



## NOTICE OF FACILITY CARE

**CLAIMANT'S STATEMENT** (please print)

Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Policy Number \_\_\_\_\_

Home Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Power of Attorney Granted to (please attach proof of Power of Attorney if applicable) \_\_\_\_\_

Address of Power of Attorney \_\_\_\_\_

Telephone Number of Power of Attorney \_\_\_\_\_

Diagnosis \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_

Do you currently need another person's help in performing any activities of daily living, such as  bathing  dressing  
 toileting  eating  walking indoors  transferring from bed to chair  controlling bladder or bowel functions  
 taking medications as prescribed? \_\_\_\_\_

Name of Facility \_\_\_\_\_

Date Entered into Facility \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

List services provided to residents \_\_\_\_\_

Does this facility have a provincial license? \_\_\_\_\_ License Number \_\_\_\_\_

Do you own Long Term Care coverages of any kind with any other Insurance Company? Yes  No  If yes, complete below:

Name of Company	Weekly/Monthly Amount of Benefit	Waiting Period for Benefits
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize any health care professional, health or social service establishment, insurance company, the Medical Information Bureau, financial institution, personal information agents or security agencies, my current employer or any former employer and public body holding personal information concerning me, particularly medical information, to supply this information to RBC Life Insurance Company and its reinsurers. Such information will be provided for investigations necessary to adjudicate my claim or assess the validity of the policy as issued.

I understand that if I refuse to provide this information, RBC Life Insurance Company will be unable to adjudicate my claim or assess the validity of the policy as issued.

A photocopy of the signed authorization to obtain this information will be as legally valid as the original.

This authorization will be valid until revoked by written notice to RBC Life Insurance Company.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF CLAIMANT

\_\_\_\_\_  
SOCIAL INSURANCE NUMBER