RBC Insurance

EVIDENCE OF INSURABILITY FORM

1122 International Boulevard, P.O. Box 5044
Burlington, Ontario L7R 4C1
905.319.9501

This area to be completed by Plan Administrator *(please note that this form will be returned if any areas are not completed)*

NAME OF EMPLOYER	POLICY NUMBER	DIVISION

COMPANY MAILING ADDRESS	CITY	PROVINCE	POSTAL CODE

PHONE NUMBER	PLAN ADMINISTRATOR

EMPLOYEE NAME	PROVINCE OF RESIDENCE	SEX	D.O.B.

OCCUPATION	CLASS	ANNUAL SALARY	DATE OF F/T EMPLOYMENT	# OF HOURS WORKED / WEEK

AMOUNT OF COVERAGE CURRENTLY IN FORCE (IF APPLICABLE)	LIFE	LTD

APPROVAL REQUESTED FOR: LIFE ☐ AD&D ☐ DEP LIFE ☐ LONG TERM DISABILITY ☐ SHORT TERM DISABILITY ☐

BASIC VOLUNTARY - AMOUNT $_____ (A VOLUNTARY LIFE APPLICATION MUST ALSO BE COMPLETED)

REASON FOR APPLICATION: OVER NEM ☐ LATE ENROLLMENT ☐ SALARY CHANGE ☐ ADD A DEPENDENT ☐ OTHER (PROVIDE DETAILS) ☐

BILLING TYPE: HEAD OFFICE SELF ACCOUNTING THIRD PARTY ADMINISTERED

TPA INFORMATION (IF APPLICABLE) NAME: ADDRESS:

This area to be completed by Applicant *(please note that this form will be returned if any areas are not completed)*

1. Full name and address of personal physician: _____
2. Date of last consultation: _____ Reason: _____
3. Height: _____ Weight: _____
4. Have you ever been treated for or have any indication of cancer or tumor, chest pain, diabetes, blood, heart, lung, kidney or liver disorder, hepatitis, high blood pressure, a mental or nervous system disorder, stress, anxiety or depression, sexually transmitted disease, stomach or intestinal disorder, stroke, ulcer, paralysis, disease or disorder of the thyroid, bones, muscles, joints, back or neck? ..... **Yes** ❑ **No** ❑
5. In the past five years, have you had any medical advice or operation, physical exam, treatment, illness abnormality or injury not listed above? ..... **Yes** ❑ **No** ❑
6. Are you currently receiving any medical advice, treatment or medication? ..... **Yes** ❑ **No** ❑
7. Do you have any symptoms or are you aware of any problems for which you have not yet consulted a doctor or other health practictioner, or has not already been listed above? ..... **Yes** ❑ **No** ❑
8. Have you ever used drugs that were not prescribed by your doctor (includes marijuana, LSD, cocaine, barbiturates or other narcotics) or been treated for or advised to seek treatment for drug or alcohol abuse? ..... **Yes** ❑ **No** ❑
9. Have you ever been diagnosed or told by a physician that you have AIDS, ARC, HIV, enlargement of lymph nodes (glands) chronic diarrhea, unusual skin lesions or unexplained infections or other immunological disorder? ..... **Yes** ❑ **No** ❑
10. Within the past 5 years, have you received disability benefits from any source or missed 5 or more consecutive days from work due to illness or injury or had any company decline, modify, cancel or rescind any life, disability income or critical illness insurance? ..... **Yes** ❑ **No** ❑

PLEASE PROVIDE DETAILS BELOW TO ANY "YES" ANSWERS

Question No.	Symptoms	Diagnosis	Treatment	Date/Duration of occurrence	Time lost from work	Name/address of doctors

I hereby declare that all answers on this form are true and complete and that any misstatements or failure to report information may be used as the basis of rescission of insurance for me. I understand that if the insurance applied for becomes effective, I will be subject to all the terms of the group policy. I further understand that additional information, including medical testing, may be required as part of the underwriting process and that this information, including medical test results, will not be shared with my employer.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health to give to RBC Life Insurance Company any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease, ailment or condition. A photocopy of this authorization shall be as valid as the original.

Signature of Applicant _____ Signature of Witness _____ Date _____

Dependents Form

(Required only if Dependent coverage is being applied for)

Particulars of spouse and children applying for coverage under this plan:

Name	Sex	Relationship	D.O.B.	Height	Weight
1.					
2.					
3.					

To the best of your knowledge are you aware of or have any of the above dependents been treated for or been given any indication of having any of the following: heart trouble, high blood pressure, cancer or tumors, kidney trouble, disease or disorder of the stomach, back problems, a nervous or mental condition, respiratory problems, AIDS, alcoholism, drug addiction or any other physical or mental disorders?

Yes ❑ **No** ❑ If yes, please give full details _____

I hereby declare that the above answers and statements are, to the best of my knowledge and belief, full, complete and true as of this date, it being understood and agreed that they are material to the risk and form part of the application and consideration for the insurance applied for.

Signature of Applicant _____ Date _____