RBC Insurance®

GROUP LIFE / ACCIDENTAL DEATH NOTICE OF CLAIM

EMPLOYER INSTRUCTIONS

❶ 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.

❷ Send these documents to **RBC Insurance** at:
P.O. Box 4435, Station A
Toronto, ON M5W 5Y8
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.

❸ 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.

RBC Insurance®

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. | | | | | | | | | |

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: _____ (MM/DD/YYYY) died on: _____ (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, _____ (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 _____

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

RBC Insurance®

GROUP LIFE / ACCIDENTAL DEATH CLAIM FORM
EMPLOYER'S STATEMENT

1. INSURANCE INFORMATION *(Complete for all claims)*

Indicate the type of claim being filed:
- ☐ Employee Life
- ☐ Dependent Life
- ☐ Accidental Death

Did the deceased have other insurance?

Group Life Insurance	☐ Yes	☐ No	☐ Unknown
Individual Life Insurance	☐ Yes	☐ No	☐ Unknown
Disability Insurance	☐ Yes	☐ No	☐ Unknown

2. EMPLOYEE INFORMATION *(Complete for all claims)*

Full Name of Insured Employee

Social Insurance Number

Date of Birth (MM/DD/YYYY)

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

Occupation

Salary/Rate of Pay
(Attach verification of earnings) $

Amount of RBC Insurance Group Life Insurance
Basic Life $
Voluntary Life $

Effective Date of RBC Insurance Life Insurance (MM/DD/YYYY)

Date of Last Change in Amount of Insurance (MM/DD/YYYY)

Amount of Last Change
Basic Life $ ☐ Increase ☐ Decrease
Voluntary Life $ ☐ Increase ☐ Decrease

Date Employed (MM/DD/YYYY)

Date Last Worked (MM/DD/YYYY)

Date of Death (MM/DD/YYYY)

Reason for Ceasing Work

Cause of Death

Are Accidental Death benefits being claimed? ☐ Yes ☐ No
If "Yes," give amounts
Basic $
Voluntary $

Was a Claim for Waiver of Premium submitted prior to death? ☐ Yes ☐ No

Was Insured considered a member/employee at date of death? ☐ Yes ☐ No

Death or Disability due to: ☐ Non-Occupational accident ☐ Occupational accident
(If Occupational, attach Employer's Accident Report)

Date and time of Accident (MM/DD/YYYY) a.m./p.m.

Have premiums terminated? ☐ Yes-give date ☐ No (MM/DD/YYYY)

If Insurance was terminated, was Insured notified of conversion right? ☐ Yes-give date ☐ No (MM/DD/YYYY)

DEPENDENT CLAIM INFORMATION *(Complete for Dependent Life &/or Dependent Accidental Death Claims only)*

Full Name of Deceased Dependent

Relationship to Employee

Date of Birth (MM/DD/YYYY)

Date of Death (MM/DD/YYYY)

Effective date of Dependent Insurance (MM/DD/YYYY)

Amount of Insurance $

BENEFICIARY INFORMATION *(Complete for all claims)*

Name of Beneficiary

Relationship to Employee

Beneficiary Date of Birth (MM/DD/YYYY)

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

Beneficiary Social Insurance Number

EMPLOYER INFORMATION *(Complete for all claims)*

Company Name

If an affiliate, subsidiary, branch or employer member, give name:

Address (Street/City/Province/Postal Code)

Telephone No.

To the attention of:

Title

Group Policy No(s).

Division No.

Class No.

Signature
X

Date (MM/DD/YYYY)

RBC Insurance®

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)

If death was due to an accident, suicide or homicide, specify which. Was an inquest held? ☐ Yes ☐ No

Was an autopsy performed? ☐ Yes ☐ No

Describe briefly. If so, by whom and with what findings?

Were the injuries described above, alone and independent of all other causes, sufficient to produce the death of a normal and healthy person? ☐ Yes ☐ No

Had he/she, in your opinion, been using alcohol, non-prescription drugs and/or prescription drugs other than as prescribed? ☐ Yes ☐ No

Have you treated or advised the deceased during the last 3 years, prior to the last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution? ☐ Yes ☐ 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 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 governmental 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, (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, and (iii) to let RBC companies know your choices under "*Other uses of your personal information*" for the sole purpose of honouring your choices.

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

Please note that this paragraph is not applicable if this form is submitted by an independent representative or a representative that is attached to a firm other than RBC Insurance®.

Other uses of your personal information

- We may use this information to promote our products and services, and promote products and services of third parties we select, which may be of interest to you. We may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided.

- We may also, where not prohibited by law, share this information with RBC companies for the purpose of referring you to them or promoting to you products and services which may be of interest to you. We and RBC companies may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided. You acknowledge that as a result of such sharing they may advise us of those products or services provided.

- If you also deal with RBC companies, we may, where not prohibited by law, consolidate this information with information they have about you to allow us and any of them to manage your relationship with RBC companies and our business.

You understand that we and RBC companies are separate, affiliated corporations. RBC companies include our affiliates which are engaged in the business of providing any one or more of the following services to the public: deposits, loans and other personal financial services; credit, charge and payment card services; trust and custodial services; securities and brokerage services; and insurance services.

You may choose not to have this information shared or used for any of these "Other uses" by contacting us as set out below, and in this event, you will not be refused insurance products or services just for that reason. We will never use or share your health information for these purposes. We will respect your choices and, as mentioned above, we may share your choices with RBC companies for the sole purpose of honouring your choices regarding "*Other uses of your personal information*".

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, to ask questions about our privacy policies or to request that the information not be used for any or all of the purposes outlined in "*Other uses of your personal information*" 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