Royal Bank of Canada

Business Loan Insurance Plan
Critical Illness Claim

Group Policy 53000

Before submitting a critical illness claim:

- Complete and sign the Claimant's Statement for your critical illness.
- Please select the Attending Physician Statement according to your illness you are claiming benefits for.
- Sign and complete the Patient Authorization on the Attending Physician's Statement.
- The doctor must complete the Attending Physician's Statement with as many details as possible.
- The complete critical illness claim package consists of 2 parts
  - a completed and signed Claimant Statement.
  - a completed and signed Attending Physician's Statement according to the illness you are claiming benefits for.

RBC Life Insurance Company can only process your claim when we have received the Claimant and Physician Statement 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.

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.
- Until RBC Life Insurance Company advises you in writing of the decision, it is your responsibility to continue paying your loan payments in full.

Important Notes:

- Proof of claim must be submitted within 180 days of the date of diagnosis or surgery.
- You are responsible for the costs, if any, of obtaining information to substantiate your claim.
- The Attending Physician's Statement must be completed by a licensed Physician or Specialist.
- Please retain a photocopy of your claim forms for your records.

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Claimant's Statement

Proof of claim must be submitted within 180 days of the date of diagnosis or surgery.

Instructions

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

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

Claim Details

Please describe the nature of your critical illness.

When was your condition diagnosed or surgery performed? (YYYY-MM-DD)	When did symptoms first commence? (YYYY-MM-DD)

Please describe the symptoms.

When did you first consult a physician in connection with your illness? (YYYY-MM-DD)

Name of Attending Physician	Telephone Number

Mailing address (Number and Street)	City or Town	Province	Postal Code

Have you undergone any tests or investigations related to the diagnosis? ☐ Yes ☐ No
If **yes**, please provide details and dates.

Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No
If **yes**, please provide details and dates.

Medical Consultations

Please provide the name and address of your personal physician.

Name of Attending Physician		Degree/Specialty	Telephone Number
Mailing address (Number and Street)	City or Town	Province	Postal Code
Attending Physician's Email Address		How long has this physician been involved in your care?	

Please provide details of any other physicians or specialists who have been consulted in connection with your illness.

Name of Physician	☐ Primary Care ☐ Consultant	Degree/Specialty	Telephone Number
Mailing address (Number and Street)	City or Town	Province	Postal Code
Attending Physician's Email Address		Date seen (YYYY-MM-DD)	

Name of Physician	☐ Primary Care ☐ Consultant	Degree/Specialty	Telephone Number
Mailing address (Number and Street)	City or Town	Province	Postal Code
Attending Physician's Email Address		Date seen (YYYY-MM-DD)	

If you have been treated at a hospital or similar institution, please supply the following information.

Name of hospital	City or town
Date of admission (YYYY-MM-DD)	Date of discharge (YYYY-MM-DD)

Please indicate the names and addresses of any other physicians who have treated you in the last 3 years.

Name of Physician		Degree/Specialty	Telephone Number
Mailing address (Number and Street)	City or Town	Province	Postal Code

Name of Physician		Degree/Specialty	Telephone Number
Mailing address (Number and Street)	City or Town	Province	Postal Code

What type(s) of treatment have you received, or are currently receiving, in connection with your condition? (i.e. medications, therapy, etc.)

Type of treatment	
Institution/Prescribing physician	Date (YYYY-MM-DD)

Type of treatment	
Institution/Prescribing physician	Date (YYYY-MM-DD)

General

Have any of your immediate biological family members (parents, brothers, sisters) had heart disease, kidney disease, stroke, diabetes, cancer, familial colon polyposis or any hereditary disease, the onset of which was prior to age 65?

☐ Yes ☐ No If **yes**, please indicate:

Relationship	Nature of illness	Age at which illness was first diagnosed
Relationship	Nature of illness	Age at which illness was first diagnosed
Relationship	Nature of illness	Age at which illness was first diagnosed

In the past 12 months, have you used cigarettes, e-cigarettes, vaping products, more than one large cigar per month, water pipes, betel nuts more than once a month, smoking cessation products or nicotine or tobacco in any other form?

☐ Yes ☐ No

Are you currently receiving or have you applied for short or long term disability benefits with RBC Life Insurance Company? ☐ Yes ☐ No

If **yes**, please indicate:

Policy number	Claim Number
Disability Claims Specialist's first name	Disability Claims Specialist's last name

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

Claimant 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 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 Insurance Board; and also to any other person, or institution having information, records or data regarding me, my medical history or treatment.

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, 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, 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

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Attending Physician's Statement
Cancer Statement

Patient information (This part of the form should be completed before the physician completes the Medical Information Section)

IMPORTANT: Please note that you are responsible for the cost of completing this form.

Patient's Last Name	Patient's First Name	Patient's Middle Name	Date of Birth (YYYY-MM-DD)
Mailing Address (number and street)	City or Town	Province	Postal Code
Telephone Number	Email address		

Patient's authorization and signature

I authorize my doctor to collect, use and disclose information with RBC Life Insurance Company, its agents and service providers for the purposes of underwriting, administration and adjudicating my claim under this insurance plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the claim. I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

Signature of Patient

Name:

Date: YYYY MM DD

Medical information

Your patient would appreciate completion of this form as soon as possible otherwise there may be delays in processing this claim.

When did your patient first have symptoms? (YYYY-MM-DD)	What were the symptoms?
When did your patient first consult you for this condition? (YYYY-MM-DD)	How long has this person been your patient?
Please provide the date this cancer was diagnosed. (YYYY-MM-DD)	

When was the patient advised of the diagnosis? (YYYY-MM-DD)

Advised by whom?

Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer.

Please provide a copy of the pathology report giving the following details:

- Type of Tumour
- Site of Tumour
- Histology and Staging

Has your patient previously suffered from cancer or any predisposing disorders? If so, please provide dates and details.

Is there a family history of cancer?

☐ Yes ☐ No

Please provide details.

Please provide details of your patient's past and present tobacco use, including amount per day and date last used.

Please provide details of your patient's past and present use of any smoking cessation products, including amount per day and date last used.

Please provide details of any other significant family history.

Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of all test results, pathology reports, surgical reports and consultation reports with respect to this condition.

Physician's authorization and signature

I certify that the information in this form is true and correct

Name of Attending Physician ☐ Primary Care ☐ Consultant

Degree/Specialty

Attending Physician's Email Address

Telephone Number

Fax Number

Mailing address (Number and Street)

City or Town

Province

Postal Code

Signature of Physician

Name:

Date: YYYY MM DD

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Attending Physician's Statement
Heart Attack Statement

Patient information (This part of the form should be completed before the physician completes the Medical Information Section)

IMPORTANT: Please note that you are responsible for the cost of completing this form.

Patient's Last Name	Patient's First Name	Patient's Middle Name	Date of Birth (YYYY-MM-DD)
Mailing Address (number and street)	City or Town	Province	Postal Code
Telephone Number	Email address		

Patient's authorization and signature

I authorize my doctor to collect, use and disclose information with RBC Life Insurance Company, its agents and service providers for the purposes of underwriting, administration and adjudicating my claim under this insurance plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the claim. I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

Signature of Patient

Name:

Date: YYYY MM DD

Medical information

Your patient would appreciate completion of this form as soon as possible otherwise there may be delays in processing this claim.

When did your patient first consult you for this condition? (YYYY-MM-DD)

How long has this person been your patient?

Was a diagnosis of heart attack made?

☐ Yes ☐ No

When was the diagnosis made? (YYYY-MM-DD)

By whom was the diagnosis made?

Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this heart attack.

Please provide description and date of onset of chest pain pertaining to the insured's heart attack.

Please provide ECG changes in detail at time of event.*

Please provide cardiac enzyme levels and/or troponin including CK - MB fraction and percentage of total CK at time of diagnosis pertaining to the insured's heart attack.

What other investigations have been performed? Please provide dates and details, or reports.

***Provide copies of tracings pertaining to the insured's heart attack, if available**

When did your patient first suffer symptoms or episodes of cardiovascular disease? (YYYY-MM-DD)

Please provide details and dates.

Please describe (including dates) any predisposing conditions or risk factors that your patient has had for cardiovascular disease.

Is there a family history of cardiovascular disease or cerebrovascular disease? Please provide details.

☐ Yes ☐ No

Please provide details of your patient's past and present tobacco use, including amount per day and date last used.

Please provide details of your patient's past and present use of any smoking cessation products, including amount per day and date last used.

Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of test results and consultation reports with repect to this condition, including a copy of the following:

- The ECG's that document this heart attack
- The cardiac enzyme level reports, including CK-MB BANS, Troponin I or Troponin T documenting this heart attack
- All ECG test results, cardiac enzyme test and consultation and discharge notes
- Reports of any other cardiac investigation performed such as coronary angiography, echocardiography, etc.

Physician's authorization and signature

I certify that the information in this form is true and correct

Name of Attending Physician	☐ Primary Care ☐ Consultant		Degree/Speciality
Attending Physician's Email Address		Telephone Number	Fax Number
Mailing address (Number and Street)	City or Town	Province	Postal Code

Signature of Physician

Name:

Date: YYYY MM DD

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Attending Physician's Statement
Stroke Statement

Patient information (This part of the form should be completed before the physician completes the Medical Information Section)

IMPORTANT: Please note that you are responsible for the cost of completing this form.

Patient's Last Name	Patient's First Name	Patient's Middle Name	Date of Birth (YYYY-MM-DD)
Mailing Address (number and street)	City or Town	Province	Postal Code
Telephone Number	Email address		

Patient's authorization and signature

I authorize my doctor to collect, use and disclose information with RBC Life Insurance Company, its agents and service providers for the purposes of underwriting, administration and adjudicating my claim under this insurance plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the claim. I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

Signature of Patient

Name:

Date: YYYY MM DD

Medical information

Your patient would appreciate completion of this form as soon as possible otherwise there may be delays in processing this claim.

When did your patient first consult you for this condition? (YYYY-MM-DD)	How long has the insured been your patient?
Was a diagnosis of stroke made? ☐ Yes ☐ No	When did the stroke occur? (YYYY-MM-DD)
Please describe the cause of the stroke.	

Please describe the measurable residual neurological deficits.

How long have the neurological deficits persisted?

By whom was the diagnosis made?

When was the patient advised of the diagnosis? (YYYY-MM-DD)

Advised by whom?

Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke.

What other investigations have been performed? Please provide dates and details, or reports.

When did your patient first suffer symptoms or episodes of cerebrovascular disease? (YYYY-MM-DD)

What were they?

Please describe (including dates) any predisposing disorders or risk factors that your patient had for cerebrovascular disease.

Is there a family history of cardiovascular disease or cerebrovascular disease?

☐ Yes ☐ No

Please provide details.

Please provide details of your patient's past and present tobacco use, including amount per day and date last used.

Please provide details of your patient's past and present use of any smoking cessation products, including amount per day and date last used.

Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of test results and consultation reports including a copy of the CT scan or MRI if available.

Physician's authorization and signature

I certify that the information in this form is true and correct

Name of Attending Physician ☐ Primary Care ☐ Consultant

Degree/Specialty

Attending Physician's Email Address

Telephone Number

Fax Number

Mailing address (Number and Street)

City or Town

Province

Postal Code

Signature of Physician

Name:

Date: YYYY MM DD