RBC Insurance

Disability Claim Form

Claimant's Name: ______________________

Policy No(s): ______________________

Employer Name *(if applicable)*: ______________________

IMPORTANT GUIDELINES

- Print legibly in ink, preferable black for photocopy purposes. DO NOT use ditto marks.
- DO NOT make erasures or use liquid paper. Stroke out an error and have the applicant initial it.

YOUR PRIVACY MATTERS TO US

At RBC Insurance®, we're committed to protecting your privacy. We respect your privacy and want you to understand how we safeguard your personal information.

How we collect your information
We collect and keep information about you, which is needed to provide the products and services you request. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, the Medical Information Bureau, the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

How we use your information
We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage claims. We may also share your information with others who work for RBC Insurance or other RBC Financial Group™ companies, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, financial institutions, third party administrators, and any references you provide. We may also share your information, when necessary for the services we provide to you, with your employer under a group insurance policy. Your health information will not be shared with your employer without your consent.

We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business.

If you have given us your social insurance number, we will use it for taxation purposes and to help identify you with Citizenship and Immigration Canada, when necessary. We may also use your social insurance number for identification purpose under a group insurance policy if you have given us permission to do so.

Please note that this paragraph is not applicable if this application is submitted by an independent representative or a representative that is attached to a firm other than RBC Insurance.

Other ways we may use your information
When you request products and services directly from RBC Insurance, there are other ways we may use your information. For example, we may use or share some of your information to help you find out about other products and services from RBC Insurance and other RBC Financial Group companies. However, we will never use or share your health information for these purposes. To better manage your relationship with other RBC Financial Group companies, and where the law allows us, we may consolidate the information we have about you with information held by the other member companies.

If, at any time, you decide that you do not want us to use your information as described here, under "Other ways we may use your information", please let us know by calling us at 1-800-663-0417.

Your right to access your information
You have a right to access the personal information that we have about you in your file. If we have information that is not correct, you can have it corrected.

To access your information or to ask us to correct information, you can contact us at:

RBC Insurance
30 Adelaide Street East, Suite 500
Toronto, Ontario
M5C 3H3
Telephone: (877) 519-9501
Facsimile: (800) 714-8861

If you would like more information about client privacy
RBC Financial Group publishes a brochure on client privacy. If you would like a copy of the brochure, please call us at 1-800-663-0417.

COMPLETING THE FORM:

We want to make sure your claim is processed accurately and quickly. To make the process as timely as possible, we have designed this Disability Claim form to collect as much information as possible from you at the beginning of the process. The information we have requested will help us determine the benefits you receive according to your contract with us.

We recognize that this form is quite detailed. However, our experience has shown us that, when this form is filled out correctly and completely, it takes us less time to assess your situation and make a decision on your claim. Due to the diversity of our policies and the nature of the claims, not all questions will be applicable to you and your situation. If a question does not apply to you, simply answer the question with "n/a." This way, we will know that you have read the question and that it does not apply to you.

CHECKLIST FOR COMPLETING THE FORM:

Please use the following guidelines to complete the form:

- use an ink pen when completing all sections and print clearly
- attach additional pages where necessary and clearly mark on each page : **Your name, the section, page and question number that the supplementary information refers to**

CLAIMANT INSTRUCTIONS

1. Complete the **Claimant's Statement of Disability** and return this section directly to RBC Life Insurance Company.
   - ► Provide proof of age (e.g. copy of a Birth Certificate, driver's licence-copies of front & back).
   - ► In the case of a Motor Vehicle Accident or other incident reported to the police, attach a copy of the police report and correspondence from all motor vehicle and other insurance carriers.
   - ► Provide copies of all correspondence related to other income replacement and insurance coverage (e.g. WCB/WSIB, CPP/QPP).
2. **If you are an employee**, please have your employer complete section **A. Employment Statement of Disability**. For purposes of this section, "claimant" refers to the insured employee.

   If you are self-employed, this section does not need to be completed.
3. **If you are self-employed**, complete section **B. Employment Statement of Disability** and return along with your Claimant's Statement of Disability. Refer to "Documents Required" section at the bottom of the Employment Statement for additional requirements.

   If you are an employee, please have your employer complete section **B. Employment Statement of Disability**. For purposes of this section, "claimant" refers to the insured employee.
4. Complete the Patient's Information section on the **Attending Physician's Statement of Disability**. Have this section completed by your doctor and returned directly to RBC Insurance.

These forms represent initial notice of claim. Omissions or errors may cause a delay. Additional documentation may be requested by RBC Insurance upon review of these forms.

EMPLOYER INSTRUCTIONS

1. Complete sections **A** and **B** of the **Employment Statement of Disability** and return directly to RBC Insurance**.** For purposes of these sections, "claimant" refers to the insured employee.
   - ► In the case of an incident reported to the police, attach a copy of the police report and correspondence from all other insurance carriers.
   - ► Provide copies of all correspondence related to other income replacement and insurance coverage (e.g. WCB/WSIB, CPP/QPP).
   - ► Refer to "Documents Required" section at the bottom of the Employment Statement for additional requirements.

THE COMPLETED FORMS MUST REACH RBC INSURANCE WITHIN 90 DAYS OF THE CLAIMED DISABILITY DATE.

If you require assistance, or have questions concerning the form, please call the Customer Care Centre at (416) 643-4700 or 1-877-519-9501.

MAIL THE COMPLETED FORM TO:
RBC Insurance Customer Care Centre
30 Adelaide Street East, Suite 500, Toronto ON M5C 3H3 **or fax to:** 1-800-714-8861

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CLAIMANT'S STATEMENT OF DISABILITY

INFORMATION ABOUT YOU

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other ______________________ ☐ Male ☐ Female

Name: Last ______________ First ______________ Middle ______________

Name commonly used (*if different from your first name*) ______________

Date of birth (MM/DD/YYYY) ______________ Social Insurance No. ☐☐☐-☐☐☐-☐☐☐ Language Preference ☐ English ☐ French

Address (Apt. / Street / City / Province / Postal Code) ______________

Indicate mailing address (*if different from above*) ______________

Home Telephone No.: (_______) ______________

Policy No(s): ______________ Business Telephone No.: (_______) ______________

All people residing with the claimant:
(attach a separate page, if required)

Name	Age	Relationship to the claimant

YOUR EMPLOYMENT DETAILS

1. Are you self-employed?

☐ Yes *(If "Yes," complete the following)*

a) Your company is a ☐ Corporation ☐ Partnership ☐ Proprietorship

b) Please indicate the date of incorporation or the date your business started: ______________ (MM/DD/YYYY)

c) What is your percentage of ownership? ______________ %

d) If there are shareholders/partners, are they related to you? ☐ Yes ☐ No

If "Yes," please elaborate: ______________

☐ No *(complete below)*

Your Employer ______________ Date of Hire (MM/DD/YYYY) ______________ Division or Department ______________

2. Occupation immediately prior to the date you ceased working ______________ Your Job Title *(if different from your occupation)* ______________

3. Are you employed in more than one occupation? ☐ Yes ☐ No

If "Yes," please include all occupations______________

INFORMATION ABOUT YOUR CLAIM

1. a) What was your last day worked? ______________ (MM/DD/YYYY)

b) On the last day worked, did you work a full day? ☐ Yes ☐ No If "No," elaborate: ______________

c) What was the reason for stopping work? ______________

(OVER)

d) What was the date you were first unable to work as a result of your condition? ______________________ (MM/DD/YYYY)

2. Is your absence from work the result of: *(Please check one)* ☐ Injury ☐ Illness

☐ Pregnancy - confined from: ________ to ________ (MM/DD/YYYY)

3. a) What were your first symptoms and when did you first notice them? ______________________

____

____

b) What prevents you from returning to work? ______________________

____

____

c) How does your current condition impact your daily living? Please provide details: ______________________

____

____

d) Prior to stopping work, did your condition require you to change the way in which you performed your occupational duties? ☐ Yes ☐ No

If "Yes," please elaborate: ______________________

____

e) Have you ever had a similar injury or illness? ☐ Yes ☐ No

If "Yes," please provide dates and details: ______________________

____

4. If your condition is the result of an injury, please answer the following:

a) Date the injury occurred: ______________________ (MM/DD/YYYY)

b) Was the accident reported to the police or any other required party? ☐ Yes ☐ No

If "Yes," to whom? ______________________

If "No," why not? ______________________

c) Where did the injury occur? ______________________

d) How did the injury occur? ______________________

____

5. a) Is this claim work-related? ☐ Yes ☐ No

b) If work-related, has it been reported for Workers' Compensation (WCB/WSIB) benefits? ☐ Yes ☐ No

If "Yes," what is the status of the claim? ☐ Pending ☐ Approved ☐ Declined

WCB/WSIB information: ______________________ | ______________________

Claim No. Date claim filed (MM/DD/YYYY)

______________________ | ______________________ (______) ________

Name of Contact Address (Street / City / Province / Postal Code) Telephone No.

If work-related and you have not applied for WCB/WSIB, please elaborate: ______________________

____

If WCB/WSIB benefits have been approved, what services/activities are being provided? *(e.g. assessment, retraining, vocational rehabilitation, return to work trials, etc.)* ______________________

____

6. a) Have you now returned to work? ☐ Yes ☐ No If "Yes," ____________ Full-time date (MM/DD/YYYY) ____________ Part-time date (MM/DD/YYYY)

Usual job? ☐ Different job? ☐ If different job, explain: ____________

b) If you have returned to work part-time, what specific occupational duties are you unable to perform and what prevents you from performing them? ____________

7. Have you discussed a return to work plan with your attending physician? ☐ Yes ☐ No
If "Yes," please provide details: ____________

8. Do you believe that your occupational duties will need to be modified in some way when you return to work? ☐ Yes ☐ No
If "Yes," please elaborate: ____________

TREATMENT HISTORY

1. List all health care providers you have consulted for any reason in the last five years. This should include your current family physician, consulting physicians, physiotherapists, chiropractors, psychologists, counsellors and therapists. Begin with the most recent. List any additional health care providers on a separate page.

Physician/Provider | Specialty

Address (Street / City / Province / Postal Code)

(_______) Telephone No. | (_______) Fax No. | Date(s) seen (MM/DD/YYYY)

Reason/Diagnosis

Physician/Provider | Specialty

Address (Street / City / Province / Postal Code)

(_______) Telephone No. | (_______) Fax No. | Date(s) seen (MM/DD/YYYY)

Reason/Diagnosis

2. List all hospitals and health care facilities where you received treatment or attended as an out-patient for any reason. Begin with the most recent. List any additional facilities on a separate page. This should include any facility visited in the last five years.

Hospital/Facility | Reason for visit

Address (Street / City / Province / Postal Code)

Date Admitted (MM/DD/YYYY) | Date Discharged (MM/DD/YYYY)

Hospital/Facility | Reason for visit

Address (Street / City / Province / Postal Code)

Date Admitted (MM/DD/YYYY) | Date Discharged (MM/DD/YYYY)

3. List all pharmacies where you have had prescriptions filled.

Names of pharmacies	Address (Street / City / Province / Postal Code)	Telephone No.
		( )
		( )

4. a) Since the onset of this condition, describe your treatments provided (*e.g. medications, procedures, tests etc.*):

b) Describe how your condition has changed since starting treatment:

YOUR OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

1. a) Do you have insurance coverage for any of the following? ☐ Yes ☐ No If "Yes," complete the chart below:

b) Have you applied for any of the following? If so, describe your current status as it applies to each category.

Sources of Income	Yes/No	Policy No.	Amount (week/month)	Date Claim Filed	Status	Date Payment Begins/Began	Date Payment Ends/Ended
Salary Continuation							
Short Term Disability							
Employment Insurance							
Association Group Plan							
Canada Pension Plan Quebec Pension Plan							
Workers' Compensation Board (WCB/WSIB) benefits							
Automobile Insurance							
Retirement Pension Plan							
Individual Disability							
Credit/Loan Insurance							
Waiver of Life Insurance Premiums							
Other (please specify)							

2. a) Have you had a prior absence from work due to medical reasons that lasted longer than 60 days? ☐ Yes ☐ No

If "Yes," Date absence began ____________ (MM/DD/YYYY) Date absence ended ____________ (MM/DD/YYYY)

Was a disability claim filed? ☐ Yes ☐ No

Provide details:

b) Have you previously filed a disability claim and/or received disability benefits for any reason? *(e.g. WCB/WSIB, disability, auto insurance)*

☐ Yes ☐ No If "Yes," Name of insurer:

Period of disability: From ____________ (MM/DD/YYYY) To ____________ (MM/DD/YYYY) Policy No.:

3. Under what other RBC Insurance policies are you currently covered? *(e.g. life insurance)*

Policy Type Policy No.

Policy Type Policy No.

FRAUD NOTICE

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

I, ______________________________ , declare that the above statements are true and complete to
(print name)

the best of my knowledge and belief.

Date ____________________ Signature of Claimant ______________________________
(MM/DD/YYYY)

AUTHORIZATION

I understand and authorize the Company (the Company refers to and includes each of RBC Life Insurance Company and RBC Insurance Services Inc., and their reinsurers) to conduct such investigation as is necessary, to gather personal information concerning me and to disclose as necessary to third parties the fact that I am making a claim to the Company for benefits. 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 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 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 claim.

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 other financial institution or insurance broker or administrator; and also my employer or former employers and any of their agents performing services relating to any employee benefits or workers' compensation; and also any federal or provincial government department or organization, including the Workers' Compensation Board, the CPP/QPP disability /retirement authorities, and the federal or provincial income tax authorities; and also to any other person, agency, credit bureau 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 evaluating my claim for benefits, my ability to return to work or for the purpose of assisting with the co-ordination of my return to work, or for the purpose of administering the policy under which my claim is made. To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to other insurance companies or any reinsurer; or to my employer and their insurance brokers or advisors or their benefit plan administrators; or to my physicians or health care providers; or to any other person or firm (including physicians, health care practitioners, rehabilitation workers, vocational evaluators) employed or engaged by the Company.

I also authorize the Company to use my Social Insurance Number for any tax reporting purposes, and all other matters relating to my insurance claim or entitlement to benefits.

This authorization does not have any expiry date. It will remain valid for as long as I am claiming eligibility for benefits or service from the Company, 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.

X ______________________________ Date: ____________________
Signature of Claimant (MM/DD/YYYY)

______________________________ Social Insurance Number: ☐☐☐-☐☐☐-☐☐☐
Name of Claimant (Please Print)

X ______________________________ Date: ____________________
Signature of Witness (MM/DD/YYYY)

____
Name of Witness (Please Print)

MAIL THE COMPLETED FORM TO:
RBC Insurance Customer Care Centre
30 Adelaide Street East, Suite 500, Toronto ON M5C 3H3 or fax to: 1-800-714-8861
If you have any questions, call toll free 1-877-519-9501 or 416-643-4700

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A. EMPLOYMENT STATEMENT OF DISABILITY

For purposes of this section, "claimant" refers to the insured employee.

THE EMPLOYER OR POLICYHOLDER

Company Name ______ Policy / Division No. *(if applicable)* ______

Address (Street / City / Province / Postal Code) ______

Industry ______ Primary Products/Services ______

(_______) ______ Telephone No.

(_______) ______ Fax No.

Language Preference ☐ English ☐ French

Name and address of office or division where the claimant works:

Name ______ Address (Street / City / Province / Postal Code) ______

Name of Benefits Administrator who should be contacted regarding this claim:

Name ______ (_______) ______ Telephone No. (_______) ______ Fax No.

Address (Street / City / Province / Postal Code) *(if different from above)* ______

THE CLAIMANT

This claim is for: Name: Last ______ First ______ Middle ______

Date of birth: ______ (MM/DD/YYYY)

Social Insurance No. ☐☐☐-☐☐☐-☐☐☐

THE CLAIMANT'S EMPLOYMENT

1. a) Date claimant was hired (MM/DD/YYYY) ______ Date claimant became insured under this plan (MM/DD/YYYY) ______

   b) Last date claimant worked (MM/DD/YYYY) ______ Date claimant would have next worked if absence from work had not begun (MM/DD/YYYY) ______

2. a) Position/Job Title on last date worked ______ Length of time in that position ______

   b) Minimum qualifications required for the job: ______

   c) Licences/Certifications Required: ______

   d) Machines/Tools/Equipment Used: ______

   e) Titles of Direct Reports: ______

3. On the claimant's last date worked, was it a full day? ☐ Yes ☐ No If "No," how many hours were worked? ______

4. Reason for stopping work: ______

5. Has the claimant returned to work for any period of time since the last date worked? ☐ Yes ☐ No

   If "Yes," provide details: ______

6. Is the claimant ☐ Permanent ☐ Part-time ☐ Temporary/Contract ☐ Other *(specify)* ______

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B. EMPLOYMENT STATEMENT OF DISABILITY

1. What are the regular hours worked per day, excluding overtime? From ________ AM/PM To _________ AM/PM

2. Please indicate one complete work week or shift cycle by showing the number of hours worked per day:

Day of Week	S	M	T	W	T	F	S
Hours							

Indicate "0" for days off

Does this cycle repeat? ☐ Yes ☐ No

Number of hours worked per week: ___________________

3. Is the work subject to: Seasonal Changes ☐ Yes ☐ No
   Business Cycles ☐ Yes ☐ No
   No Layoffs ☐ Yes ☐ No

   If "Yes" to any of the above, please describe how the work is affected, including the cause, frequency and usual type of occurrence, the effect on the total number of hours or days per week, the average number of months worked per year, the type of employment *(casual, seasonal, on-call, apprentice, etc):* ________________________________

4. Were there any recent changes to the claimant's responsibilities prior to ceasing work? ☐ Yes ☐ No

   If "Yes," what were the changes and when were they made? ________________________________

5. Can the position be performed on a part-time basis? ☐ Yes ☐ No

   If "No," explain: ________________________________

6. How many days of absence for any reason occurred in the six months prior to the disability date? *(excluding vacation and statutory holidays)* __________

   Provide dates and details: ________________________________

7. Have there been any prior claims? *(e.g. short term disability, Workers' Compensation WCB/WSIB)* ☐ Yes ☐ No

   If "Yes," provide details: ________________________________

8. Do you consider the claimant's condition to be work-related? ☐ Yes ☐ No

   If "Yes," provide details: ________________________________

9. a) Has a claim been filed for Workers' Compensation Board (WCB/WSIB) benefits? ☐ Yes ☐ No

   If "Yes," provide details: ____________ | ____________________ (_______)__________
   Claim No. Name of Contact Telephone No.

   If "No" and if work-related, explain why a claim has not been filed: ________________________________

   (If the accident is the result of an occupational injury, please provide a copy of the accident report)

   b) If benefits have been approved, what services/activities are being provided to assist the claimant? *(e.g. assessment, retraining, vocational rehabilitation, return to work trials)* ________________________________

(OVER)

JOB DESCRIPTION

1. Briefly describe this position: ______________________________

2. Describe the essential tasks of the job: (Fundamental/Primary) hrs/day hrs/month

3. Describe the non-essential tasks of the job: (Incidental/Secondary) hrs/day hrs/month

PHYSICAL DEMANDS

1. a) Activity

Activity	Longest time period performed without break	Cumulative hours per day				
1. Stand (stationary)						
2. Walk						
3. Sit						
4. Stoop/ Crouch/Squat						
5. Kneel						
6. Climb						
7. Crawl						
8. Jump						
9. Bend						
10. Twist						
11. Throw						
12. Push/Pull Above Shoulder						
Below Shoulder						
13. Reach/Stretch Above Shoulder						
Below Shoulder						
			Indicate number of times per day lifted:			
			0-10lbs	11-20lbs	21-50lbs	51-75lbs	76-100lbs
14. Lift/Carry Above Shoulder							
Below Shoulder							
15. Visual Acuity			Never	Seldom	Required	Major
Far						
Near						
Colour Discrimination						

Items 1 through 7 should total a full work day.

b) Extremity Activity

	Right	Left	Both	Right	Left	Both
Handle/Grasp						
Fine Manipulation						
Power Grip						
Torque/Twist						

2. a) Operate Foot Controls? ☐ Yes ☐ No

   b) Type of Equipment ______________________________

   Cumulative hours/day ______ Longest period performed without a break ______

3. Can this job be performed alternately sitting and standing? ☐ Yes ☐ No

COGNITIVE WORK FUNCTIONS

Do Essential Tasks require:		Yes	Hrs/Day	Hrs/Month	No
1.	Working with others?				
2.	Working alone, apart or in physical isolation from others?				
3.	Comprehending and following instructions?				
4.	Performing simple and repetitive tasks?				
5.	Performing complex or varied tasks requiring higher level of reasoning, language and/or math?				
6.	Working under deadlines?				
7.	Working frequently in excess of normal work hours?				
8.	Performing varied work tasks with frequent interruptions?				
9.	Dealing with an angry/upset/combative public?				
10.	Dealing with others who have experienced traumatizing events?				
11.	Supervising others?				
12.	Being responsible for others' output/work product?				
13.	Influencing others beyond giving simple information or directions?				
14.	Making generalizations, evaluations or decisions without immediate supervision?				
15.	Carrying out responsibility for direction, control and planning?				
16.	Performing when confronted with emergency, critical, unusual or dangerous situations?				
17.	Sustained attention to complex tasks?				

ENVIRONMENTAL DEMANDS

Exposed to:		Yes	Hrs/Day	Hrs/Month	No
1.	Weather?				
2.	Extreme cold?				
3.	Extreme heat?				
4.	Wet and/or humid *(non-weather)*?				
5.	Noise intensity level:				
	Very quiet *(isolation)*?				
	Quiet *(Library)*?				
	Moderate *(Office)*?				
	Loud *(Manufacturing)*?				
	Very loud *(Jackhammer)*?				
6.	Vibration?				
7.	Fumes, odours, dust, gases? If "Yes," what type? ______________________________				
8.	Proximity to moving mechanical parts?				
9.	Exposure to electric shock?				
10.	Working in high, exposed places?				
11.	Exposure to radiation?				
12.	Working with explosives?				
13.	Exposure to toxic or caustic chemicals?				
14.	Working on uneven ground?				
15.	Travel?				
	If "Yes," by what means? ☐ Car ☐ Plane ☐ Train → ☐ Automatic → ☐ Standard				
16.	Other? If "Yes," explain: ____				

(OVER)

INSURANCE INFORMATION

1. Is this an application for: Long Term Disability ☐ Yes ☐ No

   Life Insurance Premium Waiver ☐ Yes ☐ No

   If Life Insurance Premium Waiver, indicate the amount of insurance: $ ______________________ Class ____________

   Other insurers for your company:

	Name	Address (Street / City / Province / Postal Code)	Policy No.
Short Term Disability			
Extended Health Care			
Other insurer			

2. Did your company have LTD insurance coverage prior to this policy? ☐ Yes ☐ No

   If "Yes," provide details: ______________________ | ______________ | ______________

   Name of Previous Insurer Policy No. Effective Date (MM/DD/YYYY)

3. Was coverage added for this claimant on the first date that he/she was eligible? ☐ Yes ☐ No

   If "No," explain: ____

4. Has the claimant's coverage been continuous since first insured under the plan? ☐ Yes ☐ No

   If "No," indicate the coverage interruptions and reasons for them: ______________________________

   ____

5. Has coverage under this policy terminated for this claimant? ☐ Yes ☐ No

   If "Yes," on what date and why? ______________________________________ (MM/DD/YYYY)

   ____

OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

Sources of Income	Yes/No	Policy No.	Amount (week/month)	Date Claim Filed	Status	Date Payment Begins/Began	Date Payment Ends/Ended
Salary Continuation							
Short Term Disability							
Employment Insurance							
Association Group Plan							
Canada Pension Plan Quebec Pension Plan							
Workers' Compensation Board (WCB/WSIB) benefits							
Automobile Insurance							
Retirement Pension Plan							
Individual Disability							
Credit/Loan Insurance							
Waiver of Life Insurance Premiums							
Other (please specify)							

THE CLAIMANT'S SALARY

1. Prior to the last date worked:

$________________ Hourly Wage $________________ Annual Salary   ________________ Pay Period *(e.g. bi-weekly, monthly)*

2. In the 12 months (or the period of employment, if less than 12 months) prior to the last day worked, what was the amount paid?

$ ________________ Commission $ ________________ Bonuses $ ________________ Overtime

3. Other payment(s): ________________ Type $ ________________ Amount

________________ Type $ ________________ Amount

YOUR REHIRE OR RETURN TO WORK POLICIES

1. Does your company have a timely return-to-work program for claimants who have been off work on short term disability, long term disability or Workers' Compensation (WCB/WSIB)? *(e.g. modified work, work hardening, alternate work)* ☐ Yes ☐ No

If "Yes," whom should we contact if we identify vocational rehabilitation or return to work potential?

________________ Name   ________________ Title/Position   (_______)________________ Direct Telephone No.

2. What type of accommodations have been made for this position in the past or could be made in the future?

____

____

____

3. To your knowledge, is there a current or anticipated return to work potential for this claimant? ☐ Yes ☐ No

Explain: ____

____

____

DOCUMENTS REQUIRED *(as applicable)*

Please enclose the following documents with this Employment Statement:

- **Copy of the enrollment application for insurance, or copies of pay stubs/payroll records as of the effective date of insurance.**
- **Copy of attendance records for the past six months.**
- **Initial report of injury and decision notices relating to Workers' Compensation claim (WCB/WSIB).**
- **Copy of the job description and resume.**
- **Copy of the income reporting forms (ie. T4, T-01) for the two years prior to the last date worked.**
- **Copy of the last pay-stub/payroll record just prior to the last day of work.**

SIGNATURE OF PERSON COMPLETING THIS FORM

I declare that the above statements are true and complete to the best of my knowledge and belief.

Signature of Preparer: ________________________   Date: ________________ (MM/DD/YYYY)

Print Name: ________________________

Address: ________________________   Telephone No.: (_______) ________________

MAIL THE COMPLETED FORM TO:
RBC Insurance Customer Care Centre
30 Adelaide Street East, Suite 500, Toronto ON M5C 3H3 or fax to: 1-800-714-8861
If you have any questions, call toll free 1-877-519-9501 or 416-643-4700

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ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

WHAT WE REQUEST AND WHY

Your patient is applying for disability benefits under an RBC Life Insurance Company policy, and we will be assessing eligibility for benefits based on your patient's medical impairment.

As you can appreciate, the information provided by you is most important in our assessment of impairment. We are asking for your cooperation in providing pertinent information regarding the diagnosis, signs and symptoms, as well as details of your patient's limitations and restrictions.

We ask that you complete the Attending Physician's Statement as thoroughly as possible. Please be assured that the information, including the medical records requested, is required in the adjudication of your patient's claim and will be treated confidentially.

RBC Insurance is requesting copies of your complete file including specialist consultations, office notes for the period of treatment, test results, hospital admission histories and discharge summaries on your patient and is prepared to reimburse $50.00 for the costs associated with photocopying. If this amount is unreasonable because of the extent of your patient's file, please have your staff contact our office at (416) 643-4700 or toll free at 1-877-519-9501. **Any charge for the completion of this form, however, is the responsibility of the patient.**

We would like to thank you in advance for your cooperation.

RBC Insurance Customer Care Centre

PATIENT'S INFORMATION

Name: Last ______ First ______ Middle ______

Address (Apt. / Street / City / Province / Postal Code) ______

Telephone No.: (________)______ Policy No(s): ______

Date of birth (MM/DD/YYYY) ______ Height (in/cm) ______ Weight (lb/kg) ______

BACKGROUND

1. Date symptoms first appeared (MM/DD/YYYY) ______ Date of first visit for current condition (MM/DD/YYYY) ______ Date patient ceased work (MM/DD/YYYY) ______

2. a) Symptoms on date work ceased: ______

   b) Symptoms on date of first visit for the current condition: ______

   c) Who suggested your patient stop work: ______

3. Has your patient ever had the same or a similar condition? ☐ Yes ☐ No

   If "Yes," state when and describe: ______

4. Do you consider this condition to be chronic? ☐ Yes ☐ No

5. Date of latest visit (MM/DD/YYYY) ______ Frequency of visits ______

6. Was the patient referred to you by another physician? ☐ Yes ☐ No

   If "Yes,": Name of referring physician ______ Date referred (MM/DD/YYYY) ______

   Address (Street / City / Province / Postal Code) ______

(OVER)

7. Is the condition related to the patient's work? ☐ Yes ☐ No

If "Yes," explain: ____

____

PHYSICIAN'S DIAGNOSIS

1. a) Primary diagnosis: *(if psychiatric, indicate the DSM-IV including all axes)*

____

____

____

b) If this is a cardiac condition, include the Blood Pressure at last visit and the American Heart Association classifications:

☐ Class 1 – No limitation ☐ Class 2 – Slight limitation

☐ Class 3 – Marked limitation ☐ Class 4 – Severe limitation

2. Secondary diagnosis: *(including complications)*

____

____

____

3. Symptoms:

____

____

____

4. Objective findings: *(include the name of objective tests, the date performed and the results)*

____

____

____

5. Is the patient: ☐ Right-handed ☐ Left-handed

6. If the patient is/was pregnant, expected/actual date of confinement: ______________ (MM/DD/YYYY)

PATIENT'S TREATMENT

1. Has the patient been hospitalized? ☐ Yes ☐ No If "Yes," indicate:

______________________ ______________________

Name of hospital(s) Date(s) confined: from (MM/DD/YYYY) to (MM/DD/YYYY)

______________________ ______________________

Name of hospital(s) Date(s) confined: from (MM/DD/YYYY) to (MM/DD/YYYY)

2. Has the patient had surgery in relation to this condition, or is surgery planned? ☐ Yes ☐ No If "Yes," indicate:

______________________ ______________________

Name of procedure(s) Date(s) performed (MM/DD/YYYY)

______________________ ______________________

Name of procedure(s) Date(s) performed (MM/DD/YYYY)

3. Please list medications, their dosage, date prescribed, and expected duration:

____

____

4. Please list other types of treatment given or prescribed, dates of the treatment and expected duration:

____

____

____

5. Has the patient been referred to a rehabilitation programme? ☐ Yes ☐ No If "Yes," indicate:

Name of programme(s) ____ Date(s) attended (MM/DD/YYYY) ____ Expected duration ____

Name of programme(s) ____ Date(s) attended (MM/DD/YYYY) ____ Expected duration ____

6. Has there been a psychiatric consultation *(if applicable)*? ☐ Yes ☐ No

If "Yes," provide details: ____

7. Has the patient consulted with, or been treated by, any other health care providers? ☐ Yes ☐ No If "Yes," indicate:

Name ____ (____)____ Telephone No. ____ Treatment dates (MM/DD/YYYY) ____

Address (Street / City / Province / Postal Code) ____

Name ____ (____)____ Telephone No. ____ Treatment dates (MM/DD/YYYY) ____

Address (Street / City / Province / Postal Code) ____

8. Please comment on the response to treatment: ____

____

____

9. Is the patient following the recommended treatment plan? ☐ Yes ☐ No

If "No," comment on the reason and the effect: ____

____

10. Is the treatment expected to change? ☐ Yes ☐ No

If "Yes," in what way and when? ____

11. What are the patient's restrictions *(what the patient SHOULD NOT do)* and why? ____

____

____

12. What are the patient's limitations *(what the patient CANNOT do)* and why? ____

____

____

(OVER)

13. Has the patient had any licence or certification restricted or revoked *(e.g. driver's licence, professional certification?)* ☐ Yes ☐ No

If "Yes," the type of licence *(including class)* or certificate:

Licence No. ____________ Type of licence ____________ Date it was revoked (MM/DD/YYYY) ____________

Licence No. ____________ Type of licence ____________ Date it was revoked (MM/DD/YYYY) ____________

14. Has the patient achieved maximum medical improvement? ☐ Yes ☐ No

If "No," how soon do you expect fundamental changes in the patient's medical condition? ____________

15. What is your prognosis?

a) ☐ Recovery without impairment *(loss of function)* Number of weeks ________

b) ☐ Stabilization with continuing impairment Number of weeks ________

c) ☐ Permanent impairment

d) Comments: ____________

e) Is the patient a suitable candidate for trial employment? For his/her job? ☐ Yes ☐ No

For any other work? ☐ Yes ☐ No

16. Has there been any recommendation for a return to work now? ☐ Yes ☐ No in the future? ☐ Yes ☐ No

If "Yes," who made this recommendation, when and what was the patient's response? ____________

17. Are you providing information to any other insurers on this patient? ☐ Yes ☐ No

If "Yes," list names of companies: ____________

Please provide any other information that you feel will assist us in our understanding of your patient's condition *(e.g. work, family, other stressors):*

____

SIGNATURE

X ____________ Signature

Date (MM/DD/YYYY) ____________

Physician's Name (Please print) ____________

Degree and Specialty ____________

☐ Primary Care ☐ Consultant

Address (Street / City / Province / Postal Code) ____________

Telephone No. (   ) ____________

Fax No. (   ) ____________

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Before you mail in your completed form...

Make sure you have done **all** of the following:

- ❑ completed the form in ink
- ❑ each section of the form was completed by the **appropriate person**
- ❑ **signed and dated** all sections of the forms
- ❑ enclosed all the required forms for your claim

LIST OF REQUIRED FORMS

You must provide:

- ❑ copy of your birth certificate/passport/baptismal certificate (*if over age 50*)
- ❑ copy of all police reports (*if your injury was the result of an accident or police-reported incident)*
- ❑ any correspondence from all motor vehicles and other insurance carriers
- ❑ any correspondence from alternate sources of income (*e.g. EI, Workers' Compensation Boards, etc.*)

(Group Disability) Your employer is asked to provide:

- ❑ copy of the enrollment application form for disability coverage
- ❑ copy of employee's attendance records for the past six months
- ❑ copy of your TD1 form
- ❑ copy of T4, T-01 form etc. (*income*)
- ❑ employer's copy of medical information (*if available*)
- ❑ Workers' Compensation Boards' initial report of injury and all decision notices (*if applicable*)

If the above instructions have not been followed, your form may be returned to you.

Mail your completed form to:

RBC Insurance Customer Care Centre
30 Adelaide Street East, Suite 500
Toronto, ON M5C 3H3

or fax to: (800) 714-8861

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