RBC Insurance

Critical Illness

Insurance Application

IMPORTANT GUIDELINES

- Print legibly in ink, preferably black for photocopy purposes. DO NOT use ditto marks.
- DO NOT make erasure or use liquid paper. Strike out any error and have the applicant initial it.
- After the application has been signed, have additions initialed by the applicant. The application is a legal document forming part of the policy contract.

83550 (05/2007)

Your Privacy Matters To Us

At RBC Life Insurance Company (RBC Insurance), we're committed to protecting your privacy. We respect your privacy and want you to understand how we safeguard your personal information.

How we collect your information
We collect and keep information about you, which is needed to provide the products and services you request. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, the Medical Information Bureau, the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

How we use your information
We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage claims. We may also share your information with others who work for RBC Insurance or other RBC Financial Group® companies, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, financial institutions, third party administrators, and any references you provide.

We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business.

If you have given us your social insurance number, we will use it for taxation purposes and to help identify you with Citizenship and Immigration Canada, when necessary.

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

Other ways we use your information
When you request products and services directly from RBC Insurance, there are other ways we may use your information. For example, we may use or share some of your information to help you find out about other products and services from RBC Insurance and other companies of the RBC Financial Group. However, we will never use or share your health information for these purposes. To better manage your relationship with other companies of RBC Financial Group, and where the law allows us, we may consolidate the information we have about you with information held by the other member companies.

If, at any time, you decide that you do not want us to use your information as described here, under "Other ways we may use your information," please let us know by calling us at 1-800-663-0417.

Your right to access your information
You have a right to access the personal information that we have about you in your file. If we have information that is not correct, you can have it corrected.

To access your information or to ask us to correct information, you can contact us at:

RBC Life Insurance Company
1122 International Boulevard,
P.O. Box 5044,
Burlington, Ontario
L7R 4C1
Telephone: (888) 604-3434
Facsimile: (888) 349-7773

If you would like more information about client privacy
RBC Financial Group publishes a brochure on client privacy. If you would like a copy of the brochure, you can contact us and we would be pleased to send one to you.

RBC Insurance

CRITICAL ILLNESS RECOVERY PLAN APPLICATION

RBC Life Insurance Company

New Policy ❑ Policy Change ❑ Reinstatement ❑

PART 1 You/Your refers to the Proposed Insured. If there is insufficient space on the Application to answer any question in full, please attach a separate page signed by You.

PROPOSED INSURED

(Check one) MR ❑ MRS ❑ MS ❑ MISS ❑ DR ❑

1. PRINT Name as legally known
   a. Last _____
   b. First & Middle _____
   c. Former Name _____
   d. Birthdate : Mo ____ Day ____ Yr.____ e. Age (nearest) ___
   f. Birthplace: (Province/Country) _____
   g. Sex: M ❑ F ❑
   h. Do You understand English or French? Yes ❑ No ❑
   i. Is a French language policy requested? Yes ❑
   j. Canadian Citizen ❑ Permanent Resident ❑
   Other (specify) ❑_____

2. a. Residence address: Apt No. _____
   b. Street _____
   _____
   c. City _____
   d. Province _____ e. Postal Code _____
   f. Home Phone No. (_____) _____
   g. How long have You resided in Canada? _____yrs.
   h. Aside from vacation, are You planning to travel or live outside of North America? Yes ❑ No ❑
   If "Yes", details _____

OWNERSHIP Complete if the owner is to be other than the Proposed Insured.

3. Proposed Owner _____ Address _____
   Contingent Owner_____ Address _____
   To whom should correspondence be sent? _____

BENEFIT RECIPIENT DESIGNATION

4. Return of Premium benefits are payable to the Proposed Owner. Critical illness benefits will be paid to the Proposed Insured unless the Proposed Owner designates a different Recipient below.

_____ _____
Recipient (Print full first and last name) Relationship

All Recipient designations are revocable except in Quebec where the designation of a legally married spouse of the owner is irrevocable unless expressly stated to be revocable by checking the following box ❑ Revocable.

EMPLOYMENT INFORMATION

5. a. Occupation(s) and duties: _____
   _____
   _____
   b. Number of years in present business? _____

FINANCIAL INFORMATION

6. Your net annual earned income, as declared on Your federal income tax return was:
   Actual Last Calendar Year (specify year) (_____) $ _____
   Net earned income is Your net income after all business expenses, before personal taxes. Do not include other sources of income such as E.I. Benefits, RRSP income, family allowance or any income which is not dependent on Your ability to work.
7. Mortgage on personal residence or cottage: $ _____
8. If the Proposed Insured is not self supporting: What is the gross amount of the family earned income? $ _____

FINANCIAL QUESTIONNAIRE

If Keyperson (including Keyperson replacement or collateral coverage) or Business Loan Coverage applied for, complete the following. (Amounts must be based on most recent financial results).

9. a) Amount of Business Loan $ _____ b) Payback term _____ yrs. c) Loan details _____

   d) Purpose of Loan _____

10. a) Percentage of business owned by Proposed Insured? _____ %

   b) Total Assets $ _____

   c) Total Liabilities $ _____

   d) Book Value $ _____

   e) Fair Market Value $ _____

   f) Gross Revenues $ _____

   g) Net Income after Taxes $ _____

11. If applying for business loan coverage, are all the business owners applying for critical illness coverage? Yes ❑ No ❑

   If "Yes", provide percentage equity of each owner and amount of coverage in force and/or applied for _____

   _____

   If "No", provide reason _____

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

12. Describe **all** coverage in force. Include life and disability coverage under (A) individual, (C) association, (D) group LTD, (E) salary continuation or employer sick pay disability income coverage, (F) overhead expense, (G) buy-out, (K) key person, (L) business loan, (O) accident only (R) critical illness, (V) government plans or other (specify) _____. **If none, write "none".**

Company	Issue Date	Life	Disability	Type of Coverage A, C, D etc.form above	Amount of Coverage (e.g. monthly, lump sum)	Taxable Yes	Taxable No	Elimination Period	Benefit Period	To Be Cont'd Yes	To Be Cont'd No	Replacement Date
						❑	❑			❑	❑	
						❑	❑			❑	❑	
						❑	❑			❑	❑	
						❑	❑			❑	❑	

13. Have You applied for insurance concurrently or within the past six months with any other company? Yes ❑ No ❑ If "**Yes**", give details above.

14. Is policy applied for intended to change any existing insurance? Yes ❑ No ❑ If "**Yes**", give details above.

15. List the number of any policy in force with the Company.
   Indicate if it is to be an internal replacement (IR) or continued (Cont.) No. _____ (_____)

ADDITIONAL INFORMATION

	YES	NO
16. Have **YOU** ever:		
a. Had insurance rated, modified, rejected, cancelled or been denied renewal or reinstatement?	❑	❑
b. Been charged or convicted with any criminal offense?	❑	❑
17. Have **YOU**: within the past five years:		
a. Been charged with or convicted of any driving offenses? If **"Yes"**, give Driver's Licence No. and complete details below.	❑	❑
b. Declared personal or corporate bankruptcy? If **"Yes"**, give discharge date & complete details below.	❑	❑

Have **YOU:**	YES	NO
18 a. Within the past two years engaged in: motorcycle riding, ATV use, scuba diving, bungee jumping, parachuting, hang-gliding, motor vehicle or motorboat racing, rodeo activities, mountain climbing, snowboarding, or any other sport or avocation? Any intention of doing so in the future?	❑	❑
b. Ever piloted a plane, ultralight or glider, or do You have any intention of doing same in the future?	❑	❑

Details to "Yes" answers:

_____

_____

_____

_____

_____

PART 2 : MEDICAL HISTORY (You/Your refers to the Proposed Insured.)

PROPOSED INSURED

Name of Proposed Insured _____

1. Present Height _____ Weight _____
2. Has weight changed within the past year? Yes ❑ No ❑ If "Yes", indicate weight gained _____ or lost _____.
3. Are You presently under observation or treatment, therapy, counselling or taking medication? Yes ❑ No ❑
   If "Yes", give details _____
4. Name(s), complete address(es) and phone number(s), including area code of attending physician(s) or health care facility(ies).
   If none, write "none".
5. Date and reason for last consultation with a physician. _____
   Result: _____
6. Is this Your regular person physician? Yes ❑ No ❑
   If "No" provide complete name, complete address and phone number, including area code of Your personal physician.

MEDICAL DETAILS - Circle appropriate concern and give details of "Yes" answers on Page 4

7. Have **You**:
   a. Used tobacco products, including smoking cessation therapy **within the past 12 months**? If yes please provide details (eg. cigars or cigarettes and number smoked per week or details of smoking cessation therapy)..... Yes ❑ No ❑
   b. Used or smoked marijuana **within the past 12 months**? If yes, please provide details as to when last used and frequency of use..... Yes ❑ No ❑
   c. Ever been advised to quit smoking for health reasons?..... Yes ❑ No ❑
   d. Ever sought or received advice or treatment for the use of habit forming drugs, prescribed or non-prescribed, or used cocaine, barbiturates, marijuana, or any narcotic or habit forming drug?..... Yes ❑ No ❑
   e. Ever had a transfusion of blood or blood products?..... Yes ❑ No ❑
8. Do You consume alcoholic beverages?..... Yes ❑ No ❑
   If "Yes", Indicate weekly quantity and type _____
9. Have You ever sought or received advice or treatment for or been charged with or convicted of any offense relating to alcohol use, or used alcohol excessively?..... Yes ❑ No ❑
10. Have You ever had any known indication of or been treated for:
    a. Acquired immune deficiency syndrome, AIDS related complex or AIDS related conditions or tested positive for antibodies to the AIDS virus?..... Yes ❑ No ❑
    b. Any disease or disorder of eyes, ears, nose or throat (including loss of speech)?..... Yes ❑ No ❑
    c. Chest pain, angina, heart attack, abnormal ECG, irregular pulse, high blood pressure, heart murmur, high cholesterol, peripheral vascular disease, heart or circulatory disorder?..... Yes ❑ No ❑
    d. Kidney stone, albumin, pus, protein, blood or sugar in urine, or any disease or disorder of the kidneys, urinary tract, bladder, prostate, or genital organs?..... Yes ❑ No ❑
    e. Stroke, transient ischemic attack (TIA), cognitive impairment, memory loss, headaches, Parkinson's Disease, Alzheimer's Disease, Motor Neuron Disease, fainting, dizziness, seizures, epilepsy, paralysis, multiple sclerosis, muscle weakness, numbness or tingling of the limbs or any neurological disorder?..... Yes ❑ No ❑
    f. Anxiety, depression, mental or nervous disorder?..... Yes ❑ No ❑
    g. Gout, arthritis, lupus, rheumatism or any disorder of the skin, muscles, bones, joints or spine, amputation, paralysis or deformity?..... Yes ❑ No ❑
    h. Any disease or disorder of the blood or glandular system such as: anemia, enlarged glands, thyroid disease or diabetes?..... Yes ❑ No ❑
    i. A tumour, cancer, polyp, or other growth, any disorder of the skin or lymph glands, blood disorder or any other form of malignant disease?..... Yes ❑ No ❑
    j. Ulcer, any disease of the stomach, pancreas, colon or intestines, colitis, bleeding, liver disease or tested positive for hepatitis and/or been told You are a carrier?..... Yes ❑ No ❑

k. Any disease or disorder of the breast or reproductive organs including lumps, cysts, unusual discharge, other physical changes, abnormal mammogram findings or biopsy? Yes ❑ No ❑

l. Any type of tuberculosis, emphysema, bronchitis, asthma, pleurisy, or any disease or disorder of chest or lungs? Yes ❑ No ❑

11. Within the past five years have You used or are You currently using;

a. Special medical equipment or appliances such as a walker, cane, wheelchair, motorized cart, crutches, hospital bed, stair lift, catheter, oxygen tank, pacemaker, artificial limb or hearing aid? Yes ❑ No ❑

b. Do You need human assistance of any kind to perform any daily acitivities such a bathing, continence, dressing, eating using the toilet or transferring (for example, form chair to bed)? Yes ❑ No ❑

12. Other than the preceding have **You** ever.

a. Had any mental or physical disorder or been examined by or consulted a physician or other practitioner? Yes ❑ No ❑

b. Been under observation, or treatment in any hospital, clinic or other institution of facility? Yes ❑ No ❑

c. Had an X-ray, ECG, blood or urine test, or other diagnostic tests? Yes ❑ No ❑

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

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

f. Had any symptoms or complaints regarding Your health for which You have not yet consulted a physician or received treatment? Yes ❑ No ❑

Give full and accurate details below to any "Yes" answers. For each answer, include question number, symptoms, diagnosis, treatment date and duration of each occurrence, time lost from work, whether recovery is complete and if not, provide details of residuals. Also provide name, complete address and phone number including area code of doctor and medical facilities.

Details: _____

13. Have Your natural parents, brothers, or sisters either living or dead, ever suffered from any of the following conditions: heart or kidney disease, high blood pressure, polycystic kidney disease, stroke, diabetes, cancer, multiple sclerosis, Alzheimer's Disease, Huntington's Chorea, Motor Neuron Disease or any form of hereditary disease? Yes ❑ No ❑

If **"Yes"**, complete chart below:

Family Member Relationship / (Name)	Condition	Age at Onset	Age if Living	Age at death	Cause of death
Father					
Mother					
Brother(s) (No.)					
Sister(s) (No.)					

AGREEMENT

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 & 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 imcomplete 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 broker can authorize or approve of inaccurate or incomplete answers to the questions in this Application, or decide on any issue of insurability, or 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 insurability of the Proposed Insured. The only exception to this is provided in the Conditional Insurance Agreement and Receipt if the premium is paid in advance. I will immediately advise the Company of any changes in the answers to the questions in this 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 Pre-Notice form describing Medical Information Bureau procedures.
9. A photostatic copy of the Application will not be automatically included in the policy (except in the Province of Quebec, in accordance with provincial law). A photostatic copy of the Application will be made available upon request.
10. Any policy(ies) issued by the Company as a result of this Application will provide coverage only for critical illness due directly to: (a) any accidental bodily injury sustained or disease or sickness which first manifests itself after delivery of the policy and while the policy is in force; and (b) unless specifically excluded, any accidental bodily injury sustained or disease or sickness which first manifests itself before delivery of the policy or before the policy is in force if the Proposed Insured has fully and accurately advised the Company, on this Application or otherwise in writing, prior to delivery of the policy, of all information known or reasonably available to the Proposed Insured regarding the injury, disease or sickness, including all signs, symptoms or other manifestations.
11. Delivery of any policy issued with an amendment form is conditional upon execution of the unaltered form by me and return to, and receipt by the Company, failing which the policy will not take effect.
12. I understand that the Company will create and maintain at their office, a file for the purposes of this application and any subsequent claim. Only the employees, mandataries or agents responsible for such purposes will have access to it. 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.

This application will form part of any insurance contract issued. The contract will be of utmost good faith, based upon the statements contained in this Application. I am responsible for the accuracy of the statements and answers even if I have not read them. 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 Conditional Insurance Agreement and Receipt (applicable only if Minimum Payment has been properly made and the Receipt properly detached from the Application).

Signed at: _____ Date : _____
(City/Province) (MM/DD/YYYY)

Proposed Insured (Signature): **X** _____

Proposed Owner (Signature): **X** _____

Note: If 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

Name (Please Print): _____ Signature: **X** _____

Address : _____ Signed at: _____
(City/Province)

Telephone : _____ Date : _____
(MM/DD/YYYY)

Note: Witness cannot be related to the Proposed Insured or Proposed Owner. Witness may be the Producer, if present.

PART 3 : COVERAGE APPLIED FOR AND PREMIUM INFORMATION

COVERAGE APPLIED FOR

Plan	Supplementary Benefits
❑ Non-cancellable 10 Year Term to age 75	Disability Waiver of Premium Rider ❑ Return of Premium on Death Rider ❑
❑ Guaranteed renewable to age 65	Disability Waiver of Premium Rider ❑ Functional Dependence Rider ❑ Return of Premium on Death Rider ❑ Return of Premium on Expiry/Surrender Rider ❑ Scheduled Increase Benefit Rider ❑
❑ Guaranteed renewable to age 75	Disability Waiver of Premium Rider ❑ Functional Dependence Rider ❑ Return of Premium on Death Rider ❑ Return of Premium on Expiry/Surrender Rider ❑ Scheduled Increase Benefit Rider ❑
❑ Guaranteed renewable to age 75 , paid up at age 65	Disability Waiver of Premium Rider ❑ Functional Dependence Rider ❑ Return of Premium on Death Rider ❑ Return of Premium on Expiry Rider ❑ Scheduled Increase Benefit Rider ❑
❑ Non-cancellable to age 75	Disability Waiver of Premium Rider ❑ Return of Premium on Death Rider ❑ Return of Premium on Expiry Rider ❑ Scheduled Increase Benefit Rider ❑
❑ Non-cancellable to age 75 , paid up at age 65	Disability Waiver of Premium Rider ❑ Return of Premium on Death Rider ❑ Return of Premium on Expiry Rider ❑ Scheduled Increase Benefit Rider ❑
❑ Non-cancellable to age 100	Disability Waiver of Premium Rider ❑ Return of Premium on Death Rider ❑ Return of Premium on Expiry/Surrender Rider ❑ Scheduled Increase Benefit Rider ❑

PREMIUM INFORMATION

1. Initial deposit collected? Yes ❑ _____ No (COD) ❑
   If initial deposit collected, it is in exchange for the Conditional Insurance Agreement and Receipt.
   Make cheque payable to RBC Life Insurance Company.

2. PREMIUM MODE
   a. PAC (complete authorization form) ❑
   b. Monthly ❑ Annual ❑ Semi-annual ❑
   c. Standard ❑ d. Select ❑ # _____
   Large Case Discount ❑ # _____ 5% 10% 15% (circle one).
   New group? Yes ❑ No ❑ Existing group? Yes ❑ No ❑ List members in Producer remarks if no transmittal attached.

COMPLETE IN ALL CASES - 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, 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 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 to 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 Application.

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, which 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 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 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 Medical Information Bureau Inc. (M.I.B.); and also to any other person, agency, credit bureau or institution having information, records or data regarding me.

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 and for the purpose of evaluating any claim for benefits or to assess the validity of the policy as issued.

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 Medical Information Bureau Inc., and to other insurance companies or any reinsurer.

This authorization is valid until revoked by me in writing.

A photocopy of this authorization, as executed by me, will be as valid as the original.

Dated at _____ this _____ day of _____ year _____
(Province/City) (Month)

_____ _____
Signature of Proposed Insured Signature of Witness

COMPLETE IN ALL CASES - 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, 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 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 to 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 Application.

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, which 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 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 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 Medical Information Bureau Inc. (M.I.B.); and also to any other person, agency, credit bureau or institution having information, records or data regarding me.

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 and for the purpose of evaluating any claim for benefits or to assess the validity of the policy as issued.

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 Medical Information Bureau Inc., and to other insurance companies or any reinsurer.

This authorization is valid until revoked by me in writing.

A photocopy of this authorization, as executed by me, will be as valid as the original.

Dated at _____ this _____ day of _____ year _____
(Province/City) (Month)

_____ _____
Signature of Proposed Insured Signature of Witness

Pre-Authorized Chequing (PAC) Agreement

Ensure you read & understand the section "Your Privacy Matters to Us"

The Payor(s) named below agrees that:

1. (a) RBC Life Insurance Company (RBC Insurance) is authorized to make scheduled withdrawals to pay the premium for this policy or policies, against the account at the financial institution below, or any other financial institution that the Payor may later designate, in accordance with the rules of the Canadian Payment Association ("CPA").
   (b) such withdrawals will be on dates and in amounts in accordance with the premium schedule set out in this policy or policies,
   (c) if the amount of withdrawal should vary, pre-notification by RBC Insurance is waived,
   (d) the financial institution indicated below is authorized now or of any subsequent time to honour any requests made by RBC Insurance to withdraw from the account indicated below, including a representment or redraw within 30 days should any withdrawal not clear the account,
   (e) 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(ies),
   (f) notification of any change to the account information provided below, shall be given to RBC Insurance by the Payor 5 days prior to the next scheduled withdrawal. I/We agree that from time to time I/we may authorize RBC Insurance to deduct such payments from another account upon my/our oral or written instructions,
   (g) this Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Insurance or by the Payor,
   (h) A PAC may be disputed by the undersigned under the following conditions:
      i) If the PAC was not drawn in accordance with this Agreement; or
      ii) If this Agreement was revoked.

In the event that either (i) or (ii) applies, the Payor agrees to contact RBC Insurance. If a satisfactory resolution cannot be achieved between the Payor and RBC Insurance, then in accordance with CPA rules, in order to be reimbursed, the undersigned acknowledge(s) that a declaration to the effect that either (i) or (ii) took place, must be completed and presented to the branch holding the account up to and including 90 calendar days in the case of a personal PAC (or up to and including 10 business days in the case of a business PAC), after the date on which the PAC in dispute was posted to the account below.

I/We acknowledge that a claim on the basis that this agreement was revoked, or any other reason, is a matter to be resolved solely between me/us and RBC Insurance when disputing any PAC after the 90 calendar days in the case of a personal PAC (or up to and including 10 business days in the case of a business PAC).
(i) the names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

2. Add to existing PAC 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).

Name of Bank or Financial Institution	Transit Number	Bank Number	Account Number

Address _____

City _____ Province _____ Postal Code _____

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

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

_____ _____
Signature of Payor Signature of Second Payer (if any)

APPLICATION FOR CONDITIONAL INSURANCE ON CRITICAL ILLNESS APPLICATIONS

(NOT AVAILABLE FOR INFORMAL INQUIRIES)

DO NOT DETACH

To be answered by the Proposed Insured	Yes	No
1. Have You ever been treated for or had any indication of heart or circulatory disease, Parkinson's Disease, Alzheimer's Disease, Huntington's Chorea, heart attack, chest pain, abnormal ECG, stroke, transient ischemic attach (TIA), multiple sclerosis, paralysis, blindness, deafness, diabetes, elevated blood pressure, chronic kidney, liver or lung disease?	❑	❑
2. To the best of Your knowledge and belief, have You had any symptoms of or treatment for cancer or tumour, AIDS, ARC or HIV infections?	❑	❑
3. Have You had any symptoms of or treatment for any medical condition that resulted in hospitalization (other than normal childbirth) within the last two years?	❑	❑
4. Have You been absent from work for more than 7 days within the last 6 months because of sickness or injury?	❑	❑
5. Are You over age 65?	❑	❑
6. Has any application for insurance on Your life ever been rated, declined or modified in any way?	❑	❑
7. Are You aware of any symptoms for which You have not yet sought treatment or for which treatment is planned or pending?	❑	❑

THE CONDITIONAL INSURANCE AGREEMENT WILL ONLY BE GIVEN IF ALL OF THE ABOVE QUESTIONS ARE ANSWERED "NO" AND WILL ONLY BE VALID AND ENFORCEABLE IF SUCH ANSWERS ARE TRUE.

An applicant is only eligible to be considered for conditional insurance where the total amount of insurance under all plans being applied for from the Company is $250,000.00 or less and the Proposed Insured is under the age of 65 years. When conditional insurance is available and the Company agrees to grant conditional insurance, the amount of such conditional insurance provided will be the aggregate of all amounts applied for shown on the Application, but such conditional insurance shall not exceed the amount of $250,000 in cases where the aggregate amount applied for exceeds that amount. This Application for Conditional Insurance may be completed only at the time of completion of the insurance Application and payment of the first premium must be made on the same date. If the Proposed Insured dies or suffers a Critical Illness by an act of self destruction, whether intentional or not, the Company's liability is limited to a refund of the payment made.

I agree to the terms and conditions of the Conditional Insurance Agreement as set out below.

Date at _____ (CITY/PROVINCE) this _____ (DAY) day of _____ (MONTH) _____ (YEAR)

X _____ (SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED))

X _____ (SIGNATURE OF PROPOSED INSURED)

CICIA (05/04)

CONDITIONAL INSURANCE AGREEMENT AND RECEIPT ON CRITICAL ILLNESS APPLICATIONS

(TO BE LEFT WITH INSURED IF DEPOSIT SUBMITTED AND APPLICATION FOR CONDITIONAL INSURANCE IS COMPLETED)

The Company agrees to provide conditional insurance on the Proposed Insured named in the Application made on the date of this Agreement payable only for a single occurrence of one of the Critical Illnesses defined in the contract to the Beneficiary named in the Application, subject to the conditions set out below.

TERMINATION OF CONDITIONAL INSURANCE

1. Conditional insurance terminates automatically when a Policy providing insurance as a result of the Application becomes effective.
2. The Company may terminate conditional insurance by mailing a notice to that effect addressed to the Owner (termination being effective on mailing), in which event any money paid will be refunded. Termination shall take place notwithstanding that such refund has not yet been received by the Proposed Insured.
3 In any event, conditional insurance will terminate automatically on the expiration of ninety days from the date of this Agreement.

CONDITIONS

1. There will be conditional insurance available on the Proposed Insured only, and only if he or she is under the age of 65 years on the date of this Agreement and if the total amount of insurance being applied for is $250,000.00 or less.
2. Insurance under only one Conditional Insurance Agreement can be in effect on the Proposed Insured. If more than one Application for Conditional Insurance is submitted, effect will be given only to the one with the higher face amount.
3. Conditional Insurance is not provided for any Disability Insurance or any supplementary benefit.
4. At least 10% of the aggregate yearly premium for the amount of the Basic Plan or one month's premium for monthly premium mode must have been paid to the Company at the time of completion of the Application.

LIMITATIONS

1. No payment will be made under this Agreement for any diagnosis of cancer.
2. No payment will be made under this Agreement if death occurs within 30 days of the diagnosis of the defined critical illness.
3. If the Proposed Insured dies or suffers a covered critical illness as a result of an act of self-destruction, the Company's liability is limited to a refund of the payment made. An act of self-destruction occurs when the Insured, whether sane or insane, takes or attempts to take his/her own life or inflicts injuries on his/her own person, and the death or injury of the Insured results directly or indirectly from, or is in any manner or degree associated with, or occasioned by, the actions described previously, no matter when death or injury occurs.
4. There is no coverage under this Agreement if the cheque submitted as payment is not honoured on presentation.
5. No person has the authority to modify or waive any requirements of conditions of this Agreement.

It is acknowledged that the sum of $ _____ was paid to the Company at the time of the completion of this Application.

Date _____ (MM/DD/YYYY) Signature of Producer X _____

Detach and give to Proposed Insured

Consumer Fact Sheet

PRE-NOTICE

Information regarding your insurability and claims will be treated as confidential. The Company or our reinsurers may however, make a brief report thereon to Medical Information Bureau (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 disability 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 the MIB file, you may contact MIB, and seek a correction.

The address of MIB's information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7. Telephone No. 416-597-0590. Web site: http://www.mib.com We may also release information in our files to our reinsurers and/or other life insurance companies to whom you may apply for life or disability insurance, or to whom a claim for benefits may be submitted.

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 five 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. 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 interview will only be conducted directly with you.

Any information obtained during the PHI interview 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.

Disclosure Statement for the Province of British Columbia

Pursuant to S.90 of the Financial Institutions Act of British Columbia, the financial product you are being offered is supplied by RBC Life Insurance Company, a company licensed to carry on business in British Columbia.

In relation to any application you may make for the acquisition of life insurance, annuities or other financial products:

- I am acting as a licensed insurance representative on behalf of this company;
- I will be entitled to receive commission from the company on successful completion of this transaction. This commission may take the form of an acquisition commission and/or an on-going service commission; and
- there is no condition associated with this transaction requiring that you must transact additional or other business with either myself or the company.

Dated at _____ this _____ day of _____ Year _____
City/Province

_____
Signature of Representative

Dated at _____ this _____ day of _____ Year _____
City/Province

_____
Signature of Representative

RBC Insurance

1122 International Boulevard, P.O. Box 5044, Burlington, Ontario L7R 4C1 • 905-319-9501

REPRESENTATIVE'S REPORT

1. How long have you known the Proposed Insured ? years

2. Were the negotiations for this Application started by: You? ❑ Proposed Insured? ❑ Proposed Owner(s)? ❑

3. The Proposed Insured may be contacted by telephone for a Personal History Interview.
What is the most convenient time to contact them? Business ❑ Residence ❑ at local time.

4. Have you collected money? Yes ❑ No ❑

If yes, indicate amount collected $ Date received (mm/dd/yyyy)

5. Do the Proposed Insured and the Proposed Owner(s) 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.

6. Back date to save age? Yes ❑ No ❑
(Age is calculated based on the Age Nearest on the underwriting decision date, not the application date.)

Other special date required:

7. Evidence: The following requirements have been ordered:

Blood Profile ❑ ECG ❑ Medical Exam ❑ MVR ❑ Para-medical ❑ Urine-HIV ❑ Other (specify) ❑

Para-medical company used:

8. **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 regards to Advisor Disclosure, including providing an Advisor Disclosure Statement in writing to the Proposed Owner.

Date (dd/mm/yy)				
Representative's Signature				
Representative's Name				
Representative's Company Name				
Marketing Office				
Share	%	Servicing Representative Code	%	Representative Code

Please use this space for any special instructions or additional information which would be helpful in the underwriting of this risk. (e.g. occupation, aviation, avocation, purpose of insurance, amount, income, health problems, habits, finances, replacement, insurable interest.)

Have you detached and given to the applicant:

Medical Information Bureau's Pre-Notice ❑ CIA receipt (if applicable) ❑

Have you attached to the application:

Supplementary questionnaires (if required) ❑ Disclosure forms (Prior Notice of Replacement form in Quebec) (if applicable) ❑

Payment for the first month or CIA (if applicable) ❑ A void cheque with legible banking codes (if using PAC) ❑

RBC Insurance