



RBC Insurance

Long Term Care Questionnaire

In order for us to assess your claim, kindly have your care provider 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) _____