RBC Insurance®

Declaration of Insurability for Reinstatement or Change to RBC Life Insurance Company

Policyowner(s)	Social Insurance Number*	Policy Number

* Necessary for change to policies that require annual reporting for income tax purposes.

Policyowner Address

Life Insured (complete a separate form for each life insured)	Date of Birth
	day/month/year

SECTION A Request for Reduction** in Coverage (also complete Section H)

- ☐ Reduce Sum Insured from $ ________ to $ ________
- ☐ Remove a Life Insured (full name)
- ☐ Apply the Cash Value of my policy to provide REDUCED PAID UP INSURANCE according to the policy's non-forfeiture clause.
- ☐ Increase Waiting Period (DI/LTC) from ________ to ________
- ☐ Decrease Benefit Period (DI/LTC) from ________ to ________
- ☐ Decrease Benefit Amount (DI/LTC) from ________ to ________
- ☐ Occupational Class (Lower Risk) from ________ to ________

Complete Section G and state date of change: ________

SECTION B Exercise GIB Option (also complete Section H for disability policies)

- ☐ Exercise Life GIB option $ ________
- ☐ Exercise Disability GIB option (complete Section G and provide proof of income for last 2 years) $ ________

SECTION C Cancellation of the Following Benefit Requested (also complete Section H)

☐ Waiver of Premium ☐ Accidental Death Benefit ☐ Death and Dismemberment Benefit

☐ Rider(s): ________

SECTION D Exchange Requested**

☐ Exchange Plan Requested: ________

In the Province of Quebec only:

If the policy is jointly owned, what is the relationship of the Joint Owners? Spouse/Common Law ☐ Other ☐

****For conversion requests, please use the new form entitled "Request to Exercise a Term Conversion Privilege" located on the RBC Insurance Sales Resource Center.**

SECTION E Other Changes Requested (also complete Sections F, G, and I and applicable medical questionnaires)

- ☐ Reinstatement of the above named policy
- ☐ Remove Exclusion
- ☐ Remove Rating
- ☐ Change to Non-Smoker Rates – urine specimen required
  (for juvenile policies use the Non-Smoker Declaration for Juvenile Policies Only form)
- ☐ Change on Preferred Product – underwriting required

SECTION F Declaration of Insurability – questions to be answered by the Life Insured:
(Provide details for YES answers in the space provided or complete questionnaire where indicated *)

1. Since the date of the application for the original policy, have you:

a) participated in any hazardous occupation, activity, sports or flown in any type of aircraft for reasons other than as a fare paying passenger? (*If yes, complete applicable avocation form – i.e. Aviation Questionnaire, Scuba and Skin Diving Questionnaire, etc.) ☐ Yes ☐ No

b) applied for life, disability, critical illness or long term care coverage which is presently pending? (If yes, state company, amount of coverage applied for, and total amount of coverage to be placed with all companies.) ☐ Yes ☐ No

c) had any application for insurance declined, postponed, modified or rated? ☐ Yes ☐ No

d) made a claim or received a pension, income replacement benefit, compensation, or been off work for more than 10 days for any sickness, accident or injury? ☐ Yes ☐ No

e) consulted a doctor for treatment or testing for any symptoms, disease, disorder or accident? ☐ Yes ☐ No

2. Have you travelled outside of North America in the past 24 months or have any plans to do so in the next 24 months? (If yes, provide details including countries, cities, purposes, dates, duration of trips, accommodations and mode of transport.) ☐ Yes ☐ No

3. Have you ever sought advice or received treatment for, or had any known indication of:

a) heart attack, heart murmur, high blood pressure, elevated cholesterol, abnormal EKG, chest pain*, angina, rheumatic fever, palpitations or any other disorder of the heart, blood vessels, or circulatory system? (*If yes, complete Chest Pain Questionnaire.) ☐ Yes ☐ No

b) diabetes*, anaemia, gout, skin disorders, severe burns, thyroid disorder, bleeding tendency, leukemia, or other glandular system or blood disorder? (*If yes, complete Diabetes Questionnaire.) ☐ Yes ☐ No

c) ulcer, intestinal bleeding, colitis, diverticulitis, gallstones, jaundice, or other disorder of the liver, pancreas, gallbladder, stomach or intestines? (If yes, complete Gastrointestinal Disorder Questionnaire.) ☐ Yes ☐ No

d) dizziness, paralysis, convulsions*, seizures*, multiple sclerosis, stroke, epilepsy*, loss of speech, numbness, coma, motor neuron disease, fainting*, headache, Alzheimer's Disease or other disorder of the brain or nervous system, tremor, Parkinson's disease, muscle weakness, or Transient Ischemic Attack? (*If yes, complete Seizure Disorder Questionnaire or Loss of Consciousness Questionnaire.) ☐ Yes ☐ No

e) kidney stone, sugar, blood, pus or albumin in urine, or any disorder of the kidney, bladder, prostate or reproductive organs or any sexually transmitted disease? ☐ Yes ☐ No

f) arthritis, rheumatism, neuritis, sciatica, or other disorder of the muscles, bones or joints, systemic lupus erythematosus (SLE), lupus in any form, fibromyalgia or loss of limb? ☐ Yes ☐ No

g) bronchitis, asthma, pleurisy, emphysema, shortness of breath, chronic or persistent cough, pneumonia, tuberculosis, chronic lung disorder or any disorder of the chest or lungs, or sleep apnea? (If yes, complete Respiratory Disorder Questionnaire.) ☐ Yes ☐ No

h) cancer, tumour, cysts, polyps, or any other growth or malignancy? ☐ Yes ☐ No

i) anxiety, depression, suicidal tendencies or feelings or any emotional, behavioural, mental or nervous disorder, or chronic fatigue? (If yes, complete Nervous Disorder Questionnaire.) ☐ Yes ☐ No

j) any type of back or spinal trouble including sprains, strains, or disc disease? (If yes, complete Back & Neck Pain Questionnaire.) ☐ Yes ☐ No

k) any disease, disorder or impairment of eyes, ears, nose or throat including loss of speech? ☐ Yes ☐ No

4. FAMILY HISTORY: Have any of the Proposed Life Insured's natural parents or siblings, either living or dead, ever suffered from any of the following conditions: heart disease, high blood pressure, kidney disease, stroke, diabetes, multiple sclerosis, Alzheimer's Disease, Parkinson's Disease, cancer (specify type), hepatitis or polycystic kidney disease, Huntington's Chorea or any other hereditary disorder? ☐ Yes ☐ No

If YES, complete table:

Family Member Relationship	Age If Living	Disease	Age At Onset	Cause Of Death	Age At Death

5.	Have you ever had, or been immunized against hepatitis, or been told that you are a hepatitis carrier?	☐ Yes	☐ No
6.	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician?	☐ Yes	☐ No
7.	Other than above, have you within the past 5 years:		
a)	had any mental or physical disease or disorder?	☐ Yes	☐ No
b)	consulted a physician or other practitioner?	☐ Yes	☐ No
c)	been a patient in a hospital, clinic, sanatorium or other medical facility?	☐ Yes	☐ No
d)	had an electrocardiogram, x-ray, blood test or other diagnostic test?	☐ Yes	☐ No
8.	Have you ever used illegal or habit forming drugs or received counselling or medical advice for drug addiction? (*If yes, complete Drug Usage Questionnaire.)	☐ Yes	☐ No
9.	Do you drink alcoholic beverages? (If yes, provide weekly quantity and type in Details section.)	☐ Yes	☐ No
10.	Have you ever received counselling or medical advice pertaining to your consumption of alcohol? (*If yes, complete an Alcohol Usage Questionnaire.)	☐ Yes	☐ No
11.	Please state your height and weight: Height: Weight:		
12.	In the past 3 years have you had your driver's licence suspended or been charged with any moving violations? Driver's Licence Number:	☐ Yes	☐ No
13.	In the past 10 years have you been charged with driving while impaired? (If yes, provide details.) Driver's Licence Number:	☐ Yes	☐ No
14.	Have you ever declared personal or corporate bankruptcy?	☐ Yes	☐ No
15.	Have you ever been charged or convicted of a criminal offence or are there any criminal charges pending? (If yes, please explain.)	☐ Yes	☐ No

Details to "YES" answers from Section F

Question #	Condition	Date of Onset	Date of Full Recovery	Treatment, Medication or Other Details

16. Attending Physician (If none, please provide name and address of last Doctor or Medical Facility consulted)

Name of Attending Physician	Address of Attending Physician	
Date of Last Visit	Reason for Last Visit	Results of Last Visit

17. Smoking Status (The history listed below is relied upon to establish the policy's premium rate and is material to the insurance risk. Failure to make proper disclosure below will entitle us to render the policy null and void.)

Indicate if you have ever used any of the following and if so, the quantity and date last used:

Types of substances			Quantity	Date Last Used
Cigarettes	☐ Yes	☐ No		
Cigarillos	☐ Yes	☐ No		
Cigars (any types)	☐ Yes	☐ No		
Nicotine substitutes (e.g. Zyban, patches, gum)	☐ Yes	☐ No		
Chewing tobacco	☐ Yes	☐ No		
Pipe	☐ Yes	☐ No		
Marijuana	☐ Yes	☐ No		
Other (e.g: betel nuts)	☐ Yes	☐ No		
Did you stop smoking on doctor's orders?	☐ Yes	☐ No		

If yes, give name and address of doctor: ____________________

SECTION G

a)	Occupation :		
b)	Duties (full list):		
c)	Employer:		
d)	Are you now actively working on a full-time basis?	☐ Yes – how many hours per week?	
		☐ No – provide details:	

SECTION H Please complete this section for Disability Policies

a) Are you eligible for EI or WCB/WSIB?	☐ Yes ☐ No				
b) Do you currently have any Disability Income coverage (including Group or Association)?	☐ Yes → ☐ No	Monthly Benefit:	Waiting Period:	Benefit Period:	Are these benefits taxable? ☐ Yes ☐ No
c) Average monthly income before income tax (less business expenses, if self employed)?	$				

SECTION I Declarations and Signatures

I/We hereby certify that the statements and answers recorded on this declaration are true and complete.

I/We acknowledge that RBC Life Insurance Company ("RBC Insurance") will be entitled to render this policy null and void if I/we or the insured have made a misrepresentation in any part of the declaration for insurance, medical examination, or any questionnaire completed in connection with this declaration that is material to the insurance risk, provided that RBC Insurance cannot contest any statement made by me/us or an insured, other than fraudulent statements, once the insurance coverage has been effective during the lifetime of the insured for two years following the later of:

- the policy or coverage effective date; or
- the effective date of any reinstatement; or
- the effective date of any addition or increased amount in coverage.

However the policy will remain contestable if a claimed disability or critical illness arises before the end of the two year period.

Insurance is a contract based on trust. Failure to fully disclose facts material to this application could make your contract void.

The parties hereto have expressly requested this contract and all documents relating thereto to be drawn up in the English language. Les parties aux présentes ont expressément demandé que ce contrat et tous les documents qui s'y rapportent soient rédigés en langue anglaise.

The Life Insured and/or the Policyowner do hereby agree that:

RBC Insurance shall have the right to effect the change indicated above, either by cancellation of the present policy and issuance of a substitute policy, (in which case, the policy is deemed surrendered to RBC Insurance), or by the amendment of the present policy.

The present policy shall continue subject to its provisions, until the change requested becomes effective. The application for the present policy, this request and any statements and answers made with regard to this change shall form the basis of the contract.

If a substitute policy is issued, or the present policy is amended, and contains a copy of this application for change with changes noted in the space entitled "Corrections and Amendments", the Policy owner will either accept the policy or return it to RBC Insurance within 10 days after receipt. The Policyowner shall be presumed to have ratified the changes indicated, and to have accepted the substituted or amended policy, which will then be effective provided all premiums due as a result of this change have been paid.

Signed at ______________________ this ______________ day of ____________________ 20 __________

Life Insured Signature	Policyowner signature For corporate owned policies, include title of signing officer
Irrevocable or Preferred Beneficiary Signature (if applicable)	Assignee Signature (if applicable)
Writing Representative (print name)	Representative Signature
Representative Code (print code #)	Agency (if applicable)

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 the MIB, Inc.; 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 MIB, Inc., and to other insurance companies or any reinsurer.

The authorization to obtain information is valid until revoked by me in writing.

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

Signed at ____ this ______ day of _____________________________ 20 _________
City/Province

____ ____
Signature of Life Insured Signature of Witness

Pre-Authorized Debit (PAD) Agreement

Ensure you read and understand the section entitled “Collection and Use of Personal Information”

The Payor(s) named below agrees that:

1. (a) RBC Life Insurance Company (RBC Life) is authorized to make scheduled monthly withdrawals to pay the premium in accordance with the premium schedule set out in this policy/policies, including the initial premium if requested in this Application, against the account at the financial institution below, or any other financial institution that the Payor(s) may later designate.

   (b) **RBC Life is not required to provide notification before the Temporary Insurance Agreement premium and/or the initial premium is debited, or if the amount of withdrawal should vary.**

   (c) 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/policies.

   (d) the financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Life to withdraw premium or fees from the account indicated below, which may include a redraw within 30 days should any withdrawal not clear the account,

   (e) notification of any change to the information provided below, shall be given to RBC Life by the Payor(s), at a minimum of 5 days prior to the next scheduled withdrawal. The Payor(s) agrees that from time to time they may authorize RBC Life to deduct such payments from another account upon the Payor’s oral or written instructions.

   (f) this Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Life or by the Payor(s). The Payor(s) may obtain further information on their right to cancel a PAD agreement by visiting the Canadian Payments Association website at www.cdnpay.ca."

   (g) In the event that a PAD is disputed, the Payor(s) agrees to contact RBC Life. For recourse purposes, this PAD is considered a Personal PAD.

   The Payor(s) has certain recourse rights if any debits do not comply with this agreement. For example, the Payor(s) has the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on recourse rights, the Payor(s) may contact their financial institution or visit www.cdnpay.ca.

   (h) the names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

2. Add to existing PAD with policy number(s) ______________________

3. Special Requests (withdrawals are limited between the 1st – 28th of the month) ______________________

Bank Information:

Please attach a sample 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 Payor (if any)

THE FOLLOWING PAGES MUST BE LEFT WITH THE PROPOSED LIFE INSURED

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.

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

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Pre-Notice to Applicants Regarding the Medical Information Bureau

Information regarding your insurability will be treated as confidential. RBC Life Insurance Company (RBC Life) or its reinsurer(s) may, however, make a brief report thereon to the 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 health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information on its file.

Upon receipt of a request from you, MIB will arrange a disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information Office is: MIB, Inc., 330 University Avenue, Toronto, Ontario M5G 1R7 – Telephone (416) 597-0590. Web site: http://www.mib.com

RBC Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.