full.**

Diagnosis

Primary: _____

Secondary: _____

If Childbirth: Expected or Actual Delivery Date: _____ (DD/MM/YYYY)

☐ Vaginal ☐ C-Section

Occupational Illness / Injury

Is condition arising from employment? ☐ Yes ☐ No

Date of first visit pertaining to this condition: _____ (DD/MM/YYYY)	First date of work absence due to this condition: _____ (DD/MM/YYYY)
Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐ Name of institution: _____	Date admitted: _____ (DD/MM/YYYY) Date discharged: _____ (DD/MM/YYYY)

If surgery was performed, please provide description and date of surgery:

Description: _____ Date: _____ (DD/MM/YYYY)

Treatment (drug, dosage, physiotherapy, other):

Prognosis (please provide prognosis for recovery):

ATTENDING PHYSICIAN'S STATEMENT CONTINUED – For Absences That May be Greater Than 4 weeks

Has your patient been treated for this condition in the past? ☐ Yes ☐ No

If "Yes", date: _____ (DD/MM/YYYY)

Describe current symptoms, severity and frequency:

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other :_____

Please attach copies of all relevant:

- **Test results/investigations (if test results are not attached we will interpret this as tests were not performed).**
- **Consultation reports.**

If consultation report is not attached, indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist: _____ Specialty: _____ Date of Visit: _____ (DD/MM/YYYY)

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations:

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period:

To your knowledge, is your patient following the recommended treatment program? ☐ Yes ☐ No

In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Prognosis (provide the prognosis for recovery, if not completed on page 1):

Note

The information in this statement will be kept in a life, health or disability benefits file with RBC Life Insurance Company and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Attending Physician: (please print)	Certified Specialty:	Physician's Stamp
Address: (Street / City / Province / Postal Code)		
Telephone No.: ( )	Fax No.: ( )	
Signature	Date: _____ (DD/MM/YYYY)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.

MAIL THE COMPLETED FORM TO:

RBC Life Insurance Company, Life and Health Claims Department
P.O. Box 4435, Station A, Toronto ON, M5W 5Y8; or fax to 1-800-714-8861
If you have any questions, call toll free 1-877-519-9501 or 416-643-4700

COLLECTION AND USE OF PERSONAL INFORMATION

Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about you such as:

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

We may collect information from you, 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 agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

Using your personal information

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

- to verify your identity and investigate your personal background;
- to issue and maintain insurance products and services you may request;
- to evaluate insurance risk and manage claims;
- to better understand your insurance situation;
- to determine your eligibility for insurance products and services we offer;
- to help us better understand the current and future needs of our clients;
- to communicate to you any benefit, feature and other information about products and services you have with us;
- to help us better manage our business and your relationship with us; 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. If you are insured under a group insurance policy obtained through your employer, we may also share your information with your employer when necessary for the services we provide to you. Your health information will not be shared with your employer without your consent.

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

Your right to access your personal information

You may obtain access to the information we hold about you 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, you 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

You 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.