



LoanProtector® HomeProtector®

Disability Benefit Claim Form

Important information about claiming disability benefits

LoanProtector Group
Policy Number H28445
HomeProtector Group
Policy Number H60101

Please review your insurance papers for details on coverage prior to submitting a claim. Your insurance papers consist of the LoanProtector or HomeProtector booklet, the completed Application or Application Confirmation letter, as well as any documents submitted as evidence of insurability (if applicable).

How to claim for benefits.

To claim for disability insurance benefits on an insured Royal Credit Line®, personal loan or mortgage:

- Forward the **fully completed** Disability Benefit Claim Form and Attending Physician's Statement (attached) to the Insurer, Canada Life Assurance Company of Canada (Canada Life), via the Insurance Service Centre. To contact the Insurance Service Centre call 1-800 ROYAL 2-3 (1-800-769-2523).

IT IS IMPORTANT NOT TO CLOSE OR REFINANCE YOUR LOAN/MORTGAGE WHILE THE CLAIM IS BEING PROCESSED. TO DO SO MAY INVALIDATE YOUR CLAIM.

FOR FASTER PROCESSING OF YOUR CLAIM, PLEASE INCLUDE:

- A completed and signed Attending Physician's Statement
- A completed and signed Disability Benefit Claim Form
- Any additional information that you think is relevant to your claim

IMPORTANT: The claim cannot be forwarded to Canada Life until we receive all the required documentation. Please ensure all information provided is fully complete to avoid unnecessary delays in the processing of your request. To facilitate this process, you may wish to contact your doctor to ensure that this information is provided promptly. Additional information may be required to process the claim (e.g. additional medical information, accident report, etc.) If so, you will be advised in writing.

When do I submit a claim for disability insurance benefits?

You must submit a claim for disability insurance benefits

- When you are unable to perform the regular duties of your current job and know your disability will last for more than 60 consecutive days.
- Within 150 days from the day your disability started, otherwise the claim may be declined.

How will I be notified of Canada Life's decision?

If a claim is approved by Canada Life, they will advise you directly in writing. If a claim is declined, Canada Life will advise you in writing, explaining the reason the claim has been declined. A separate letter will be sent to the Insurance Service Centre to advise them of Canada Life's decision. The reason(s) why your claim has been declined will not be shared with the Insurance Service Centre.

When will a disability claim not be paid?

A disability claim will not be paid:

- If you do not provide the initial information and/or any ongoing information required to properly assess and process your claim when requested by Canada Life, or
- If there is insufficient information to support your disability. In this case, Canada Life may give you the opportunity to provide more information, or
- If your disability last less than 60 consecutive days, or
- If you were not eligible for the disability insurance.

Please refer to your HomeProtector/LoanProtector Insurance Application and/or Booklet for when your benefit won't be paid or when benefit payments end, including details concerning the Pre-Existing Health Conditions.

Who is responsible for keeping payments up to date?

It is your responsibility to keep the mortgage, loan or Royal Credit Line payment up to date until Canada Life makes a decision on your claim. Disability payments can only begin after the 60 day waiting period and after the claim has been approved by Canada Life.

Who do I contact for more information?

The Insurance Service Centre is responsible for the administration and servicing of your claim. Representatives are available to take your calls and respond to your insurance related questions. These representatives will deal directly with Canada Life to help ensure your claim is processed quickly. If you have any questions or require information about the status of your claim, please call the Insurance Service Centre at: 1-800 ROYAL 2-3 (1-800-769-2523).

To maintain confidentiality of your medical information, only information for the administration and servicing of your claim will be held by the Insurance Service Centre.



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SRF#

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The Canada Life
Assurance Company
(the Insurer) has issued
policies of Creditor's
Group Insurance to
Royal Bank of Canada
and including
associated companies
Royal Bank Mortgage
Corporation, Royal
Trust Corporation of
Canada and Royal
Trust Company
("Royal").

Use these **two** forms to claim disability benefits for an insured Royal Credit Line[®], personal loan or mortgage:

1. **Disability Benefit Claim Form**
 - Must be completed by claimant
2. **Attending Physician's Statement**
 - Part 1 must be completed by the claimant
 - Part 2 must be completed by the physician treating the claimant.

The claimant is responsible for the securing of the Attending Physician's Statement and any charge for it's completion.

Please note the following points before making your claim:

- Review your Certificate of Insurance to find out what conditions and limitations apply to a claim.
- No benefits are paid during the first 60 consecutive days of a disability. If approved, your first benefit payment is payable from the first payment due date following the 60th day of disability.
- If it appears that your disability will not last for more than 60 days, do not submit a claim. If it is certain your disability will last longer than 60 days, have the attached forms completed and submit them as soon as possible.
- You will be notified in writing if the Insurer requires further information or medical proof to process your claim. If your claim is approved, you will be notified what payments will be made to Royal on your behalf and the date until which payments will continue.
- As soon as you return to work, please let the Insurance Service Centre know so your final claim payment can be made and your file closed.
- It is your responsibility to keep your mortgage or loan payments up to date while your claim is under review.

Please send the completed forms and a copy of your Insurance Application to:

RBC Insurance Services Inc.
Insurance Service Centre
P.O. 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 or 1-800-769-2523, or send a fax to: 1-800-864-6102.
The Insurance Service Centre will add information about the Royal Credit Line,
personal loan, or mortgage to these documents and send them to the Insurer.

General Information - Must be Completed by the Claimant

Client Card No.

Type of Loan

 Mortgage

Branch Transit No.

 Personal Loan

Branch Telephone No.

 Royal Credit Line (RCL)

Disability Claimant Information - Must be Completed by the Claimant

Your Name and Address

First Name

Initial

Last Name

Maiden Name (If applicable)

Gender

 Male Female

Mailing Address (street and number)

City or Town

Province

Postal Code

Date of Birth (month/day/year)

Telephone Contact No.

Fax No. (If applicable)

Email Address

Tell us about your most recent job:

Your occupation

Self Employed?

 Yes No

Seasonally Employed?

 Yes No

Name of your employer

Employment start date
(month/day/year)

Name of supervisor or contact person

Employer's address (street and number)

(____/____/____)

City or Town

Province

Postal Code

Office Telephone

(____) _____ - _____ ext: _____

Give us a brief job description



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Disability Claimant Information Continued

Tell us about your most recent employment history

Employer _____	Duration (month/day/year) From (___ / ___ / ___) To (___ / ___ / ___)	Contact Name (supervisor) _____	Contact Telephone (___) ___ - _____
Employer _____	Duration (month/day/year) From (___ / ___ / ___) To (___ / ___ / ___)	Contact Name (supervisor) _____	Contact Telephone (___) ___ - _____
Employer _____	Duration (month/day/year) From (___ / ___ / ___) To (___ / ___ / ___)	Contact Name (supervisor) _____	Contact Telephone (___) ___ - _____

Tell us about your disability

Last day worked before disability (month/day/year) (___ / ___ / ___)	Are you still disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Returned to work (month/day/year) (___ / ___ / ___)	Expected to return to work (month/day/year) (___ / ___ / ___)	Date of Disability (month/day/year) (___ / ___ / ___)
Cause of disability <input type="checkbox"/> Accident <input type="checkbox"/> Illness	If cause was an accident, please provide details _____ _____			Date of accident (month/day/year) (___ / ___ / ___)
Location of accident <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	Other, (please specify) _____			

How did the accident happen?

When did the illness begin? (month/day/year) (___ / ___ / ___)	Nature of illness or injury _____	Present Treatment (drugs, diet, physiotherapy) _____
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Have you been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, when (___ / ___ / ___)	From (month/day/year) (___ / ___ / ___)	To (month/day/year) (___ / ___ / ___)	At which hospital? _____
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Have you ever had a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, tell us when and describe the condition _____
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Are you entitled to any other disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, check the appropriate box(es) below		
<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Group disability coverage at work	<input type="checkbox"/> Automobile insurance	
<input type="checkbox"/> Canada or Quebec Pension plan	<input type="checkbox"/> Other government plan	<input type="checkbox"/> Private plan	

Tell us about the physicians that you have consulted in the past five years

Name of your family physician _____		
Street Address and city or town _____	Office Telephone No. (___) ___ - _____	Office Fax No. (___) ___ - _____
Name of treating physician (other than family physician) _____		
Street address and city or town _____	Office Telephone No. (___) ___ - _____	Office Fax No. (___) ___ - _____
Name of treating physician (other than family physician) _____		
Street address and city or town _____	Office Telephone No. (___) ___ - _____	Office Fax No. (___) ___ - _____

Signature and authorization

By signing here, you authorize the Insurer to obtain, collect and exchange personal information with:

Personal information agencies and investigation agencies, other insurers, medical practitioners and institutions having relevant personal medical services for the Insurer, and the Insurance Service Centre to provide and exchange any personal information required to process a claim relating to the HomeProtector or LoanProtector coverage.

You also authorize all physicians, hospitals, clinics, dispensaries, sanatoriums, druggists, employers and all other agencies to provide a copy of your medical and employment records to the Insurer you have authorized.

You acknowledge that a photocopy of this authorization is as valid as the original.

Signature of Claimant _____

Date (month/day/year) (____ / ____ / ____)

SRF#

Please include any other information that you feel is relevant to support your claim (i.e. accident report, pictures, etc.)



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Attending physician's statement

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Number H60101

How to complete the form:

Part 1 - Must be completed by the claimant

Part 2 - Must be completed by the physician treating the claimant.

If you have any questions, call the Insurance Service Centre at **1-800 ROYAL 2-3 (1-800 769-2523)**.

The claimant is responsible for the securing of the Attending physician's statement and any fee which may be charged for its completion.

Note: This form may also be used for submitting supplementary information (for continuation of disability benefit only).

Part 1 - Claimant's authorization

Personal information about the claimant

Client Card No.

First Name

Initial

Last Name

Gender

Male Female

Maiden Name (if applicable)

Mailing Address (street and number)

City or Town

Province

Postal Code

Date of Birth (month/day/year)

Telephone Contact No.

Fax No. (if applicable)

Email Address (if applicable)

Signature of claimant

By signing here, the claimant authorizes his or her attending physician to release any information relating to this claim to the Insurer and policyholder. You acknowledge that a photocopy of this authorization is as valid as the original.

Signature of claimant _____

Date (month/day/year) (____ / ____ / ____)

Part 2 - Attending physician's statement

Tell us about the claimant's disability

What is the primary cause of the disability?

Describe the symptoms

When did these symptoms first appear? (month/day/year)

(____ / ____ / ____)

When did the claimant first visit you? (month/day/year)

(____ / ____ / ____)

When did the disability begin? (month/day/year)

(____ / ____ / ____)

Is the condition due to injury or sickness from employment? Yes No

What was the date of the claimant's last visit? (month/day/year)

(____ / ____ / ____)

What is the frequency of the claimant's visit?

Weekly Monthly Other, specify _____

Are there any additional conditions or complications? Yes No

If Yes, please describe the condition or complication

Is the disability due to pregnancy?

Yes No

Expected date of confinement (month/day/year)

(____ / ____ / ____)

Has the claimant ever had a similar condition? Yes No

If Yes, please give details (i.e. date of first symptoms, date of diagnosis, etc.)

Describe the claimant's treatment.



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Attending physician's statement part two

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Part 2 - Attending physician's statement

Describe therapy and projected duration of treatment program.

What is the date and
description of surgery (if any)?
(month/day/year)

(___ / ___ / ___)

Description

Describe the claimant's prognosis

If the claimant was referred to you, what is the name of the referring physician?

If you have referred the claimant to a specialist, what is the name of the specialist?

Please describe the extent of the claimant's disability by
checking one of these boxes.

1. Able to leave home
2. Home confined
3. Bed confined
4. Hospital confined

If you checked box 1 or 2, please give us more detail about the claimant's
disability by checking one of the boxes below.

- a. No limitation of functional capacity; capable of strenuous activity
- b. Minimal limitation of functional capacity; capable of moderate activity
- c. Medium limitation of functional capacity; incapable of light activity
- d. Severe limitation of functional capacity; incapable of minimal activity

If you checked box a, b, c or d above, explain why the claimant cannot do his or her work.

Please tell us any additional information which would help us assess this claim

Name and address of attending physician

First Name and Initial

Last Name

Street Address and City or Town

Business Telephone No.

Fax No.

Email Address

(___) ___ - ___

(___) ___ - ___

Specialty

Signature of physician

By signing here, you acknowledge that the
answers given above are true and complete
to the best of your knowledge

Signature of
attending physician

Date (month/day/year)
(___ / ___ / ___)

When you have completed
this form, please give it to the
claimant or send it to:

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