



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.



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

- Date of your injury or date you first noticed symptoms of your illness: _____
(MM/DD/YYYY)
- Describe your current disabling condition and its cause: _____

- Does your current condition prevent you from caring for yourself? Yes No If "Yes," explain: _____

- 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)
<input type="checkbox"/> Bathing	_____	<input type="checkbox"/> Transferring _____
<input type="checkbox"/> Dressing	_____	<input type="checkbox"/> Continence _____
<input type="checkbox"/> Toileting	_____	<input type="checkbox"/> Feeding _____

TREATMENT

- 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
- If hospitalized, provide name and address of hospital: _____
Dates of Confinement: _____ (MM/DD/YYYY)
- List all other physicians consulted for this condition:

Dates of consultation	Name, phone number and address of Physicians
_____	_____
_____	_____
_____	_____
- 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 RBC Life Insurance Company and its participating 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, 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 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.

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, 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 evaluating my claim for benefits, my ability to return to work or for the purpose of administering the policy under which my claim is made. 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 firm (including physicians, health care practitioners, rehabilitation workers, vocational evaluators) employed or engaged by the Company.

I also authorize the Company to use my Social Insurance Number for my insurance file identification, any tax reporting purposes, and all other matters relating to my insurance claim or entitlement to benefits.

This authorization does not have any expiry date. It will remain valid for as long as I am claiming benefits or service from the Company. A photocopy of this authorization, as executed by me, will be as valid as the original.

X _____
Signature of Claimant

Date: _____
(MM/DD/YYYY)

Name of Claimant (Please Print)

S.I.N. Number

X _____
Signature of Witness

Date: _____
(MM/DD/YYYY)

Name of Witness (Please Print)



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.: ()



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: _____ procedure and result: _____
(MM/DD/YYYY)

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

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: _____

(OVER)

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.
- Contenance:** 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

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

Physician's Name Primary Care Consultant

Address (Street/City/Province/Postal Code)

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

MAIL THE COMPLETED FORM TO:

RBC Life Insurance Company, Life and Health Claims Department
P.O. Box 4435, Station A, Toronto, ON M5W 5Y8 or fax to: 1-800-714-8861
If you have any questions, call toll free 1-877-519-9501 or 416-643-4700