RBC Insurance

Long Term Care Questionnaire

In order for us to assess your claim, kindly have <u>your care provider</u> answer the following questions:

1. Is this a claim for: Facility Care ☐ Home Care ☐

2. Name of Insured: Date care commenced:

_____ _____

3. Name, address and telephone number of Facility / Home Care Provider:

_____

4. Current proof of payment made to the above Facility / Home Care provider ***(please attach copies of cheques/receipts, admission statements and invoices – kindly note that without these documents, we will be unable to assess this claim*)**

5. **Is the Insured able to perform the following activities independently?**

ACTIVITY	YES	NO
Walking (details/comments):		
Bath (details/comments):		
Transferring from a bed or chair (details/comments):		
Dressing (details/comments):		
Toileting (details/comments):		
Eating (details/comments):		
Taking Medications (details/comments)		

6. Please describe the type of care you are providing or attach a copy of your Plan of Care:

Name and Signature of Director of Patient Care (if Facility Care) _____

Name and Signature of Home Care Provider (if Home Care) _____

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RBC Life Insurance Company
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