

GROUP LIFE / ACCIDENTAL DEATH NOTICE OF CLAIM

EMPLOYER INSTRUCTIONS

- 1 Send the Claimant's Statement to the beneficiary for completion and have it returned to you. Complete the Employer's Statement.

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

- 2 Send these documents to **RBC Insurance** at:
30 Adelaide Street East, Suite 500
Toronto, ON M5C 3H3
Tel 416-643-4700
Toll Free 1-877-519-9501
Fax 1-800-714-8861

- Employer's Statement.
- Claimant's Statement.
- The original enrollment form and any change of beneficiary form(s).
- If the beneficiary is the Estate of the Insured, a copy of the court appointment naming the executor, administrator or personal representative.

- 3 For all Accidental Death claims:

Provide a completed Physician's Statement.

For Life Insurance amounts up to \$50,000:

Provide a copy of the funeral director's statement or a completed Physician's Statement.

For Life Insurance amounts over \$50,000:

Provide a certified copy of the death certificate or a completed Physician's Statement.



GROUP LIFE / ACCIDENTAL DEATH CLAIM FORM CLAIMANT'S STATEMENT

1. My name in full is: _____ Date of Birth: _____
(MM/DD/YYYY)

Address: _____
Apt. Street City Province Postal Code

I am making a claim in the capacity of: _____ under Policy No(s) _____
(state whether Beneficiary, Administrator, Guardian, Trustee or Assignee)

issued to _____ now deceased. Beneficiary S.I.N. No.

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2. What was your relationship to the deceased? _____ What was the deceased's date of birth? _____
(MM/DD/YYYY)

3. The deceased was injured on: _____ died on: _____
(MM/DD/YYYY) (MM/DD/YYYY)

4. Was death the result of an accident? Yes No If "Yes," please describe: _____

5. When and where was the deceased first attended by a physician in relation to this claim? _____

6. List all physicians and hospitals where treatment was received over the past five years:

Name of Physician/Hospital	Address	Dates Seen

7. Did the deceased have other life insurance at the time of death? Yes No If "Yes," please provide names of companies and amounts of insurance: _____

FRAUD NOTICE

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

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

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

AUTHORIZATION

To Whom It May Concern:

I, _____, hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, coroner's office, police department, insurance company to disclose or furnish to the Company (the Company refers to and includes each of the RBC Life Insurance Company, and its participating reinsurers) its subsidiaries or representatives, any and all information with respect to any illness including AIDS, AIDS Related Complex (ARC), mental illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records concerning _____, that may be requested. I also authorize his/her employer to disclose all information needed to process the claim.

The information provided to the Company, its subsidiaries or representatives is to be used solely for the administration of claim(s) as captioned above.

A photocopy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

Date (MM/DD/YYYY)

Relationship of Authorized Person to Deceased

Authorized Person's Signature



GROUP LIFE / ACCIDENTAL DEATH CLAIM FORM PHYSICIAN'S STATEMENT

FULL NAME OF DECEASED	DATE OF DEATH _____ (MM/DD/YYYY)
RESIDENCE AT DEATH	PLACE OF DEATH
AGE AT DEATH OR DATE OF BIRTH _____ (MM/DD/YYYY)	(IF HOSPITAL OR INSTITUTION, GIVE NAME)

CAUSE OF DEATH (Enter only one cause for each of a, b and c). Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury or complication which caused death).	INTERVAL BETWEEN ONSET AND DEATH
(a)	(a)
Antecedent causes: (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last).	
Due to (b)	(b)
Due to (c)	(c)
Other significant conditions: (Contributing to the death but not related to the disease or condition causing death).	

DATE OF FIRST ATTENDANCE IN LAST ILLNESS _____ (MM/DD/YYYY)	DATE OF LAST ATTENDANCE IN LAST ILLNESS _____ (MM/DD/YYYY)
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If death was due to an accident, suicide or homicide, specify which. Describe briefly.	Was an inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Was an autopsy performed? If so, by whom and with what findings? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were the injuries described above, alone and independent of all other causes, sufficient to produce the death of a normal and healthy person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had he/she, in your opinion, been using alcohol, non-prescription drugs and/or prescription drugs other than as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you treated or advised the deceased during the last 3 years, prior to the last illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to either question, please provide the following:

NAME	ADDRESS	NATURE OF ILLNESS OR INJURY	DATES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any charge for the completion of the form is the responsibility of the Claimant.

X
Signature _____ Date (MM/DD/YYYY) _____ Degree and Specialty _____

Physician's Name _____ Primary Care Consultant

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

Telephone No. () _____ Fax No. () _____

MAIL THE 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