Disability Insurance Application

USE THIS APPLICATION FOR ALL DISABILITY INSURANCE PRODUCTS EXCEPT THE FUNDAMENTAL SERIES®
## FINANCIAL REQUIREMENTS FOR ALL APPLICANTS

<table>
<thead>
<tr>
<th>Business/Employment Status</th>
<th>Applied for and in Force for Less Than $10,000 ($400,000 lump sum)</th>
<th>Applied for and in Force for $10,000 or More (lump sum of $400,001 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If applicant is:</td>
<td>Then include with application:</td>
<td>Then include with application:</td>
</tr>
<tr>
<td>Employee, no ownership share of the business</td>
<td>No financial documents required</td>
<td>T4 and T1*</td>
</tr>
<tr>
<td>Employee with business expense deductions or commissioned employee with expense deductions</td>
<td>T1*</td>
<td>T4 and T1*</td>
</tr>
<tr>
<td>Owner/shareholder of incorporated business</td>
<td>T1* and Income Statement of business</td>
<td>T4 and T1* and complete Business Financial Statements**</td>
</tr>
<tr>
<td>Unincorporated professional, business owner or partner</td>
<td>T1* and T2125</td>
<td>T1* and T2125</td>
</tr>
<tr>
<td>Incorporated farmer</td>
<td>T1* and Balance Sheet, Income Statement and Schedule 8 (Capital Cost Allowance) from the last financial statements of the corporation; and T2 Schedule 1 (Net Income (Loss) for Income Tax Purposes) from the most recent T2 Corporate Tax Return</td>
<td></td>
</tr>
<tr>
<td>Unincorporated farmer</td>
<td>T1* and all pages of form T2042 (Statement of Farming Activities); or T1* and form T1163 (Statement A) and Form T1175 (Farming – Calculation of Capital Allowance)</td>
<td></td>
</tr>
</tbody>
</table>

### 4A Executive – Part of a Multi-Life Sale of 3 or More Individuals

If applicant is:

- Employee, no ownership share of the business
  - Then include with application: Census or letter on company letterhead, signed and dated by the appropriate company official, with their title. Document must include clear breakdown of all applicants’ salaries, bonuses and any other compensation for the last two years. If original document is not available or not submitted, census can be submitted as an email from the appropriate company official, not from the producer or applicant.

- Corporate owner/shareholder
  - Same as for “Employee, no ownership share of business” plus complete Business Financial Statements** of the business for the last complete fiscal year

### Disability Buy Sell Coverage Business Structure

If applicant is:

- Owner/shareholder of an incorporated business
  - Then include with application: T1* or T4 and complete Business Financial Statements** for the past two years

- Unincorporated professional, business owner or partner
  - T1* and complete Business Financial Statements** for the past two years

### Business Overhead Expense Coverage*

All applicants

Include with application: Business Overhead Expense Coverage supplement. No financial documents required.

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* T1 means all pages up to and including line 260 of the most recent T1 General federal tax return.
** The Business Financial Statements include the Income Statement (profit & loss statement), balance sheet, and notes for the last complete fiscal year.
* There are no routine financial requirements for Business Overhead Expense applications provided the financial documentation is not required for any other type of coverage applied for concurrently. Proof of earnings and expenses is required at claim time.
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.

In the event our service provider is located outside 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.
COLLECTION AND USE OF PERSONAL INFORMATION

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 “Financial fraud prevention and privacy protection” brochure, by calling us at the toll free number shown above or by visiting our website at www.rbc.com/privacysecurity.
The application is a legal document forming part of the Policy contract.

CONSUMER FACT SHEET
PRE-NOTICE

Information regarding your insurability and claims will be treated as confidential. RBC Life Insurance Company (RBC Life) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction.

The address of MIB’s information office is

MIB, Inc.,
330 University Avenue,
Toronto, Ontario,
Canada, M5G 1R7
Telephone: 416-597-0590
Website: www.mib.com

RBC Life or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

PERSONAL HISTORY INTERVIEW (PHI)

As part of the underwriting process, you may be asked to respond to a telephone interview. The Personal History Interview (PHI) is conducted by specially trained interviewers. The interview will take approximately 20 minutes. Since we want to conduct the interview at a time most convenient for you, we ask you on the application whether you wish to be contacted at home or at work and the best time to call.

The questions asked by the interviewer amplify the information on your application for insurance. These questions relate to personal, financial and medical aspects of insurability and will form part of the contract. The answers contained in the Personal History Interview and/or supplementary questionnaire(s) completed by you during a telephone interview and included in your contract are true and correct and form part of your application for insurance. We also use the PHI process to gather information which may have been omitted or only partially explained. Because of the nature of the information obtained, the PHI will only be conducted directly with you.

Any information obtained during the PHI will be kept strictly confidential and will not be released to anyone without your written consent.

Your co-operation in this process is greatly appreciated and enables us to provide you with the best quality underwriting.
This page has been left blank intentionally.
PART 1 (You/Your refers to the Proposed Insured)

(Check one)

PROPOSED INSURED Mr. Mrs. Ms. Miss Dr. [ ]

1. Print name as legally known:
   a. Last [ ]
   b. First & Middle [ ]
   c. Former Name [ ]
   d. Birthdate: Day [ ] Month [ ] Year [ ]
   e. Birthplace: Country [ ]
   f. Sex: M [ ] F [ ]
   g. Do You understand English or French? Yes [ ] No [ ]

If No, please ensure a Statement of Understanding is signed by the Proposed Insured and the Proposed Owner(s) and submitted with this application.

h. Is a French language policy requested? Yes [ ] No [ ]

i. Canadian Citizen [ ] Permanent Resident [ ]
   Other (Specify) [ ]
   j. How long have You resided in Canada? [ ] yrs

2. a. Home Address: Number [ ]
   b. Street [ ]
   c. City [ ]
   d. Province [ ]
e. Postal Code [ ]
   f. Home Phone No. ( )
   g. Work Phone No. ( )
   h. Mobile Phone No. ( )
   i. Premium notices to be sent to:
      Residence [ ] Business [ ]

   If premium notices are to be sent to someone other than the Owner/Insured, please complete Part 3, question 2 (page 18).

3. Indicate the best way for us to contact the Proposed Insured by telephone for a Personal History Interview
   (Local time)
   [ ] Home [ ] Monday [ ] Thursday [ ] 8 a.m. - 12 p.m.
   [ ] Work [ ] Tuesday [ ] Friday [ ] 12 p.m. - 4 p.m.
   [ ] Mobile [ ] Wednesday [ ] Saturday [ ] 4 p.m. - 8 p.m.

EMPLOYMENT INFORMATION

4. a. Occupation [ ]
   b. Professional Designation(s) or Degree(s) [ ]
   c. Breakdown of Duties:
      Office [ ] % time spent
      Supervision in an office [ ] % time spent
      Supervision on-site [ ] % time spent
      Manual [ ] % time spent
      Driving [ ] % time spent
      Other [ ] % time spent

   Details of “Manual” and “Other” Duties
   Total = 100%

   d. How many hours per week do You work? [ ]
   e. What % of this time is spent working in Your home? [ ]

f. Is employment seasonal? Yes [ ] No [ ]

g. If Yes, how many weeks worked per year? [ ]

5. a. Do You have any part-time or other full-time jobs? Yes [ ] No [ ]
   b. If Yes, describe exact duties, number of hours worked per week and income.
6. a. Business/Employer Name

b. Business/Employer Address: Suite No.  c. Street

d. City  e. Province  f. Postal Code

g. Describe the nature of the business.

h. Number of years with present employer?  i. Number of years in this type of business?

j. Are You a commissioned salesperson?  Yes  No

**If You are self-employed, provide the following details:**

k. How long have You been self-employed? (years)

l. Number of full-time employees excluding owners?

m. Organization of Business:  
   - Sole Owner
   - Partnership
   - Corporation

n. What is Your percentage of ownership? %

o. Do You income split for tax purposes?  Yes  No

p. If Yes, what amount do You income split? $

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**COVERAGE APPLIED FOR**

Include Illustration with submitted application.  
If the Illustration has been signed by the client, there is no need to complete this section.

7. Select the product and occupation class:

<table>
<thead>
<tr>
<th>Product Name(s)</th>
<th>Monthly Indemnity</th>
<th>Elimination Period</th>
<th>Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Professional Series®</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>The Foundation Series®</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>The Bridge Series®</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Quantum®</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Business Overhead Expense</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Disability Buy Sell</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Key Person Protector</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Retirement Protector</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Business Loan Protector</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
</tbody>
</table>

8. Select additional benefits applied for:

<table>
<thead>
<tr>
<th>Product Name(s)</th>
<th>Monthly Indemnity</th>
<th>Elimination Period</th>
<th>Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future Income Option</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Short Term Partial Disability</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Cost Of Living Adjustment</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Enhanced Definition of Disability</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Own Occupation</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
<tr>
<td>Healthcare Profession Rider</td>
<td>BASE $</td>
<td>AMI* $</td>
<td>BASE $</td>
</tr>
</tbody>
</table>

If not listed above, provide details:
COVERAGE APPLIED FOR, continued

9. Is this application part of a Wage Loss Replacement Plan? Yes ☐ No ☐

If Yes, complete Wage Loss Replacement Plan Amendment Form (p. 21).

10. a) Is the Student Savings Plan requested? Yes ☐ No ☐

b) Expected date of Graduation

c) Date of first year of Practice

11. Large Case Discount ☐ # 5% ☐ 10% ☐ 15% ☐

12. Existing group? Yes ☐ No ☐ If Yes, specify group name

13. Select/Risk or Salary Allotment/Maximizer/Performer ☐ #

List members in the producer remarks on page 27.

IF APPLYING FOR BUSINESS LOAN PROTECTOR

14. Describe the purpose and amount of the loan. If the loan exceeds $50,000, attach a letter from the lending financial institution.

EXISTING AND PENDING COVERAGES (Must be answered in all cases)

15. Describe all coverages in force and pending, including any with RBC. Include life, critical illness and disability coverage under (A) Individual, (B) Association, (C) Group LTD, (D) Salary Continuation or Employer Sick Pay Disability Income Coverage, (E) Overhead Expense, (F) Buy Sell, (G) Key Person, (H) Business Loan, (J) Accident Only, (K) Government Plans, or (O) Other.

Specify (O) Other

If none, write “None.”

If APPLYING FOR BUSINESS LOAN PROTECTOR

14. Describe the purpose and amount of the loan. If the loan exceeds $50,000, attach a letter from the lending financial institution.

EXISTING AND PENDING COVERAGES (Must be answered in all cases)

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Specify (O) Other

If none, write “None.”

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Amount and Type of Insurance (Life, CI or Disability) (A, B, C, D, etc.)</th>
<th>Year and Month Issued</th>
<th>Elmination Period</th>
<th>Benefit Period</th>
<th>Taxable Yes No</th>
<th>Policy listed is to be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ Type</td>
<td>Policy #</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Continued</td>
</tr>
<tr>
<td>$ Type</td>
<td>Policy #</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Replaced by this Policy</td>
</tr>
<tr>
<td>$ Type</td>
<td>Policy #</td>
<td></td>
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<td></td>
<td></td>
<td>Continued</td>
</tr>
<tr>
<td>$ Type</td>
<td>Policy #</td>
<td></td>
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<td></td>
<td></td>
<td>Replaced by this Policy</td>
</tr>
<tr>
<td>$ Type</td>
<td>Policy #</td>
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<td></td>
<td>Continued</td>
</tr>
<tr>
<td>$ Type</td>
<td>Policy #</td>
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<td></td>
<td></td>
<td>Replaced by this Policy</td>
</tr>
</tbody>
</table>

16. Have You applied for insurance concurrently or within the past six months with any other company? Yes ☐ No ☐

If Yes, indicate details.

REVOCAABLE BENEFICIARY DESIGNATION

The revocable beneficiary designation applies only to disability policies that contain the Survivor Benefit and/or the Accidental Death and Dismemberment Benefit rider. Do not complete if You are applying for Business Loan Protector, Buy Sell, or Key Person.

17. Beneficiary Equally or Survivors (if any) Relationship Birthdate (dd/mm/yyyy)
OWNERSHIP

Complete if the Owner is not the Proposed Insured. This must be completed for Disability Buy Sell and Key Person Insurance, or if Wage Loss Replacement Plan is selected.

18. Print legal name of Proposed Owner

Address

Print legal name of Proposed Owner

Address

Do You understand English or French? Yes No If No, please ensure a Statement of Understanding is signed by the Proposed Insured and the Proposed Owner(s) and submitted with this application.

To whom should correspondence be sent?

FINANCIAL INFORMATION (Refer to requirements on the inside of the cover page)

Net earned income is Your net income after all business expenses, before personal taxes. Do not include other sources of income such as EI benefits, retirement benefits, family allowance or any income which is not dependent on Your ability to work. Do NOT include PERKS. They will be included in the calculations at our office if the Proposed Insured is eligible.

19. a) Your net annual earned income as declared on Your federal income tax return for the last TWO calendar years was

Calendar Year  | Amount
---|---
| $|
| $|

b) If you are an employee, what is your current annual salary? $ 

20. Does Your annual unearned income exceed $30,000? Yes No

If Yes, indicate total annual unearned income

$ 

21. Does Your liquid net worth exceed $6,000,000? Yes No

If Yes, indicate net worth

$ 

22. Have You ever declared personal or corporate bankruptcy or filed any form of Proposal? Yes No

If Yes, provide the discharge date and complete details below.

<table>
<thead>
<tr>
<th>Date of Discharge or Proposal</th>
<th>Complete Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

ADDITIONAL INFORMATION

23. Have You collected EI, workers’ compensation benefits, or any form of social assistance in the past 12 months, including maternity leave? Yes No

If Yes, provide details.

<table>
<thead>
<tr>
<th>Date Started</th>
<th>Date Ended</th>
<th>EI</th>
<th>WSIB</th>
<th>Maternity</th>
<th>Other</th>
</tr>
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<tr>
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<td>Describe</td>
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<td></td>
<td>Describe</td>
</tr>
</tbody>
</table>
24. Are You eligible for:  
   a. Employment Insurance  YES NO
   b. WSIB/WCB  YES NO
   c. CCQ for Disability Coverage  YES NO

25. Have You ever piloted a plane, ultralight or glider, or do You have any intention of doing so in the future?  YES NO

   If Yes, please complete the Aviation Questionnaire.

26. Have You within the last 12 months traveled outside Canada or the United States of America, or do You have plans to do so within the next 12 months? If Yes, provide full details, including countries and cities, length of stay in each country, and the reason for the visit; or complete the Travel Questionnaire.  YES NO

   Details

27. Have You within the past two years engaged in any hazardous or contact sports or activities, including but not limited to racing, scuba diving deeper than 100ft (30m), skydiving, heli-skiing or back-country skiing, or do You have plans to do so?  YES NO

   If Yes, provide details or complete the appropriate questionnaire.

<table>
<thead>
<tr>
<th>Hazardous Sport or Activity Type</th>
<th>Dates, Frequency, Professional/Amateur, Recreational/Commercial</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

28. Have You ever had life, disability or critical illness insurance rated, modified, rejected, cancelled, rescinded, or have You been denied renewal or reinstatement?  YES NO

   If Yes, provide details.

<table>
<thead>
<tr>
<th>Indicate Type of Insurance</th>
<th>Rated</th>
<th>Modified</th>
<th>Rejected</th>
<th>Cancelled</th>
<th>Rescinded</th>
<th>Denied Renewal or Reinstatement</th>
<th>Insurer</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

29. Have You ever received disciplinary action from Your licensing body and/or been charged with or convicted of any criminal offence?  YES NO

   If Yes, provide details.

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Details Including Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
30. Have You within the past 10 years been charged with or convicted of any driving offences or violations, including impaired driving, and/or have You had a driver’s license revoked or suspended, or are any such charges pending? ................................................................. Yes ☐ No ☐

If Yes, provide the driver’s license number and complete details below, including dates, offense type, how many km/h over the limit.

<table>
<thead>
<tr>
<th>Driver’s License Number</th>
<th>Details, Dates, Offense Type(s), km/h Over Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PART 2: MEDICAL HISTORY (You/Your refers to the Proposed Insured)

Legal Name of Proposed Insured

1. Current Height
   - cm
   - ft/in
   - Current Weight
   - kg
   - lb

2. Have You lost 10lb/5kg or more within the past year?
   - Yes  □  No  □
   - Reason
   - Amount Lost
     - kg
     - lb

3. Are You presently under medical observation or investigation, treatment, therapy, counselling, or taking medication?
   - Yes  □  No  □
   - Details
   - Name of Medication
   - Dose Amount
   - Frequency Taken
   - Date Started

4. Have You had any symptoms or complaints regarding Your health for which You have not yet consulted a physician or received treatment?
   - Yes  □  No  □
   - Details

5. Who is Your family physician or regular healthcare provider or clinic?
   - (If none, write “None.”)
   - Provide the full address and phone number.

6. Provide the name of the healthcare provider who has Your most recent health record if different from Your regular healthcare provider or clinic.

7. What are the date and reason for Your last consultation with ANY physician or healthcare provider, the name of the provider, and the outcome/results?

MEDICAL DETAILS (Circle the appropriate concern and provide details)

8. Have You used tobacco products, such as cigarettes, cigars, cigarillos, or e-cigarettes, including smoking cessation therapy such as Zyban, patches or gum, and/or tobacco substitutes such as chewing tobacco, pipes or bowls, snuff, betel nuts, betel leaves, supari, paan, gutka, hookah, or shisha, within the past 24 months?
   - Yes  □  No  □
   - Details / Product Type (cigars, cigarettes, etc.)
   - Number (per week)
   - Date Last Used
   - Details of Smoke Cessation Therapy (type, date last used)

9. Have You used marijuana and/or Hashish within the past 5 years?
   - Yes  □  No  □
   - If Yes, indicate the quantity and frequency of use, and date last used.
10. Do You consume alcoholic beverages? ................................................................. Yes ☐ No ☐

    If Yes, provide details.

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
<th>Day</th>
<th>Week</th>
<th>Month</th>
<th>Year</th>
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<tbody>
<tr>
<td>Beer</td>
<td>cans/bottles</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Wine</td>
<td>glasses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Liquor</td>
<td>ml/oz</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>

Have You:

11. Ever sought or received advice or treatment relating to alcohol use, or used alcohol excessively? ......................... Yes ☐ No ☐

    If Yes, please complete the Alcohol Questionnaire.

12. Ever sought or received advice or treatment for the use of drugs, prescribed or non-prescribed, or used cocaine, barbiturates, crack, or any other narcotic drug? .................................................... Yes ☐ No ☐

    If Yes, please complete the Drug Questionnaire.

13. Ever been absent from work for 15 consecutive days or more for any injury and/or illness? ................................. Yes ☐ No ☐

    Details

14. Had a transfusion of blood or blood products prior to 1995? ................................................................. Yes ☐ No ☐

    Details

Have You ever had any known indication of or been treated for:

15. a. Acquired immune deficiency syndrome, AIDS related complex, AIDS related conditions; or have you tested positive for antibodies to the AIDS virus or human immunodeficiency virus (HIV)? ............................. Yes ☐ No ☐

    Details

    b. Any disease or disorder of the eyes, ears, nose or throat (including loss of speech)? ................................. Yes ☐ No ☐

    Details

    c. Sleep apnea, chronic insomnia, or any other sleep disorder? ............................................................ Yes ☐ No ☐

    Details

    d. Chest pain, heart attack, angina, abnormal ECG, irregular pulse, heart murmur, high blood pressure, high cholesterol, peripheral vascular disease or any disease or disorder of the heart or circulatory system? ........... Yes ☐ No ☐

    Details

    e. Stroke, transient ischemic attack (TIA), headaches, Parkinson’s disease, Alzheimer’s disease, motor neuron disease, fainting spells, dizziness, seizures, epilepsy, paralysis, multiple sclerosis, muscle weakness, numbness or tingling of the limbs, or any disease or disorder of the brain or nervous system? ................. Yes ☐ No ☐

    If Yes to fainting spells or epilepsy, please complete the Loss of Consciousness Questionnaire.

    Details
Have You ever had any known indication of or been treated for:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>f. Any disease or disorder of the kidneys, urinary tract, bladder, prostate, or genital organs, kidney stones, or albumin, blood, or sugar in the urine?</td>
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<tr>
<td>g. Anxiety, depression, nervousness, stress, fatigue, burnout, eating disorder, other emotional disorder, psychiatric disorder, mental disorder or psychosis; or have You ever attempted suicide?</td>
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<tr>
<td>h. Chronic fatigue, chronic fatigue syndrome, Epstein-Barr virus, fibromyalgia, or chronic pain?</td>
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<tr>
<td>i. Cancer, dysplastic nevi, tumour, cyst, mass, lesion, lump, nodule, polyp or other growth, any disorder of the skin or lymph glands, blood disorder or any form of malignant disease?</td>
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<tr>
<td>j. Diabetes, elevated blood sugar, thyroid disease, rheumatism, rheumatic fever, lupus, gout, or syphilis?</td>
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<td>k. Work-related allergies, environmental hypersensitivity or illness, or non-seasonal allergies?</td>
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<td>l. Any disease or disorder of the reproductive organs or breast including lumps, cysts or other masses, other physical changes, abnormal mammogram findings or any biopsy?</td>
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<td>m. Any amputation or deformity, hernia or rupture, deep vein thrombosis or varicose veins?</td>
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<td>n. Any arthritis, disease or disorder of the hip, ankle, knee, wrist, elbow, shoulder, hands, feet or any other joint?</td>
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<tr>
<td>o. Any type of back or spinal trouble (includes neck area) including sprain, strain, or disc disease or disorder?</td>
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<td>p. Any type of asthma, emphysema, bronchitis, pleurisy, tuberculosis, or any disease or disorder of the chest or lungs?</td>
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</table>
Have You ever had any known indication of or been treated for:

q. Any type of peptic ulcer, indigestion, colitis, or any disease or disorder of the stomach, colon or intestines, gall bladder, liver; or have You tested positive for hepatitis and/or been told You are a carrier? ............... Yes ☐ No ☐

►► If Yes, please provide details or complete the Gastrointestinal Questionnaire.

Details

Other than the information provided in Part 2, numbers 1-15, have You in the last 10 years:

16. a. Been examined by or consulted a physician, chiropractor, psychologist, physiotherapist, osteopath, homeopath, or other practitioner? ................................................................. Yes ☐ No ☐

Details

b. Been under observation or treatment in any hospital or other institution or facility, or been advised to be admitted? ................................................................. Yes ☐ No ☐

Details

c. Had an X-ray, ECG, CT scan, MRI, blood or urine test, or other diagnostic tests? ......................... Yes ☐ No ☐

Details

d. Had any surgical operation, treatment, special diet, or any illness, ailment, abnormality or injury? ........ Yes ☐ No ☐

Details

e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? ........ Yes ☐ No ☐

Details

17. Have Your natural parents, brothers or sisters, either living or dead, ever suffered from any of the following conditions: heart disease, polycystic kidney disease, high blood pressure, a stroke, diabetes, cancer, multiple sclerosis, Alzheimer’s disease, Huntington’s disease, motor neuron disease or any form of hereditary disease? . . Yes ☐ No ☐

►► If Yes, complete the chart below.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mother</th>
<th>Age at Onset</th>
<th>Father</th>
<th>Age at Onset</th>
<th>Sister</th>
<th>Age at Onset</th>
<th>Brother</th>
<th>Age at Onset</th>
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Female Applicants Only

18. a. Have You ever had a miscarriage, preeclampsia, caesarean section or other complication of pregnancy? . . Yes ☐ No ☐

Details

b. Any complications with Your most recent pregnancy? ................................................................. Yes ☐ No ☐

Details

c. Are You pregnant? ................................................................. Yes ☐ No ☐

►► If Yes, give due date.
### CONDITIONAL DISABILITY INSURANCE AGREEMENT (CIA)

If either of the following questions are answered Yes, the Proposed Insured is not eligible for CIA.

1. Has the **Proposed Insured**, within the past two years, been treated for heart trouble, a stroke or cancer, or had treatment recommended?  
   - **Yes** [ ]  
   - **No** [ ]

2. Has the **Proposed Insured**, within the past 90 days, been admitted to a hospital or a medical facility, or been advised to be admitted?  
   - **Yes** [ ]  
   - **No** [ ]

Dated at ___________________________ (City/Province)  
this ___ day of ___________ (Month/Year)

Proposed Insured (Signature) X  
Signature of Proposed Owner (if different than Proposed Insured) X

---

As needed, provide additional details below to any Yes answers from Part 2.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Conditions, Symptoms, Duration, Results and Treatment</th>
<th>Date of Onset</th>
<th>Name of Healthcare Provider</th>
<th>Date of Recovery</th>
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CONDITIONAL DISABILITY INSURANCE AGREEMENT (CIA) RECEIPT
(applicable only if CIA is applied for)

Received a payment of $ on (date) with the Application for insurance on behalf of (the Proposed Insured).

DEFINITIONS
For the purpose of this Conditional Insurance Agreement:
“You” means the Proposed Insured on the Application.
“We”, “Us” and “Our” mean the Company.
“Minimum Payment” means an initial deposit of one month’s premium for the monthly premium mode and 10% of the annual premium for all other modes.
“Effective Date” means the later of the following:
(a) The date We receive the Minimum Payment; or
(b) The date of completion of the Application and all medical examinations and supplementary tests which We may require according to Our underwriting guidelines and practices; or
(c) The date of issue requested by the Proposed Owner at the time of the Application.

CONDITIONAL INSURANCE
We accept this payment and will insure You commencing on the Effective Date subject to all of the following:

CONDITIONS PRECEDENT
(a) The amount of the payment is equal to or greater than the Minimum Payment; and
(b) You have completed the Application and all medical examinations and supplementary tests which We may require according to Our underwriting guidelines and practices; and
(c) You are insurable according to Our underwriting guidelines and practices under any policy currently offered by Us; and
(d) The Producer Declaration has been signed by a licensed producer or agent.

We will not insure You under this Agreement, in any event, if:
(a) Either question 1 or 2 of the CIA is answered Yes or left blank; or
(b) There is any material misrepresentation on the Application; or
(c) Death is by suicide; or
(d) You are not insurable according to Our underwriting guidelines and practices under any policy currently offered by Us.

If conditional insurance becomes effective, it will be exactly as applied for only if, according to Our underwriting guidelines and practices, You are insurable for the Policy and amount exactly as applied for, at our standard rate of premium, with no exclusions, limitations, reductions or other modifications. Otherwise, the conditional insurance will be the modified policy under which You would have been insurable on the Effective Date according to Our underwriting guidelines and practices.

However, in no event will We be liable under this Agreement for accidental death benefits, including any insurance currently in force or pending with Us, in excess of $100,000.

TERMINATION
If conditional insurance becomes effective, it will terminate on the earliest of the following:
(a) The date that any policy issued as a result of the Application is delivered to You and comes into effect; or
(b) 90 days from the Effective Date; or
(c) The date that We write to advise that We are unable to approve the issuance of a policy.

RETURN OF PAYMENT
If conditional insurance does not become effective, Our liability will be limited to the return of the payment tendered with this Agreement.
PART 3: PREMIUM AND PAYMENT INFORMATION

If either question 1 or 2 on the Receipt and Conditional Insurance Agreement (CIA) is Yes, the producer may not accept an initial deposit with the application, and the CIA is void.

1. a. Method of Payment: Monthly ☐  Annually ☐

b. Pre-Authorized Debit Plan (PAD) (Complete the PAD authorization form) ☐ OR Direct Bill ☐

c. Initial deposit collected? Yes ☐ No (COD) ☐

If initial deposit is collected, it is in exchange for the Receipt and CIA (last page of application package).

d. Conditional Insurance Agreement (CIA) premium to be withdrawn by PAD? Yes ☐ No ☐

If No, make cheque payable to RBC Life Insurance Company.

e. Complete the following. Provide deposit amount for each product requested.

<table>
<thead>
<tr>
<th>Product</th>
<th>Deposit</th>
<th>Product</th>
<th>Deposit</th>
<th>Product</th>
<th>Deposit</th>
<th>Product</th>
<th>Deposit</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td></td>
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</table>

If deposit cheque is for more than one applicant, please provide the legal name(s).

2. PREMIUM NOTICES AUTHORIZATION AND AGREEMENT (Complete only if this Policy is to be part of a List Bill and if premium notices are to be sent to someone other than the Owner/Insured.)

X , owner of the insurance policy, hereby authorizes the Company to

send all premium notices, premium lapse notices, or pay any premium refunds to and accept premium payments from

Premium Payor Legal Name and Address

Mandatory for ALL applications

3. Have you detached and given to the applicant
   [ ] MIB, Inc., Pre-Notice
   [ ] CIA Receipt (final page of the application package; if deposit collected)
   [ ] Supplementary Questionnaires (if required)

4. Have you attached to the application
   [ ] Notice of Replacement of Insurance (Quebec only, if applicable)
   [ ] Payment for the First Month or Blank CIA (if deposit not collected)
   [ ] A Void Cheque with Legible Banking Codes (if using PAD)
   [ ] Statement of Understanding Signed by the Proposed Insured and the Proposed Owner(s), if English or French is not understood
   [ ] Illustration
PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Ensure You read and understand the section entitled “Collection and Use of Personal Information.”

The Payor(s) named below agrees that:

1. (a) RBC Life Insurance Company (RBC Life) is authorized to make scheduled monthly withdrawals against the account at the financial institution below or any other financial institution that the Payor(s) may later designate to pay the premium in accordance with the premium schedule set out in this Policy/these policies, including the initial premium and/or the Conditional Insurance Agreement premium, if requested in this application.

(b) RBC Life is not required to provide notification before the Conditional Insurance Agreement premium and/or the initial premium is debited, or if the amount of the withdrawal should vary.

(c) Unless otherwise indicated in the Special Requests section below, such withdrawals shall be dated on the day of the month on which the premium is due under the Policy or, if more than one policy is included in this Agreement, the withdrawals shall be dated to coincide with the existing policy/policies.

(d) The financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Life to withdraw premiums or fees from the account indicated below, which may include a redraw within 30 days should any withdrawal not clear the account.

(e) Notification of any change to the information provided below shall be given to RBC Life by the Payor(s) a minimum of 5 days prior to the next scheduled withdrawal. The Payor(s) agrees that from time to time they may authorize RBC Life to deduct such payments from another account upon the Payor’s oral or written instructions.

(f) This Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Life or by the Payor(s). The Payor(s) may obtain further information on their right to cancel a PAD agreement by visiting the Canadian Payments Association website at www.cdnpay.ca.

(g) In the event that a PAD is disputed, the Payor(s) agrees to contact RBC Life. For recourse purposes, this PAD is considered a Personal PAD.

The Payor(s) has certain recourse rights if any debits do not comply with this agreement. For example, the Payor(s) has the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on recourse rights, the Payor(s) may contact their financial institution or visit www.cdnpay.ca.

(h) The names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

2. Add to existing PAD with policy number(s)

3. Special Requests (Withdrawals are limited between the 1st – 28th of the month)

Bank Information

Please attach a specimen cheque marked “Void” (a line of credit account cannot be used).

<table>
<thead>
<tr>
<th>Name of Bank or Financial Institution</th>
<th>Transit Number</th>
<th>Bank Number</th>
<th>Account Number</th>
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<th>Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
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<th>day of</th>
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<th>(City/Province)</th>
<th>(Month/Year)</th>
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Print Legal Name of Payor (Account Holder)

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Print Legal Name of Second Payor (Account Holder) (if any)

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Signature of Payor

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Signature of Second Payer (if any)

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BUSINESS OVERHEAD EXPENSE SUPPLEMENT (Complete only if being applied for)

Below is needed unless income documentation, including expense breakdowns, has been submitted.

Proposed Insured

Use Your actual current monthly average expenses. If Your expenses are shared, include only Your portion. Exclude any payments to Yourself or to any other member of Your occupation. Only those expenses which qualify as tax deductions for income tax purposes will be considered as reimbursable for this product.

Are Your office expenses shared with anyone else?  Yes ☐ No ☐ If Yes, what is Your share? %

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Rent</td>
<td>$</td>
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<tr>
<td>Telephone</td>
<td>$</td>
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<tr>
<td>Employees’ Wages</td>
<td>$</td>
</tr>
<tr>
<td>Leased Equipment</td>
<td>$</td>
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<tr>
<td>Rental Equipment</td>
<td>$</td>
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<tr>
<td>Utilities</td>
<td>$</td>
</tr>
<tr>
<td>Principal and Interest on Business Loans</td>
<td>$</td>
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<tr>
<td>Business Liability Insurance Premiums</td>
<td>$</td>
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<tr>
<td>Professional Dues and Memberships</td>
<td>$</td>
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<tr>
<td>Office Supplies</td>
<td>$</td>
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<tr>
<td>Depreciation or Scheduled Instalment Payments of Principal of Business Loans Including Mortgage</td>
<td>$</td>
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<tr>
<td>Other Fixed, Monthly and Necessary Overhead Expenses (Give full details if over 10% of total)</td>
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<td>Total</td>
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I hereby declare that this information is true and complete and shall form part of my application.

Date DD/MM/YYYY

Proposed Insured Signature X
The Owner and the Insured hereby acknowledge and agree that the individual disability insurance policy for which they are applying, or have applied for, is intended to form part of a “Wage Loss Replacement Plan” which either already exists or will be established immediately by the Owner of the Policy. All premiums will be paid solely and directly by the Owner. Any claim benefits (other than waiver of premium) will be paid to the Insured as taxable claim benefits.

The Owner and the Insured acknowledge and understand that in the event that a valid Wage Loss Replacement Plan acceptable to Canada Revenue Agency is not established and maintained:

(a) The premiums paid by the Owner may be disallowed retroactively by Canada Revenue Agency as a tax deductible expense; and

(b) Canada Revenue Agency may require the Insured, retroactively, to include the amount of the premiums as a taxable payroll benefit in calculating his or her personal income taxes.

The Owner and the Insured specifically acknowledge and agree that they alone shall be solely and completely responsible for establishing and continuing to maintain a valid Wage Loss Replacement Plan acceptable to Canada Revenue Agency. The Owner and the Insured acknowledge and agree that they do not rely upon any tax or other advice whatsoever from the Company or its employees regarding the validity of the Wage Loss Replacement Plan. The Owner and the Insured specifically agree that the Company and its employees shall not be liable in any way for tax or other advice received from any broker, or for tax arrears or otherwise resulting from termination or invalidity of the Wage Loss Replacement Plan.

The Owner and the Insured specifically agree that, in the event that a valid Wage Loss Replacement Plan is not established or, if established, it terminates or ceases to be valid or acceptable to Canada Revenue Agency, or in the event that the Insured ceases for any reason to be a member of the Plan:

(a) The Owner and the Insured immediately will notify the Company, in writing, at its office, located at 6880 Financial Drive, Mississauga, Ontario L5N 7Y5;

(b) Effective as of the date of termination or invalidity of the Plan or the date that the Insured ceases to be a member, whichever occurs earlier, the monthly benefit provided by the Policy shall be reduced to the amount for which the Insured would have qualified based upon the Company’s non-taxable issue limits including eligibility for EI disability benefits that are currently in effect or that were in effect on the Date of Issue of the Policy, whichever is more favourable to the Insured;

(c) The Insured immediately shall repay to the Company any and all excess claim benefits paid by the Company prior to its receipt of notification that a valid Plan was not established or terminated or ceased to be valid or that the Insured ceased to be a member, whichever occurred earlier; and

(d) The Policy premium will be reduced to the amount that the Company would have required for the reduced monthly benefit referred to in (b) above. The Company will refund to the Owner any excess premiums paid by the Owner.

The Amendment will apply notwithstanding any Policy provision to the contrary. All other provisions of the Policy will remain the same.

This Amendment will form part of the Policy. The effective date of this Amendment shall be the same as the Date of Issue of the Policy.

I agree to this Amendment:

Insured Signature X

Witness Signature X

Owner Signature X

Witness Signature X

Dated at this day of (City/Province) (Month/Year)
RBC Life Insurance Company is herein referred to as “the Company.”

It is understood and agreed as follows:

1. I have read the statements and answers recorded in Parts 1 and 2. They are true and complete and correctly recorded. They will become part of this Application and any policy(ies) issued. I understand that false or incomplete answers to any question will affect the coverage and benefits available under the Policy, and may mean that there will be no coverage, and may result in legal action.

2. I will discontinue any policy(ies) shown to be discontinued immediately upon delivery to me of my Policy(ies) issued by the Company as a result of this Application. The Company will rely on such answers in determining the amount, if any, of insurance it will issue. If any policy(ies) shown to be discontinued is(are) not discontinued, the Policy(ies) issued by the Company as a result of this Application shall be void.

3. I understand that no agent or producer can authorize or approve inaccurate or incomplete answers to the questions in this Application, or decide on any issue of insurability, waive any of the Company’s rights or responsibilities or make any changes to the Policy or the rights and obligations stated in it. The Company will not be bound by any statement made to any agent or producer which is not recorded in this Application.

4. The Company has the right to require medical exams and tests to determine insurability.

5. The insurance applied for will take effect only if and when the Policy actually has been delivered to the Proposed Owner, any and all conditions for delivery of the Policy to the Proposed Owner have been satisfied completely and there has been no change in the health or insurability of the Proposed Insured. The only exception to this is provided in the Receipt and Conditional Insurance Agreement, detached here from and issued if the premium is paid in advance. I immediately will advise the Company of any changes in the answers to the questions in the Application.

6. The Company is authorized to obtain an investigative consumer report on me.

7. Acceptance by the Proposed Owner of any policy issued as a result of this Application will ratify any changes.

8. I hereby acknowledge receipt of the Pre-Notice form describing the MIB, Inc. procedures.

9. Any policy that the Company issues in response to this Application will not provide coverage for any disability that is due to a) an accidental bodily injury sustained before the policy is delivered, or b) a disease or sickness that first manifests itself before the policy is delivered. However, the issued policy will provide coverage for such disability if the Proposed Insured has, before the policy is delivered, fully disclosed to the Company, on this Application or otherwise in writing, all information known or reasonably available to the Proposed Insured regarding the injury, disease or sickness, including all signs, symptoms or other manifestations, and the Company has chosen not to exclude the injury, sickness or disease.

10. The Company may issue a policy to me with an amendment form. I must sign the amendment form (without making any alterations) and return it to the Company. The Policy will not provide coverage unless the Company receives the signed amendment form.

11. I have read the section entitled “Collection and Use of Personal Information” appearing in this Application and understand and agree to its terms.

12. If my Representative or I provide any document to the Company by way of email, pdf, or fax transmission, the Company may rely on the document as though it were an original document. The Company may assume that any email, pdf, or fax transmission that my Representative or I send to the Company is a reliable communication. The Company may convert any paper records related to my Application or Policy into electronic images as part of the Company’s normal business practices. Any electronic image will be an authoritative copy of the paper record. The electronic image will be legally binding and admissible in any legal proceeding as conclusive evidence of the contents of the paper record in the same manner as the original paper record.

13. I understand that the Company will create and maintain at their office a file for the purposes of this Application and any subsequent claim. I am entitled to consult the personal information contained in this file and, where applicable, have it rectified by formulating a written request to the Company. Only the employees, mandataries or agents responsible for such purposes will have access to it.

This Application and any telephone interview, application supplement(s), and/or questionnaire(s) will form part of any insurance contract issued. The contract will be in utmost good faith, based upon the statements contained in this Application and any telephone interview, application supplement(s), and/or questionnaire(s). I am responsible for the accuracy of the statements. Before signing, I have verified that all answers are correct and complete and that I have initialed any changes to those answers. Inaccurate answers to any questions may affect my eligibility for coverage and/or benefits.

I have read, understood and agree with the terms of the Receipt and Conditional Insurance Agreement (applicable only if the Minimum Payment has been properly made and the Receipt properly detached from the Application).

Signed at ________________________ Date ________________________
(City/Province) (DD/MM/YYYY)

Proposed Insured (Signature) X Proposed Owner (Signature) X

Note: If the Policy is to be owned by a corporation, this Application must be signed by an Officer of the Company other than the Proposed Insured.

WITNESS

Legal Name (Please print) ________________________ Signature X ________________________

Address ________________________ Signed at ________________________ Date ________________________
(City/Province) (DD/MM/YYYY)

Telephone ________________________
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AUTHORIZATION

I understand and authorize the Company (RBC Life Insurance Company and its 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 that 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 performance of their duties, or to 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 to have any errors in the personal information noted and corrected by formulating a written request to the Company. 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 or employment that is relevant to this Application that they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other healthcare 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 or reinsurance company or other financial institution; and also my employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also the MIB, Inc.; and also any other person, agency, credit bureau or institution having information, records or data regarding me. This Authorization to obtain information is valid until revoked by me in writing. If I choose to revoke this Authorization to obtain information, consequences may include termination of the underwriting process and/or the policy, if one has been issued.

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 assessment of insurance risk for underwriting purposes; for the purpose of evaluating any claim for benefits, assessing the validity of the Policy as issued, and issuing and delivering the Policy. Only to the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received to the MIB, Inc.; to other insurance companies or any reinsurer; and to my Servicing Representative, such as my insurance advisor or broker. This Authorization to disclose information as reasonably necessary is valid until revoked by me in writing.

I authorize the Company to disclose to my Servicing Representative material information regarding my health and personal history solely for the purpose of explaining underwriting decisions. This disclosure could include history of mental illness, infectious disease, drug and alcohol use, record of criminal activity, or other facts that have a material effect on the Company’s decision to insure me. This Authorization to disclose information for this purpose is valid until 60 days after the later of the day the Company issues a new or amends the existing policy; or the day the Company notifies me in writing that my Application has been declined, withdrawn, or filed incomplete.

I do not agree to the disclosure of health and personal information to the Servicing Representative

I also authorize the Company to release to my healthcare professional any medical information obtained for this insurance Application, including the results of any blood or urine test or urine drug screening tests for the purpose of revealing findings that might require further investigation or treatment or for the purpose of explaining any underwriting decision. This Authorization to disclose medical information is valid until revoked by me in writing. A photocopy of this Authorization, as executed by me, will be as valid as the original. Any alteration of this Authorization will render it null and void.

Dated at this day of __________ (City/Province) (Month/Year)

Proposed Insured (Signature) X
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REPRESENTATIVE’S REPORT

1. Were the negotiations for this application started by:  
   You [ ]  
   Proposed Owner(s) [ ]  
   Proposed Insured [ ]

2. Have you collected money?  
   Yes [ ]  
   No [ ]  
   If Yes, indicate amount collected: $[ ]  
   Date Received (dd/mm/yyyy) [ ]

3. Back date to save age?*  
   Yes [ ]  
   No [ ]  
   *To a maximum of 30 days prior to the client signature date.

4. Other Special Date Required [ ]

5. Evidence: The following requirements have been ordered:  
   Blood Profile [ ]  
   MVR [ ]  
   Paramedical [ ]  
   Urine-HIV [ ]  
   Other (Specify) [ ]

6. Para-Medical Company Used [ ]

6. Representative’s Declaration:

I have clearly explained the provisions and limitations of the Policy being applied for and, if applicable, the Conditional Insurance Agreement to the Proposed Insured and the Proposed Owner(s). All of the questions in the application were clearly asked of, or read by, the Proposed Insured and the Proposed Owner(s). To the best of my knowledge, they understood all of the questions. To the best of my knowledge, all of the answers and statements on the application have been fully and accurately recorded. I am not aware of any pertinent information about the Proposed Insured(s) that has not been disclosed on the application. If a policy is issued, I will deliver it to the Proposed Owner(s) only after obtaining confirmation that all conditions for delivery have been completely satisfied and there has been no change in the insurability of the Proposed Insured. I understand that I cannot modify the application, the Conditional Insurance Agreement or the terms of the Policy, if issued. I have complied with my duties and obligations in regard to Advisor Disclosure, including providing an Advisor Disclosure Statement in writing to the Proposed Owner.

Date (dd/mm/yyyy) [ ]

Representative’s Signature [ ]

Representative’s Name [ ]

Representative’s Company Name [ ]

Marketing Office [ ]

Share % [ ]  
   Servicing Representative Code [ ]
   Representative Code [ ]

RBC Insurance

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Please use this space for any special instructions or additional information which would be helpful in the underwriting of this risk.