Royal Bank of Canada

Business Loan Insurance Plan
Disability Insurance Claim

Group Policy 52000

Before submitting a disability claim:

- Complete and sign the Claimant's Statement for Disability.
- Sign and complete Section 1 of the Initial Disability Insurance Medical Statement.
- The doctor must complete Section 2 of the Initial Disability Insurance Medical Statement with as many details as possible.
- The complete disability claim form consists of 3 parts
  - Employer's Statement
  - Claimant's Statement, and
  - Initial Disability Insurance Medical Statement

RBC Life Insurance Company can only process your claim when we have received all 3 parts fully completed. To prevent delays, please be sure the forms are completed in full and provide as much information as possible to help with the adjudication of the claim.

- As our consulting physicians do not examine you, we depend on the quality of the medical information given by your doctor to assess your claim.
- RBC Life Insurance Company evaluates the information included on the statements and determines if you are medically unable to work.

Please send the completed forms to:

RBC Insurance Services Inc.
Insurance Service Centre
PO Box 53, Postal Station A
Mississauga, ON L5A 2Y9

If you have any questions call the Insurance Service Centre toll-free at:
1-800 ROYAL 2-3 (1-800-769-2523) or send a fax to: **1-800-864-6102.**

Until your claim is approved:

- RBC Life Insurance Company will inform you if further information is required in order to assess your claim.
- You are responsible for continuing to make your loan payments in full until your claim is assessed and benefit payments begin.

Important Notes:

- Proof of claim must be submitted within 150 days of the date of disability.
- There is a 60 day waiting period. If your claim is approved, payment of benefits will commence after completion of the waiting period.
- Any costs for information to substantiate the claim are your responsibility.
- Section 2 of the Initial Disability Insurance Medical Statement must be completed by a licensed Doctor of Medicine.
- It is your responsibility to notify RBC Life Insurance Company of your return-to-work date.

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Employer's Statement

To be completed by claimant if self-employed and submitted with the documentation described below. Proof of claim must be submitted within 150 days of the date of disability.

Instructions

The "Employer's Statement" must be fully completed, making sure all questions are answered. Please be sure to sign and date the Certification.

Employee Information

Employee's Last Name	Employee's First Name	Employee's Middle Name	Date of Birth (YYYY-MM-DD)
Address	City or Town	Province	Postal Code
Telephone Number	Email Address	Is this Employee employed in the business as a family member? ☐ Yes ☐ No	
Employee's commencement date of employment (YYYY-MM-DD)	Employee's last scheduled working day (YYYY-MM-DD)	Employee's last day worked (YYYY-MM-DD)	

Work Details

What was the reason for discontinuing work?

☐ Vacation ☐ Lay-off ☐ Leave of absence ☐ Disability ☐ Other/Specify:

Date employee is expected to return to work **Full-time** (YYYY-MM-DD)	Date employee is expected to return to work **Part-time** (YYYY-MM-DD)	Date employee returned to work **Full-time** (YYYY-MM-DD)	Date employee returned to work **Part-time** (YYYY-MM-DD)

If the disability is the result of an accident, have you submitted a report of this accident to WCB/WSIB?

☐ Yes ☐ No

What was the employee's occupation or assignment at the date he/she ceased work?
RBC Life Insurance Company requires a copy of the employee's job description, if none is available then list all essential job duties performed.

Employment type?

☐ Full-time ☐ Part-time ☐ Seasonal

Indicate number of hours worked per week

If seasonal, indicate inclusive annual dates of employment (YYYY-MM-DD):
From To

Where does he/she conduct business?

☐ Home office ☐ Business office ☐ Other: _____

Give dates and details of sick leave during the 12 months preceding commencement of disability.

If he/she changed occupations or assignments during the 12 months before ceasing work, describe the previous occupation or assignment and give the reason for change and the effective date of this change. Include changes to his/her hours worked per day/week.

If you are self-employed: The eligibility requirements of this contract state that you must be working a minimum average of 20 hours per week in order to qualify for this insurance. If you are self employed, we must confirm the above. We require a copy of your income tax report you filed last year and all pay stubs for the period from the last calendar year to the date of disability.

Certification and Signature

I certify that, according to the records of this organization, the above information is correct.

Name of Employer	Telephone Number	Fax Number	Email Address
Address	City or Town	Province	Postal Code

Signature of Authorized Official

Name:

Title:

Date: YYYY MM DD

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Claimant's Statement

Proof of claim must be submitted within 150 days of the date of disability.

Instructions

- The "Claimant's Statement" must be fully completed, making sure all questions are answered. Please be sure to sign and date the Claimant Authorization.
- Print clearly in block letters.

Is a separate Accidental Dismemberment Claim being submitted as well? ☐ Yes ☐ No

Claimant Information

Claimant's Last Name	Claimant's First Name	Claimant's Middle Name	Date of Birth (YYYY-MM-DD)	Claimant's SRF Number

Mailing Address (number and street)	City or Town	Province	Postal Code

Sex	Language	Telephone Number	Email address
☐ Male ☐ Female	☐ English ☐ French		

Business Name	Business SRF Number	Business Loan Number

Details of Disability

To your knowledge, what is the diagnosis of your illness/injury?	What treatment are you receiving at present (medicine, diet, advice, physiotherapy)?
What, if any, restrictions has your physician placed on your work activities?	What occupational duties are you no longer able to perform as a result of your condition?
On what date did the first symptoms of your illness or injury appear? (YYYY-MM-DD)	Date on which you first consulted a physician for your present illness or injury (YYYY-MM-DD)

If the disability is due to an accident, where did the accident happen? ☐ At Home ☐ At Work ☐ Elsewhere (Where)?	Date of accident (YYYY-MM-DD)	How did the accident/injury happen?
If a motor vehicle accident, were you the operator of the vehicle? ☐ Yes ☐ No If **yes,** forward copies of the police accident report if possible	From what date have you been totally and continuously disabled from performing your occupation? (YYYY-MM-DD)	

Are you now

☐ House confined? ☐ Bed confined? ☐ Hospital confined? ☐ Mobile?

Describe your daily activities

Have you performed any work or activities for compensation or profit since becoming disabled? ☐ Yes ☐ No

If **yes,** please give details

On what date do you expect to be able to resume active employment, either full or part time? (YYYY-MM-DD)

Give names and addresses of all physicians who you consulted with or sought treatment from during your present illness or injury.

Name of Physician	Address

Give names and address of all physicians who you consulted with or sought treatment from in the **past three years** and provide details.

Nature of Illness/Injury	Dates of visits/treatments	Treatment prescribed (medicines, diet, etc.)	Name and addresses of Physicians

If as a result of any of these prior illnesses/injuries, a change in habits or work restrictions were advised, please describe what the changes were and from what date.

List any surgery performed during any hospitalizations in the past three years.

Type of surgery	Date of surgery	Name of hospital	Name of surgeon

If the Initial Disability Insurance Medical Statement is not being sent with this claim form, is your doctor sending it directly?

☐ Yes ☐ No If no, please explain

Please indicate the policy numbers of any group or individual insurance policies under which you are insured by RBC Life Insurance Company.

Claimant Authorization

Fraud Notice

Any person who knowingly files a Claimant's Statement containing false or misleading information is subject to criminal and civil penalties.

_____ , declare that the above statements are true and complete to the best of my knowledge and belief.
(Print Name)

Signature of Claimant

Name:

Date: YYYY MM DD

Authorization

I understand and authorize the Company (the Company refers to and includes each of RBC Life Insurance Company, RBC Insurance Services Inc., and the service providers and representatives which they engage or employ) to conduct such investigation as is necessary, to gather personal information concerning me from third party sources, including the collection of any personal information that is available online, including, without limitation, news websites, social media, professional or business directories and public registries, and to disclose as necessary to third parties that I am making a claim to the Company for benefits and relevant information concerning that claim. 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 the performance of their duties, or the persons to whom I have granted access, in writing, or to any other person or organization authorized by law. I have read, understand and agree with the Global Privacy Notice published at https://www.rbc.com/privacysecurity/ca/global-privacy-notice.html.

I acknowledge and agree that if I choose to use, or instruct the Company to use, any electronic communication that is not encrypted, including without limitation, any fax or email communication, that (i) security, privacy and confidentiality cannot be ensured, (ii) such communication is not reliable and may not be received by the intended recipient in a timely manner or at all, (iii) such communication could be subject to interception, loss or alteration, and (iv) I assume full responsibility for the risks in connection with such communication and the Company will not be responsible or liable in any way in connection with such communication, including without limitation, any unauthorized access to or interception, loss or alteration of such communication.

Your Authorization to Disclose Personal Information

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, employment, education or training, which they have in their possession or control.

Persons to whom this Authorization Applies: Any physician, nurse, counsellor, psychologist, 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 company or administrator; and also any federal or provincial government department or organization, including the Workers' Compensation Board/Workplace Safety and Insurance Board, or institution having information, records or data regarding me, my medical history or treatment, or my past and present income, employment, education or training.

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 purpose of determining coverage and entitlement to benefits under the policy, my ability to return to work and/or for the purpose of assisting with the co-ordination of my return to work, or for the recovery of any overpayment of benefits incurred by me, and/or for the purposes of fulfilling its (or RBC Financial Group's) obligations or investigations with respect to audits, anti-money laundering, terrorist financing, fraud detection, prevention or suppression or other criminal activities. To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received to my physicians or health care providers; or to any other person or organization (including physicians, health care practitioners, rehabilitation workers, and vocational evaluators) employed or engaged by the Company.

I also authorize the Company to collect, use and disclose, as necessary and relevant, my personal information from any prior claim(s) and/or for any subsequent claim(s).

This authorization does not have any expiry date. It will remain valid for as long as I am claiming eligibility for benefits or services from the Company and while the Company pursues subrogation rights or the recovery of any overpayment of benefits incurred by me, if necessary, whether or not benefits are being paid, and whether or not either party takes the position that there has been a breach of contract. A photocopy of this authorization, as executed by me, will be as valid as the original.

Signature of Claimant

Name:

Date: YYYY MM DD

Signature of Witness

Name:

Date: YYYY MM DD

The patient is responsible for any fees related to the completion of this form.

Initial Disability Insurance Medical Statement

Section 1 — Patient Information and Consent
TO BE COMPLETED BY THE PATIENT

Patient Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd/mm/yyyy)

Date Last Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.
I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

_____ _____
Patient Signature Date of Consent (dd/mm/yyyy)

Section 2 — Medical Statement
TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify)_____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

_____

Secondary and/or Complications: _____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): Vaginal ☐ C-Section ☐

Is this condition due to:

Occupational Illness Yes ☐ No ☐
Occupational Injury Yes ☐ No ☐
Motor vehicle accident Yes ☐ No ☐
Other accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____

First date of work absence due to condition: (dd/mm/yyyy) _____

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1)**

_____

_____

_____

_____

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

Date of next visit: (dd/mm/yyyy)

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐ Unknown ☐

If yes, date: (dd/mm/yyyy) _____ Treatment Provider: _____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

_____

_____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

Did/will the patient have day surgery? Yes ☐ No ☐

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

- **If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.**
- **For disabilities expected to be greater than 4 weeks, please complete all pages.**

Investigations

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **consultation reports**
- **clinical notes**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) _____ Type of license: _____

Is the patient capable of managing their own affairs? Yes ☐ No ☐

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐

Workplace Issues ☐ Social/Family Issues ☐ Financial/Legal Issues ☐ Personality issues ☐ Addiction ☐ Other ☐

Please elaborate: _____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician/Medical Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)	Specialty and license/registration number	Date Signed (dd/mm/yyyy)

Address (Street, City, Province, Postal Code)	Telephone # (+ area code) Fax # (+ area code) Email address

Signature