RBC Insurance®

SPOUSE DISABILITY NOTICE OF CLAIM

EMPLOYER INSTRUCTIONS

1. Complete the Employer's Statement and attach Proof of Enrolment. Send this form along with the Spouse's Statement and the Attending Physician's Statement to the claimant.

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.

CLAIMANT INSTRUCTIONS

1. Ensure that the Employer's Statement is completed. Complete the Spouse's Statement and return along with the Employer's Statement directly to our office:

   RBC Insurance
   P.O. Box 4435, Station A
   Toronto, ON M5W 5Y8
   Tel 416-643-4700
   Fax 1-800-714-8861
   Toll Free 1-877-519-9501

2. Send the Attending Physician's Statement to the treating physician and have this form returned directly to our office.

RBC Insurance®

SPOUSE DISABILITY CLAIM FORM
SPOUSE'S STATEMENT

To be completed by the Claimant (Claimant is the Insured Spouse). A designated representative may complete this form if the Claimant is unable to do so.

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. Male ❑ Female ❑

Name of Claimant: _____ Social Insurance No.: ☐☐☐ ☐☐☐ ☐☐☐
Last First Middle

Address: _____
Apt. Street City Province Postal Code

Telephone No. (H): (_____)_____ Date of Birth: _____
(MM/DD/YYYY)

Name of Employee: _____ Social Insurance No.: ☐☐☐ ☐☐☐ ☐☐☐
Last First Middle

Policy Number: _____

Date of Marriage or date that you began residing with the Insured Employee: _____
(provide a copy of the marriage certificate, if applicable) (MM/DD/YYYY)

INFORMATION ABOUT YOUR CLAIM

1. Date of your injury or date you first noticed symptoms of your illness: _____ (MM/DD/YYYY)
2. Describe your current disabling condition and its cause: _____
3. Does your current condition prevent you from caring for yourself? ❑ Yes ❑ No If "Yes," explain: _____
4. Which of the following Activities of Daily Living (ADLs) do you currently require personal assistance in performing?

	Date on which you first required and received assistance (MM/DD/YYYY)		Date on which you first required and received assistance (MM/DD/YYYY)
❑ Bathing	_____	❑ Transferring	_____
❑ Dressing	_____	❑ Continence	_____
❑ Toileting	_____	❑ Feeding	_____

TREATMENT

5. Date of first treatment by a physician for this condition: _____ (MM/DD/YYYY)
   Doctor's Name: _____ Specialty: _____
   Address: _____ Telephone No.: (_____)_____
   Street City Province Postal Code
6. If hospitalized, provide name and address of hospital: _____
   Dates of Confinement: _____ (MM/DD/YYYY)
7. List all other physicians consulted for this condition:

Dates of consultation	Name, phone number and address of Physicians
_____	_____
_____	_____
_____	_____

8. In which of the following locations are you currently receiving care?
   ❑ Residence ❑ Nursing Home ❑ Assisted Living/Personal Care Facility ❑ Hospital **(complete if discharged within last 3 months)**
   Dates of admission and discharge at this facility: _____ (MM/DD/YYYY)
   Address: _____ Telephone No.: (_____)_____

(OVER)

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
(print name)

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)

_____ _____
Name of Claimant (Please Print) S.I.N. Number

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

_____
Name of Witness (Please Print)

RBC Insurance®

SPOUSE DISABILITY CLAIM FORM
EMPLOYER'S STATEMENT

To be completed by the Employer

EMPLOYER INFORMATION

Name:	Group Policy No.:
Address (Street/City/Province/Postal Code):	Telephone No.: ( ) Fax No.: ( )

Name and address of division where employee works, if different from above (Street/City/Province/Postal Code):

EMPLOYEE INFORMATION

Name of Employee (Last, First, Middle):	Occupation:	Social Insurance Number ☐☐☐ ☐☐☐ ☐☐☐
Address (Apt/Street/City/Province/Postal Code):		Telephone No.: ( )

Date of Hire: _____ (MM/DD/YYYY)	Date employee became insured under this plan: _____ (MM/DD/YYYY)	Date spouse became insured under this plan: _____ (MM/DD/YYYY)

Name, address and policy number of your medical insurance carrier:

CLAIMANT (INSURED SPOUSE) INFORMATION

Name of Claimant (Last, First, Middle):	Date of Birth: _____ (MM/DD/YYYY)	Social Insurance Number ☐☐☐ ☐☐☐ ☐☐☐
Address (Apt/Street/Province/Postal Code):		Telephone No.: ( )

SIGNATURE

Name of person completing this form:

Signature of Representative:	Date: _____ (MM/DD/YYYY)
Title of Authorized Representative:	Telephone No.: ( )

RBC Insurance®

SPOUSE DISABILITY CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

AUTHORIZATION

Patient Name | Age | Policy No(s).

I hereby authorize the release to RBC Insurance® and its reinsurers any information requested in respect to this claim.

X _____ _____

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

Note: The Patient is responsible for securing completion of this form and any charge for its completion.

PATIENT INFORMATION

Name: Last | First | Middle

Date of Birth (MM/DD/YYYY) | Height (in/cm) | Weight (lb/kg) | Blood Pressure

DIAGNOSIS

Primary Diagnosis:

Symptoms:

Objective findings: (include the name of objective tests, the date performed and the results)

Are there secondary conditions contributing to the disability? ❑ Yes ❑ No

If "Yes," what are they?

If this is a cardiac condition, what is the functional capacity?

❑ Class 1 - No limitation ❑ Class 2 - Slight limitation ❑ Class 3 - Marked limitation ❑ Class 4 - Complete limitation

When did symptoms first appear? _____ (MM/DD/YYYY)	Date of Patient's first visit _____ (MM/DD/YYYY)	Date of Patient's last visit _____ (MM/DD/YYYY)

Has the Patient undergone surgery? ❑ Yes ❑ No

If "Yes," give date: _____ (MM/DD/YYYY) procedure and result: _____

If "No," do you expect surgery to be performed in the future? ❑ Yes ❑ No If "Yes," give date: _____ (MM/DD/YYYY) and type of surgery: _____

What medication and dosage is the patient currently taking?

Please indicate other types and frequencies of treatment:

Has the Patient been referred to a medical rehabilitation or therapy program? ❑ Yes ❑ No If "Yes," give details:

Have you referred the Patient for other types of consultations? ❑ Yes ❑ No If "Yes," give details:

Has the Patient been hospital confined? ❑ Yes ❑ No If "Yes," please indicate:

Name of Hospital: _____

Address: _____

Dates of Confinement: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

Has your Patient had loss of cognitive functioning? Cognitively impaired means deterioration or loss in intellectual capacity and the Patient needs another person's assistance or verbal cueing for his/her own protection or the protection of others. ❑ Yes ❑ No
If "Yes," please explain and provide supporting documentation:

_____

Based upon your observation of this Patient, medical history and condition, indicate which of the following Activities of Daily Living (ADLs) the patient needs hands-on or stand-by assistance in performing:

- ❑ **Bathing:** The ability to wash oneself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- ❑ **Dressing:** The ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- ❑ **Toileting:** The ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
- ❑ **Transferring:** The ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- ❑ **Continence:** The ability to either: a) voluntarily control bowel and bladder function; or b) if incontinent, be able to maintain a reasonable level of personal hygiene.
- ❑ **Eating:** The ability to get nourishment into the body.

Date the Patient first required assistance with ADLs: _____ (MM/DD/YYYY) Is the need for assistance ❑ persistent ❑ periodic

_____

How soon do you expect fundamental changes in the Patient's medical condition?

_____

Remarks: Please provide comments and further details that you feel would be helpful

REQUIRED ATTACHMENTS

After you have fully completed this form, please attach:

- Office notes for at least the past two years but longer if available
- Test results
- Hospital Admission/Discharge Summaries
- Consulting Physician Reports

Including the above information with the claim submission will allow us to make a more timely claim determination for your Patient. We are willing 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 1-877-519-9501.

SIGNATURE

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

_____ ❑ Primary Care ❑ Consultant
Physician's Name

_____
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

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.