LoanProtector®
HomeProtector®

Important information about Claiming Critical Illness benefits

Critical Illness Benefit Claim Form

LoanProtector® Group
Policy Number H.28544
HomeProtector® Group
Policy Number H.60200

How to claim for benefits.

To claim for Critical Illness insurance benefits on an insured Royal Credit Line® account, personal loan or mortgage, **fully complete** the attached **Critical Illness Benefit Claim Form** and have a licensed doctor complete the **Attending Physician's Statement** (attached) and forward it to the Insurer, The Canada Life Assurance Company (Canada Life), via the Insurance Service Centre.

Insurance Service Centre
PO Box 53, Postal Station A
Mississauga, ON L5A 2Y9

or fax to: 1-800-864-6102

The Insurance Service Centre will then forward your claim to Canada Life, the Insurer.

Important:

- The claim cannot be forwarded to Canada Life until we receive all the required documentation. Please ensure all information is fully complete to avoid unnecessary delays in the processing of your request. Please include:
  - A completed and signed Critical Illness Benefit Claim form
  - A signed Authorization - Sections 1 & 2
  - A completed and signed Attending Physician's Statement
  - Any additional information that you think is relevant to your claim
- Please note that Canada Life may require additional medical information from your physician or other information in order to process the claim. You will be advised in writing in either case.
- IF YOU CLOSE OR REFINANCE YOUR LOAN/MORTGAGE OR INCREASE YOUR ROYAL CREDIT LINE LIMIT TO GREATER THAN $100,000 WHILE THE CLAIM IS BEING PROCESSED, THIS MAY RESULT IN YOUR CLAIM NOT BEING PAID. PLEASE CONTACT THE INSURANCE SERVICE CENTRE AT 1-800 ROYAL 2-3 (1-800-769-2523) IF YOU NEED FURTHER INFORMATION.
- It is your responsibility to keep the mortgage, loan or Royal Credit Line® payments up to date while your claim is under review by Canada Life.
- Critical illness claim forms must be received by the Insurer within 180 days from the date of Diagnosis of the critical illness; otherwise, the claim may be denied.

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

If a claim is approved by Canada Life, they will advise the Insurance Service Centre and the Insurance Service Centre will notify you directly in writing. If a claim is denied, Canada Life will advise you in writing, explaining the reason the claim has been denied. A separate letter will be sent to the Insurance Service Centre to advise them of Canada Life's decision; however, it will not include the reason(s) if a claim has been denied.

If you are an RBC Royal Bank® Online Banking client, you will receive automatic status updates on your claim.

Who do I contact for more information?

The Insurance Service Centre is responsible for the administration and servicing of the 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 the claim is processed quickly. If you have any questions or require information about the status of the claim, please call the Insurance Service Centre at 1-800 ROYAL 2-3 (1-800-769-2523).

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

For additional information, including limitations and exclusions, please refer to your certificate of insurance for details on coverage. The certificate of insurance consists of the LoanProtector® or HomeProtector® booklet and/or Fact Sheet and Product Summary and any applicable addendums and/or amendments, the completed application or application confirmation letter, as well as any documents submitted as evidence of insurability (if applicable.)

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The Canada Life Assurance Company (the Insurer) has issued group creditor insurance policies to Royal Bank of Canada, including the associated companies Royal Bank Mortgage Corporation, Royal Trust Corporation of Canada and Royal Trust Company (RBC Royal Bank).

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

1. **Critical Illness Benefit Claim Form**
   - Must be completed by the claimant or an Authorized Representative
2. **Attending Physician's Statement**
   - Part 1 must be completed by the claimant or an Authorized Representative
   - Part 2 must be completed by the licensed physician treating the claimant.

The claimant or an Authorized Representative is responsible for the securing of the Attending Physician's Statement and any charge for its 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.
- 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 RBC Royal Bank® on your behalf and the date until which payments will continue.
- It is your responsibility to keep your mortgage, Royal Credit Line® and loan payments up to date while your claim is under review.

Please send the completed forms 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 (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.

Critical Illness Claimant Information - Must be Completed by the Claimant or an Authorized Representative

Name of Claimant - Last Name	First Name	Initial(s)

Maiden Name *(if applicable)*	Date of Birth *(YYYY/MM/DD)* / /

Mailing Address *(number and street)*	City or Town

Province	Postal Code	Telephone No.	Email Address *(if applicable)*

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

Current family physician's name	Telephone No.	Fax No.	Email Address

Current family physician's address *(number and street)*	City or Town	Province	Postal Code

Name of treating physician *(other than family physician)*	Specialty	Approximate dates of visits **From:** yyyy / mm / dd	**To:** yyyy / mm / dd

Treating physician's address *(number and street)*	City or Town	Province	Postal Code

Telephone No.	Fax No.	Email Address

Name of treating physician *(other than family physician)*	Specialty	Approximate dates of visits **From:** yyyy / mm / dd	**To:** yyyy / mm / dd

Treating physician's address *(number and street)*	City or Town	Province	Postal Code

Telephone No.	Fax No.	Email Address

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Critical Illness Benefit Claim Form

Section 1 - 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, pharmacists, employers and all other agencies to provide a copy of your medical and employment records to the Insurer, for the purposes of adjudicating and administering your claim.

You understand that your personal information is needed by Canada Life to investigate, assess and administer your critical illness claim. You acknowledge that your consent enables Canada Life to process your claim and that refusing to consent may result in delay in decision or denial of the claim.

This Authorization is effective as of the date below. You may revoke this consent at any time by sending a written instruction to Canada Life.

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

Signature of Claimant or Authorized Representative **Date**

X _____ _____

year/ month / day

Section 2 – Authorization Form to Release Personal Information – Must be completed by the claimant

Claimant Authorization Form to Release Personal Information:

If you wish to authorize someone other than yourself (such as a family member or friend) to communicate with The Canada Life Assurance Company (Canada Life) on your behalf with respect to your claim, please complete this Authorization Form. Communication will be limited to matters related to the claim for benefits. This authorization shall remain valid for the duration of the claim for benefits or until otherwise revoked by you. A reproduction of this authorization shall be as valid as the original.

I _____ authorize Canada Life to communicate personal information that relates to my claim for benefits with:

Name of the appointed person who is authorized to communicate on your behalf	Relationship to the appointed person
Address of the appointed person	Telephone No.

Please select one option: ☐ Excluding medical information ☐ Including medical information

**If no option is selected, medical information will not be released by Canada Life to the authorized appointed person.

Signature of Claimant/Insured	Date *(year/month/day)*

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Critical Illness Benefit Claim Form

Attending Physician's Statement

How to complete the form:

Part 1 - Must be completed by the claimant

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

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

The claimant or an Authorized Representative is responsible for the securing of the Attending Physician's Statement and any fee which may be charged for its completion.

Part 1 - Claimant's Authorization or Authorized Representative

Name of Claimant - Surname	First Name	Initial(s)

Email Address *(If applicable)*	Date of Birth *(YYYY/MM/DD)* / /

Mailing Address *(number and street)*	City or Town	Province	Postal Code

Telephone No.	Mobile No.	Business No.

Signature of Claimant or Authorized Representative

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 or Authorized Representative X _____

Date _____ year / month / day

Part 2 - Attending Physician's Statement

Patient Information

Last Name	First Name	Initial(s)	Date of Birth *(year/ month/ day)*

Diagnosis			

Date symptoms first appeared *(year/ month/ day)*	Exact Date of First diagnosis *(year/ month/ day)*

Has the patient ever had a similar condition? ☐ Yes ☐ No

If Yes, please give details *(i.e. date of first symptoms, date of diagnosis, duration, etc yyyy/ mm/ dd)*

Has the patient been hospitalized? ☐ Yes ☐ No	If yes, provide length of stay *(year/ month/ day)* From: To:

Hospital Name	Hospital Telephone No.	Hospital Fax No.	

Hospital Address *(number and street)*	City or Town	Province	Postal Code

We require copies of all specialist consultation notes, admission/discharge records relating to the cause of claim. For the following conditions, please ensure attached documentation includes but is not limited to:

Heart Attack: ECG's from the day of event and lab results supporting diagnosis including previous and new cardiac enzyme levels.

Stroke: Diagnostic evidence supporting stroke diagnosis and current neurological deficits that have been present for over 30 days.

Cancer: Diagnostic evidence to confirm uncontrolled growth and spread of malignant neoplasm including initial and final biopsy/pathology reports.

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

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Name and Address of Attending Physician

Attending Physician - Surname		First Name	Specialty
Name of Facility/Clinic *(Hospital, Medical Centre)*			
Mailing Address *(Number and Street)*			City or Town
Province	Postal Code	Business Telephone No.	Fax No.
Email Address			

Names and addresses of other treating physicians

Surname, First Name		Specialty	
Mailing Address *(Number and Street)*		City or Town	Province / Postal Code
Telephone No.	Fax No.	Email Address	
Surname, First Name		Specialty	
Mailing Address *(Number and Street)*		City or Town	Province / Postal Code
Telephone No.	Fax No.	Email Address	

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 Physician _____

Date _____
year / month / day

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

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

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Communication will be limited to matters related to the claim for benefits. This authorization shall remain valid for the duration of the claim for benefits or until otherwise revoked by you. A reproduction of this authorization shall be as valid as the original.

I _____ **authorize** Canada Life to communicate personal information that relates to my claim for benefits with:

_____
(Appointed Person who is authorized to communicate on your behalf)

Please select one option:

☐ Excluding medical information

☐ Including medical information

If no option is selected, medical information will not be released to the authorized appointed person.

_____ _____
Signature Date