PRINT INSTRUCTIONS: This form prints on 8-1/2 x 11" paper. Please set paper size accordingly.

RBC Insurance®

Disability Claim Form

Claimant's Name: _____

Policy No(s): _____

Employer Name *(if applicable)*: _____

IMPORTANT GUIDELINES

- Print legibly in ink, preferable black for photocopy purposes. DO NOT use ditto marks.
- DO NOT make erasures or use liquid paper. Stroke out an error and have the applicant initial it.

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 governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

Using 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

COMPLETING THE FORM:

We want to make sure your claim is processed accurately and quickly. To make the process as timely as possible, we have designed this Disability Claim form to collect as much necessary information as possible from you at the beginning of the process. The information we have requested will help us determine the benefits you receive according to your contract with us.

We recognize that this form is quite detailed. However, our experience has shown us that, when this form is filled out correctly and completely, it takes us less time to assess your situation and make a decision on your claim. Due to the diversity of our policies and the nature of the claims, not all questions will be applicable to you and your situation. If a question does not apply to you, simply answer the question with "n/a." This way, we will know that you have read the question and that it does not apply to you.

CHECKLIST FOR COMPLETING THE FORM:

Please use the following guidelines to complete the form:

- use an ink pen when completing all sections and print clearly
- attach additional pages where necessary and clearly mark on each page : **Your name, the section, page and question number that the supplementary information refers to**

Type of policy / Claim Form Section	Group Disability	Group Life Waiver	Individual Disability
Claimant's Statement	You	You	You
Employer's Statement	Your Employer	Your Employer	If employed, Your Employer If self-employed, n/a
Occupation Statement	Your Employer	Your Employer	You
Attending Physician's Statement	Your Doctor	Your Doctor	Your Doctor

CLAIMANT INSTRUCTIONS

- It is your responsibility to ensure that the appropriate person completes each section.
- Please print your policy number at the top of every section. As the form is made up of detachable sections, providing the policy number will ensure that your claim form stays together though all the stages of your claim.
- Complete the Patient's Information section only on the **Attending Physician's Statement of Disability.** Have your Attending Physician complete the rest of this section and return directly to RBC Life Insurance Company.
- Provide proof of age (e.g. copy of your driver's licence-copies of front & back/birth certificate/passport/baptismal certificate along with photo id).
- In the case of a Motor Vehicle Accident or another incident reported to the police, attach a copy of the police report and correspondence from all motor vehicle and other insurance carriers.
- Provide copies of all correspondence related to other income replacement and insurance coverage (e.g. WCB/WSIB, CPP/QPP, automobile insurance benefits).
- Provide a copy of your job description.

EMPLOYER INSTRUCTIONS

- In the case of an incident, attach a copy of the incident or police report and correspondence from all other insurance carriers.
- Provide copies of all correspondence related to other income replacement and insurance coverage (e.g. WCB/WSIB, CPP/QPP, automobile insurance benefits).
- Refer to **"Documents Required"** section at the bottom of the Employment Statement for additional requirements.

These forms represent initial notice of claim. Omissions or errors may cause a delay. Additional documentation may be requested by RBC Life Insurance Company upon review of these forms.

THE COMPLETED FORMS MUST REACH RBC LIFE INSURANCE COMPANY WITHIN 90 DAYS OF THE CLAIMED DISABILITY DATE.

If you require assistance, or have questions concerning the form, please call the Claims Department at (416) 643-4700 or 1-877-519-9501.

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

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CLAIMANT'S STATEMENT OF DISABILITY

YOUR INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____ ☐ Male ☐ Female

Name: Last | First | Middle

Name commonly used *(if different from your first name)* | Date of birth (MM/DD/YYYY)

Language Preference ☐ English ☐ French Provincial Health Card No. _____

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

Indicate mailing address *(if different from above)*

Home Telephone No.: (_____) _____

Policy No(s): _____ Business Telephone No.: (_____) _____

YOUR EMPLOYMENT

1. Are you self-employed?

→ ☐ Yes *(If "Yes", complete the following)*

a) Your company is a ☐ Corporation ☐ Partnership ☐ Proprietorship

b) Please indicate the date of incorporation or the date your business started: _____ (MM/DD/YYYY)

c) Do you have any other related companies? ☐ Yes ☐ No

If "Yes", please explain: _____

d) What is your percentage of ownership? _____ %

e) If there are shareholders/partners, are they related to you? ☐ Yes ☐ No

If "Yes", please explain: _____

→ ☐ No (*If "No", complete the following)*

Your Employer | Date of Hire (MM/DD/YYYY) | Division or Department

2. Occupation immediately prior to the date you ceased working | Your Job Title *(if different from your occupation)* | Hours worked per week

3. Are you employed in more than one occupation? ☐ Yes ☐ No

If "Yes", please include all occupations and employers: _____

YOUR SALARY

1. $ _____ Hourly Wage $ _____ Annual Salary _____ Pay Period *(e.g. bi-weekly, monthly)*

2. In the 12 months (or the period of employment, if less than 12 months) prior to the last day worked, what was the amount paid?

$ _____ Commission $ _____ Bonuses $ _____ Overtime

3. Other payment(s): _____ Type $ _____ Amount

_____ Type $ _____ Amount

(OVER)

YOUR CLAIM DETAILS

1. a) What was your last day worked? _____ (MM/DD/YYYY)

   b) On the last day worked, did you work a full day? ☐ Yes ☐ No If "No", explain: _____

   _____

   c) What was the reason for stopping work? _____

   d) What was the date you were first unable to work as a result of your condition? _____ (MM/DD/YYYY)

2. Is your absence from work the result of: *(Please check one)* ☐ Injury ☐ Illness

3. If your condition is the result of an injury, please answer the following:

   a) Date the injury occurred: _____ (MM/DD/YYYY)

   b) Was the injury reported to the police or any other required party? ☐ Yes ☐ No

   If "Yes", to whom? _____

   If "No", why not? _____

   c) Where did the injury occur? _____

   d) How did the injury occur? _____

4. a) What were your first symptoms and when did you first notice them? _____

   _____

   _____

   b) What prevents you from returning to work? _____

   _____

   _____

   c) How does your current condition impact your daily living? Please provide details: _____

   _____

   _____

   d) Prior to stopping work, did your condition require you to change the way in which you performed your occupational duties? ☐ Yes ☐ No

   If "Yes", please explain: _____

   e) Have you ever had a similar injury or illness? ☐ Yes ☐ No

   If "Yes", please provide dates and details: _____

   f) Have you had a prior absence from work due to medical reasons that lasted longer than 60 days? ☐ Yes ☐ No

   If "Yes", Date absence began _____ (MM/DD/YYYY) Date absence ended _____ (MM/DD/YYYY)

   Was a disability claim filed? ☐ Yes ☐ No Provide details, including names(s) of insurer(s): _____

   _____

   g) Have you previously filed a disability claim and/or received disability benefits for any reason? (e.g. WCB/WSIB, disability, auto insurance)

   ☐ Yes ☐ No If "Yes", name of insurer: _____

   Period of disability: From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY) Policy No.: _____

5. Is this claim work-related? ☐ Yes ☐ No **If "Yes" complete question #6 / If "No", go to question #7**

6. Has this been reported for Workers' Compensation (WCB/WSIB) benefits?

☐ Yes If "Yes", what is the status of the claim? ☐ Pending ☐ Approved ☐ Declined ☐ Appealed

WCB/WSIB information: _____ | _____
Claim No. Date claim filed (MM/DD/YYYY)

_____ | _____ | (_____) _____
Name of Contact Address (Street / City / Province / Postal Code) Telephone No.

If WCB/WSIB benefits have been approved, what services/activities are being provided? (e.g. assessment, retraining, vocational rehabilitation, return to work trials, etc.) _____

_____

☐ No If "No", please explain: _____

_____

7. a) Have you now returned to work? ☐ Yes ☐ No If "Yes", _____ _____
Full-time date (MM/DD/YYYY) Part-time date (MM/DD/YYYY)

☐ Usual occupation? ☐ Different occupation? If different occupation, explain: _____

_____

b) If you have returned to work part-time or on a modified basis, what specific occupational duties are you unable to perform and what prevents you from performing them? _____

_____

8. Have you discussed a return to work plan with your attending physician? ☐ Yes ☐ No

If "Yes", please provide details: _____

_____

9. Do you believe that your occupational duties will need to be modified in some way when you return to work? ☐ Yes ☐ No

If "Yes", please explain: _____

_____

_____

YOUR TREATMENT

1. List all health care providers you have consulted for any reason in the last five 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 No. Fax No. Date(s) seen (MM/DD/YYYY)

_____
Reason/Diagnosis

_____ | _____
Physician/Provider Specialty

_____
Address (Street / City / Province / Postal Code)

(_____) _____ (_____) _____ | _____
Telephone No. Fax No. Date(s) seen (MM/DD/YYYY)

_____
Reason/Diagnosis

(OVER)

2. List all hospitals and health care facilities where you received treatment or attended as an out-patient for any reason. Begin with the most recent. List any additional facilities on a separate page. This should include any facility visited in the last five years.

Hospital/Facility _____ Reason for visit _____

Address (Street / City / Province / Postal Code) _____

Date Admitted (MM/DD/YYYY) _____ Date Discharged (MM/DD/YYYY) _____

Hospital/Facility _____ Reason for visit _____

Address (Street / City / Province / Postal Code) _____

Date Admitted (MM/DD/YYYY) _____ Date Discharged (MM/DD/YYYY) _____

3. List all pharmacies where you have had prescriptions filled in the last five years.

Names of pharmacies	Address (Street / City / Province / Postal Code)	Telephone No.	Who Prescribed

4. a) Since the onset of this condition, describe your treatments provided (*e.g. procedures, tests, etc.*): _____

b) Describe how your condition has changed since starting treatment: _____

YOUR OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

1. Do you have insurance coverage, or have you applied, for any of the following? ☐ Yes ☐ No If "Yes", complete the chart below:

Sources of Income	Yes/No	Policy No.	Amount (week/ month)	Date Claim Filed	Status	Date Payment Begins/Began	Date Payment Ends/Ended
Salary Continuation							
Short Term Disability							
Employment Insurance							
Association Group Plan							
Canada/Quebec Pension Plan Disability and/or Retirement							
Workers' Compensation Board (WCB/WSIB)							
Automobile Insurance							
Retirement Pension Plan							
Individual Disability							
Credit/Loan Insurance							
Waiver of Life Insurance Premiums							
Other (please specify)							

2. Under what other RBC Insurance policies are you currently covered? (e.g. life insurance, creditor, auto insurance)

Policy Type _____ Policy No. _____

Policy Type _____ Policy No. _____

FRAUD NOTICE

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

I, _____ , declare that the above statements are true and complete to
(print name)

the best of my knowledge and belief.

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

_____ Social Insurance Number: ☐☐☐-☐☐☐-☐☐☐
Name of Claimant (Please Print)

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

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EMPLOYER'S STATEMENT OF DISABILITY

For purposes of this section, "claimant" refers to the insured employee.

EMPLOYER

Company Name | Policy No. | Division No. *(if applicable)*

Address (Street / City / Province / Postal Code)

Industry | Primary Products/Services

(_____) _____ Telephone No. | (_____) _____ Fax No. | Language Preference ☐ English ☐ French

Name and address of office or division where the claimant works:

Name | Address (Street / City / Province / Postal Code)

Name of Benefits Administrator who should be contacted regarding this claim, if applicable:

Name | (_____) _____ Telephone No. | (_____) _____ Fax No.

Address (Street / City / Province / Postal Code) *(if different from above)*

If there is a Third Party Administrator (TPA), please provide name and contact information: _____

CLAIMANT

This claim is for:

Name: Last | First | Middle

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

Date of birth: _____ (MM/DD/YYYY) Social Insurance No. ☐☐☐-☐☐☐-☐☐☐

CLAIMANT'S EMPLOYMENT

1. a) Date claimant was hired (MM/DD/YYYY) | Date claimant became insured under this plan (MM/DD/YYYY)

   b) Last date claimant worked (MM/DD/YYYY) | Date claimant would have next worked if absence from work had not begun (MM/DD/YYYY)

2. Position/Job Title on last date worked | Length of time in that position

3. Was coverage added for this claimant on the first date that he/she was eligible? ☐ Yes ☐ No
   If "No", explain: _____

4. Has the claimant's coverage been continuous since first insured under the plan? ☐ Yes ☐ No
   If "No", indicate the coverage interruptions and reasons for them: _____

5. Has coverage under this policy terminated for this claimant? ☐ Yes ☐ No
   If "Yes", on what date and why? _____

6. On the claimant's last date worked, was it a full day? ☐ Yes ☐ No If "No", how many hours were worked? _____

7. Reason for stopping work: _____

(OVER)

8. Has the claimant returned to work for any period of time since the last date worked? ☐ Yes ☐ No

If "Yes", provide details: _____

9. Is the claimant ☐ Permanent ☐ Part-time ☐ Temporary/Contract ☐ Other *(specify)* _____

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

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

Day of Week	S	M	T	W	T	F	S
Hours							

Does this cycle repeat? ☐ Yes ☐ No

Number of hours worked per week: _____

Indicate "0" for days off

12. Is the work subject to: Seasonal Changes ☐ Yes ☐ No
Business Cycles ☐ Yes ☐ No
Layoffs ☐ Yes ☐ No

If "Yes" to any of the above, please describe how the work is affected, including the cause, frequency and usual type of occurrence, the effect on the total number of hours or days per week, the average number of months worked per year, the type of employment *(casual, seasonal, on-call, apprentice, etc):* _____

13. Were there any recent changes to the claimant's responsibilities prior to ceasing work? ☐ Yes ☐ No

If "Yes", what were the changes and when were they made? _____

14. Can the position be performed on a part-time basis? ☐ Yes ☐ No

If "No", explain: _____

15. How many days of absence for any reason occurred in the six months prior to the disability date? *(excluding vacation and statutory holidays)* _____

Provide dates and details: _____

(Attach attendance records, if available)

CLAIMANT'S SALARY

1. Prior to the last date worked: $ _____ Hourly Wage $ _____ Annual Salary _____ Pay Period *(e.g. bi-weekly, monthly)*

2. Was this the salary used to calculate the premium? ☐ Yes ☐ No

If "No", what salary was used and please explain: _____

3. In the 12 months (or the period of employment, if less than 12 months) prior to the last day worked, what was the amount paid?

$ _____ Commission $ _____ Bonuses $ _____ Overtime

4. Other payment(s): _____ Type $ _____ Amount

_____ Type $ _____ Amount

CLAIMANT'S OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

1. Is this also an application for: Life Insurance Premium Waiver ☐ Yes ☐ No

   AD&D Premium Waiver ☐ Yes ☐ No

   If Life Insurance Premium Waiver, indicate the amount of insurance: $ _____ Class _____

   Other insurers for your company:

	Name	Address (Street / City / Province / Postal Code)	Policy No.
Short Term Disability			
Extended Health Care			
Other insurers:_____			

2. Did your company have LTD insurance coverage prior to this policy? ☐ Yes ☐ No

   If "Yes", provide details: _____ | _____ | _____
   Name of Previous Insurer | Policy No. | Effective Date (MM/DD/YYYY)

3. Please complete the chart below:

Sources of Income	Yes/No	Policy No.	Amount (week/ month)	Date Claim Filed	Status	Date Payment Begins/Began	Date Payment Ends/Ended
Salary Continuation							
Short Term Disability							
Employment Insurance							
Association Group Plan							
Canada/Quebec Pension Plan Disability and/or Retirement							
Workers' Compensation Board (WCB/WSIB)							
Automobile Insurance							
Retirement Pension Plan							
Individual Disability							
Credit/Loan Insurance							
Waiver of Life Insurance Premiums							
Other (please specify)							

4. Have there been any prior claims? *(e.g. short term disability, Workers' Compensation WCB/WSIB)* ☐ Yes ☐ No

   If "Yes", provide details: _____

   _____

5. Do you consider the claimant's condition to be work-related? ☐ Yes ☐ No

   If "Yes", provide details: _____

   _____

6. a) Has a claim been filed for Workers' Compensation Board (WCB/WSIB) benefits? ☐ Yes ☐ No

   If "Yes", provide details: _____ | _____ | (_____) _____
   Claim No. | Name of Contact | Telephone No.

   If "No" and if work-related, explain why a claim has not been filed: _____

   _____

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

(OVER)

b) If benefits have been approved, what services/activities are being provided to assist the claimant? *(e.g. assessment, retraining, vocational rehabilitation, return to work trials)* _____

_____

_____

RETURN TO WORK

1. Does your company have a return to work program for claimants who have been off work on short term disability, long term disability or Workers' Compensation (WCB/WSIB)? *(e.g. modified work, work hardening, alternate work)* ☐ Yes ☐ No

   If "Yes", whom should we contact if we identify vocational rehabilitation or return to work potential?

   _____ | _____ (_____)_____

   Name | Title/Position | Direct Telephone No.

2. What type of accommodations have been made for this position in the past or could be made in the future?

   _____

   _____

3. Is there a current or anticipated return to work potential for this claimant? ☐ Yes ☐ No

   Explain: _____

   _____

4. Were there any performance issues with the claimant? ☐ Yes ☐ No

   Explain: _____

   _____

DOCUMENTS REQUIRED

Please enclose the following documents with this Employer's Statement:

- **Copy of the enrollment application for insurance, or copies of pay stubs/payroll records as of the effective date of insurance.**
- **Copy of the income reporting forms (ie. T4, T-01) for the two years prior to the last date worked.**
- **Copy of the last pay-stub/payroll record just prior to the last day of work.**
- **Copy of attendance records for the past six months.**
- **Copy of the job description and minimum qualifications, licences/certifications and resume.**
- **Initial report of injury and decision notices relating to Workers' Compensation claim (WCB/WSIB), *if applicable*.**

SIGNATURE OF PERSON COMPLETING THIS FORM

I declare that the above statements are true and complete to the best of my knowledge and belief.

Signature of Preparer _____ Date: _____ (MM/DD/YYYY)

Print Name: _____

Title: _____

Address: _____ Telephone 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

OCCUPATION STATEMENT OF DISABILITY

JOB DESCRIPTION

1. Briefly describe this position: _____

2. Describe the essential tasks of the job: *(Fundamental/Primary)* hrs/day hrs/month

3. Describe the non-essential tasks of the job: *(Incidental/Secondary)* hrs/day hrs/month

4. a) Minimum qualifications required for the occupation: _____

   b) Licences/Certifications Required: _____

   c) Number of Direct Reports: _____

PHYSICAL DEMANDS (or attach a Physical Demands Analysis)

1. a) Activity

Activity	Longest time period performed without break	Cumulative hours per day
1. Stand (stationary)		
2. Walk		
3. Sit		
4. Stoop/ Crouch/Squat		
5. Kneel		
6. Climb		
7. Crawl		
8. Jump		
9. Bend		
10. Twist		
11. Throw		
12. Push/Pull		
Above Shoulder		
Below Shoulder		
13. Reach/Stretch		
Above Shoulder		
Below Shoulder		
14. Lift/Carry		
Above Shoulder		
Below Shoulder		
15. Visual Acuity		
Far		
Near		
Colour Discrimination		

Items 1 through 7 should total a full work day.

Indicate number of times per day lifted:				
0-10lbs	11-20lbs	21-50lbs	51-75lbs	76-100lbs
Never	Seldom	Required	Major	

b) Extremity Activity

Extremity Activity	Right	Left	Both	Right	Left	Both
Handle/Grasp						
Fine Manipulation						
Power Grip						
Torque/Twist						

2. a) Operate Foot Controls? ☐ Yes ☐ No

   b) Type of equipment/machines used: _____

Cumulative hours/day _____ Longest period performed without a break

3. Can this job be performed alternately sitting and standing? ☐ Yes ☐ No

(OVER)

COGNITIVE WORK FUNCTIONS

Do Essential Tasks require:	Yes	Hrs/Day	Hrs/Month	No
1. Working with others?	☐	_____	_____	☐
2. Working alone, apart or in physical isolation from others?	☐	_____	_____	☐
3. Comprehending and following instructions?	☐	_____	_____	☐
4. Performing simple and repetitive tasks?	☐	_____	_____	☐
5. Performing complex or varied tasks requiring higher level of reasoning, language and/or math?	☐	_____	_____	☐
6. Working under deadlines?	☐	_____	_____	☐
7. Working frequently in excess of normal work hours?	☐	_____	_____	☐
8. Performing varied work tasks with frequent interruptions?	☐	_____	_____	☐
9. Dealing with an angry/upset/combative public?	☐	_____	_____	☐
10. Dealing with others who have experienced traumatizing events?	☐	_____	_____	☐
11. Supervising others?	☐	_____	_____	☐
12. Being responsible for others' output/work product?	☐	_____	_____	☐
13. Influencing others beyond giving simple information or directions?	☐	_____	_____	☐
14. Making generalizations, evaluations or decisions without immediate supervision?	☐	_____	_____	☐
15. Carrying out responsibility for direction, control and planning?	☐	_____	_____	☐
16. Performing when confronted with emergency, critical, unusual or dangerous situations?	☐	_____	_____	☐
17. Sustained attention to complex tasks?	☐	_____	_____	☐

ENVIRONMENTAL DEMANDS

Is the claimant exposed to:	Yes	Hrs/Day	Hrs/Month	No
1. Extreme cold?	☐	_____	_____	☐
2. Extreme heat?	☐	_____	_____	☐
3. Wet and/or humid *(non-weather)*?	☐	_____	_____	☐
4. Noise intensity level:				
Quiet *(Library)*?	☐	_____	_____	☐
Moderate *(Office)*?	☐	_____	_____	☐
Loud *(Manufacturing)*?	☐	_____	_____	☐
5. Vibration?	☐	_____	_____	☐
6. Fumes, odours, dust, gases? If "Yes", specify: _____	☐	_____	_____	☐
7. Exposure to electric shock, radiation, explosives, chemicals, etc? If "Yes", specify: _____	☐	_____	_____	☐
8. Proximity to moving mechanical parts?	☐	_____	_____	☐
9. Working in high, exposed places?	☐	_____	_____	☐
10. Working on uneven ground?	☐	_____	_____	☐
11. Travel?	☐	_____	_____	☐
If "Yes", by what means? ☐ Car ☐ Plane ☐ Train → ☐ Automatic ☐ Standard				
12. Other? If "Yes", explain: _____	☐	_____	_____	☐

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

WHAT WE REQUEST AND WHY

Your patient is applying for disability benefits under a policy of disability insurance underwritten by RBC Life Insurance Company.

As you can appreciate, the information provided by you is important to our adjudication of your patient's claim. We are asking for your cooperation in providing pertinent information regarding the diagnosis, signs and symptoms, as well as details of your patient's limitations and restrictions.

We ask that you complete the Attending Physician's Statement as thoroughly as possible. Please be assured that the information, including the medical records requested, is required for the adjudication of your patient's claim and will be treated confidentially.

RBC Life Insurance Company is requesting copies of your complete file for the period of treatment for this condition, including specialist consultations, office notes, test results, hospital admission histories, discharge summaries and medical reports prepared for other insurers on your patient and is prepared to reimburse $50.00 for the costs associated with photocopying. If this amount is unreasonable because of the extent of your patient's file, please have your staff contact our office at (416) 643-4700 or toll free at 1-877-519-9501. **Any charge for the completion of this form, however, is the responsibility of the patient.**

We would like to thank you in advance for your cooperation.

PATIENT'S INFORMATION

Name: Last _____ First _____ Middle _____

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

Telephone No.: (_____)_____ Policy No(s): _____

Date of birth (MM/DD/YYYY) _____

PATIENT'S HISTORY

Height *(in/cm)* _____ Weight *(lb/kg)* _____

1. Date symptoms first appeared (MM/DD/YYYY) _____ Date of first visit for current condition (MM/DD/YYYY) _____ Date patient ceased work (MM/DD/YYYY) _____

2. a) Symptoms on date work ceased: _____

   b) Symptoms on date of first visit for the current condition: _____

3. Who suggested your patient stop work? _____

   Reason for not working:

   a) Therapeutic to the patient? ☐ Yes ☐ No If "Yes", please state therapeutic goals and suggested duration of time off work: _____

   b) Inability to function? ☐ Yes ☐ No If "Yes", please explain: _____

   c) Other: _____

4. Has your patient ever had the same or a similar condition? ☐ Yes ☐ No

   If "Yes", state when and describe: _____

5. Do you consider this condition to be chronic? ☐ Yes ☐ No

(OVER)

6. _____ | _____
Date of latest visit (MM/DD/YYYY) Frequency of visits

7. Was the patient referred to you by another physician? ☐ Yes ☐ No

If "Yes",: _____ | _____
Name of referring physician Date referred (MM/DD/YYYY)

_____
Address (Street / City / Province / Postal Code)

8. Is the condition related to the patient's work? ☐ Yes ☐ No If "Yes", explain: _____

_____

9. Has the patient had any licence or certification restricted or revoked *(e.g. driver's licence, professional certification?)* ☐ Yes ☐ No

_____ _____ _____
Licence No./Certification Type of licence/certification Date it was revoked (MM/DD/YYYY)

_____ _____ _____
Licence No./Certification Type of licence/certification Date it was revoked (MM/DD/YYYY)

PHYSICIAN'S DIAGNOSIS

1. a) Primary diagnosis: *(if psychiatric, indicate each axis of DSM-IV-TR)*: _____

_____

b) If this is a cardiac condition, include the Blood Pressure at last visit and the American Heart Association classifications:

☐ Class 1 – No limitation ☐ Class 2 – Slight limitation ☐ Class 3 – Marked limitation ☐ Class 4 – Severe limitation

2. Secondary diagnosis: *(including complications)*: _____

_____

3. Symptoms: _____

_____

4. Objective findings: *(include type of objective tests, date(s) performed and results)* _____

_____

_____

5. What are the patient's restrictions *(what the patient SHOULD NOT do)* and why? _____

_____

6. What are the patient's limitations (what the patient CANNOT do) and why? _____

_____

7. Is the patient: ☐ Right-handed ☐ Left-handed

8. If the patient is/was pregnant, expected/actual date of confinement: _____ (MM/DD/YYYY)

PATIENT'S TREATMENT

1. Has the patient been hospitalized? ☐ Yes ☐ No If "Yes", indicate:

_____ _____
Name of hospital(s) Date(s) confined: from (MM/DD/YYYY) to (MM/DD/YYYY)

_____ _____
Name of hospital(s) Date(s) confined: from (MM/DD/YYYY) to (MM/DD/YYYY)

2. Has the patient had surgery in relation to this condition, or is surgery planned? ☐ Yes ☐ No If "Yes", indicate:

_____ _____
Name of procedure(s) Date(s) performed (MM/DD/YYYY)

_____ _____
Name of procedure(s) Date(s) performed (MM/DD/YYYY)

3. Please complete the chart below:

Medication Name	Date Started	Dose	Response	Side-effects	Date Dose Changed	Date Discontinued

4. Please list other types of treatment given or prescribed, dates of the treatment and expected duration: _____

_____

_____

_____

5. Has the patient been referred to a rehabilitation programme? ☐ Yes ☐ No If "Yes", indicate:

_____ _____ _____
Name of programme(s) Date(s) attended (MM/DD/YYYY) Expected duration

_____ _____ _____
Name of programme(s) Date(s) attended (MM/DD/YYYY) Expected duration

6. Has there been a psychiatric consultation *(if applicable)*? ☐ Yes ☐ No

If "Yes", provide details: _____

7. Has the patient consulted with, or been treated by, any other health care providers? ☐ Yes ☐ No If "Yes", indicate:

_____ (_____)_____ _____
Name Telephone No. Treatment dates (MM/DD/YYYY)

_____
Address (Street / City / Province / Postal Code)

_____ (_____)_____ _____
Name Telephone No. Treatment dates (MM/DD/YYYY)

_____
Address (Street / City / Province / Postal Code)

8. Please comment on the response to treatment: _____

_____

_____

9. Is the patient following the recommended treatment plan? ☐ Yes ☐ No

If "No", comment on the reason and the effect: _____

_____

10. Is the treatment expected to change? ☐ Yes ☐ No

If "Yes", in what way and when? _____

If "No", please provide details: _____

11. Has the patient achieved maximum medical improvement? ☐ Yes ☐ No

If "No", how soon do you expect fundamental changes in the patient's medical condition? _____

_____

(OVER)

RETURN TO WORK PLAN

1. What is your prognosis?

   a) ☐ Recovery without impairment *(loss of function)* Number of weeks _____

   b) ☐ Stabilization with continuing impairment Number of weeks _____

   c) ☐ Permanent impairment

   d) Comments: _____

2. Do you have a clear understanding of your patients's occupational duties? Please describe: _____

   _____

3. Is the patient a suitable candidate for trial employment?

   For his/her job? ☐ Yes ☐ No If "Yes", are modifications needed? ☐ Yes ☐ No

   If yes, please explain: _____

   For any other work? ☐ Yes ☐ No If "Yes", are modifications needed? ☐ Yes ☐ No

   If yes, please explain: _____

4. Has a return to work plan been discussed with your patient? ☐ Yes ☐ No

   If "Yes", please provide anticipated date, time-frame and plan: _____

   _____

   If "No", please state reasons, including any barriers that interfere with a return to work: _____

   _____

5. What is the patient's response towards returning to work? _____

   _____

6. Are you providing information to any other insurers on this patient? ☐ Yes ☐ No

   If "Yes", list names of companies: _____

COMMENTS

Please provide any other information that you feel will assist us in our understanding of your patient's condition *(e.g. work, family, other stressors):*

_____

_____

_____

SIGNATURE

X _____ _____

Signature Date (MM/DD/YYYY)

_____ _____

Physician's Name (Please print) Degree and Specialty

_____ ☐ Primary Care ☐ Consultant

Address (Street / City / Province / Postal Code)

Telephone No. ( ) _____ 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

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Before you mail in your completed form…

Make sure you have done **all** of the following:

- ❑ completed the form in ink
- ❑ each section of the form was completed by the **appropriate person**
- ❑ **signed and dated** all sections of the forms
- ❑ enclosed all the required forms for your claim

List of required forms

You must provide:

- ❑ copy of your birth certificate/passport/baptismal certificate/driver's licence along with photo ID
- ❑ copy of all police reports or incident reports (*if your injury was the result of an accident or police-reported incident)*
- ❑ any correspondence from all motor vehicle and other insurance carriers
- ❑ any correspondence from alternate sources of income (*e.g. STD, EI, WCB/WSIB, CPP/QPP etc.*)
- ❑ copy of your job descriptions(s)

Your employer is asked to provide:

- ❑ copy of the enrollment application form for disability coverage, or copies of pay stubs/payroll records
- ❑ copy of the income reporting forms (i.e. T4, T-01) for the two years prior to the last date worked
- ❑ copy of the last pay-stub/payroll record just prior to the last day of work
- ❑ copy of attendance records for the past six months
- ❑ copy of the job description, minimum qualifications and resume
- ❑ copy of the initial report of injury and decision notices relating to Workers' Compensation claim (WCB/WSIB) (*if applicable*)

Your physician is asked to provide:

- ❑ copy of his/her complete file for the period of treatment for this condition, including: specialist consultations; medical reports prepared for other insurers; WCB/WSIB, CPP/QPP or EI; office notes; test results; hospital admissions, histories and discharge summaries

If the above instructions have not been followed, your form may be returned to you.

RBC Insurance®

Mail your completed form to:

RBC Life Insurance Company, Life and Health Claims Department
P.O. Box 4435, Station A, Toronto, ON M5W 5Y8

or fax toll free to: (800) 714-8861