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 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 disability claim form consists of 3 parts
  - Employer's Statement
  - Claimant's Statement, and
  - Attending Physician's 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.
- The Attending Physician's 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? | Indicate number of hours worked per week | If seasonal, indicate inclusive annual dates of employment (YYYY-MM-DD): |
|---|---|---|
| ☐ Full-time ☐ Part-time ☐ Seasonal | | 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

Royal Bank of Canada

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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 Attending Physician's Statement of Disability 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

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## Attending Physician's Statement

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

**Instructions**

- To keep your report confidential, please return it to the claimant to be submitted with their claim form.
- Any cost incurred for the completion of this form is the patient's responsibility.
- The purpose of this report is to assist us in making a disability determination. When filling out this report, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to treatment to enable us to make this determination.

## Patient Authorization

I authorize my doctor to use, release and exchange information with RBC Life Insurance Company, its agents and service providers for the purpose of underwriting, administration and adjudication of my claims under this Plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.

Signature of Patient

Name:

Date: YYYY MM DD

## Medical information

**History**

When did symptoms first appear or accident/injury happen? (YYYY-MM-DD)

Date the patient ceased work because of incapacity (YYYY-MM-DD)

Has the patient ever had the same or similar condition? ☐ Yes ☐ No
If **yes,** state date and describe.

If the condition is long-standing, how would you describe its evolution since onset?

☐ Improved ☐ Remained the same ☐ Slight deterioration ☐ Significant deterioration

Is condition due to injury or sickness arising out of patient's employment?

☐ Yes ☐ No ☐ Unknown

If condition due to accident/injury, how did the accident/injury occur?

Was the patient impaired by alcohol or drugs at the time of the accident/injury?

☐ Yes ☐ No ☐ Unknown

Is condition due to, or related to, pregnancy?

☐ Yes ☐ No

If **yes,** please indicate date of confinement (YYYY-MM-DD)

Is the patient receiving or in need of treatment for the use of alcohol or drugs?

☐ Yes ☐ No

Is this condition due to a self-inflicted injury or attempted suicide?

☐ Yes ☐ No

Is this condition due to elective cosmetic or experimental surgery or treatment?

☐ Yes ☐ No

**Diagnosis** (including any complications)

| Primary Diagnosis | Secondary Diagnosis | Subjective symptoms |
|---|---|---|
| | | |
| | | |

Objective findings (include current X-rays, EKG's, laboratory data and any clinical findings)

**Date of Treatment**

Date of first visit (YYYY-MM-DD)

Date of last visit (YYYY-MM-DD)

Frequency of visits

☐ Weekly ☐ Monthly ☐ Other (specify): _____

**Nature of Treatment** (including surgery and medications prescribed, if any)

**Progress**

Has patient:

☐ Recovered ☐ Remained Unchanged

☐ Improved ☐ Retrogressed

Is patient:

☐ Ambulatory ☐ Bed confined

☐ House confined ☐ Hospital confined

Has patient been hospital confined?

☐ Yes ☐ No

If **yes,** give name and address of hospital.

Confinement Dates (YYYY-MM-DD)

From To

**Cardiac** (if applicable)

Functional capacity (American Heart Association)

☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood pressure (last visit)

Systolic _____ / Diastolic _____

**Physical Impairment**

☐ Class 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0 - 10%)
☐ Class 2 - Medium manual activity (15 - 30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work (35 - 55%)
☐ Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity. (60 - 70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity (75 - 100%)
☐ Specific limitation? (bending, lifting, etc.) _____

**Remarks:**

Explain what prevents the patient from a return to full or partial duties.

Do you feel the patient could return to work provided some of his/her duties/hours could be modified? If so, state what these would be and the date you anticipate the patient can return to modified duties/hours.

**Mental/Nervous Impairment (**if applicable)

Please use DSM-IV terminology, including multi-axial assessment and general assessment of function GAF

Axis I (Primary)

Axis II

Axis III

Axis IV

Axis V - GAF current lowest in past year

State at which GAF level the patient would be fit to resume full time work. _____

**Remarks:**

Explain how the patient's psychological limitations prevent him/her from performing the essential duties of his/her occupation.

Do you feel the patient could return to work provided some of his/her duties/hours could be modified? If so, state what these would be and the date you anticipate the patient can return to modified duties/hours.

Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ☐ Yes ☐ No

**Prognosis**

Is patient now totally incapacitated? **(Patient's Job)**

☐ Yes ☐ No

Is patient now totally incapacitated? **(Any other work)**

☐ Yes ☐ No

If **no,** when was patient able to resume work?

YYYY-MM-DD ☐ Indefinite ☐ Never

_____

If **yes,** when do you expect patient will recover sufficiently to resume work?

YYYY-MM-DD ☐ Indefinite ☐ Never

_____

Please provide the dates the patient consulted you for this or any other condition in the last three years.

| Dates (month/year) | History (Physical Findings) | Diagnosis | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Provide us with any copies of any available test results, hospital records, consultation notes, and specialist reports in the last three years.

Indicate the names and addresses of any other physicians who have treated this patient in the last 3 years.

| Name/Specialty | Reason for referral/treatment | Address | Telephone/Fax |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Attending Physician's Signature

| 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