Royal Bank of Canada

Life Benefit Claim
Business Loan Insurance Plan

Group Policy 52000

Instructions:

1. **Complete Section 2 & 3** if death occurs within 2 years of the application for insurance, any advance of funds or if death is the result of an accident.
2. **Attach:** Original or certified true copy of Death Certificate or Funeral Director's Statement; Original copies of all Applications for Insurance.

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.**

Section 1 - General Information

Business Name		Business SRF Number	Loan Number
Contact Name	Telephone Number	Mobile Number	Email Address
Business Address	City or Town	Province	Postal Code
Business Account Manager		Telephone Number	Fax Number

Deceased's Last Name	Deceased's First Name	Deceased's Middle Name	Date of Birth (YYYY-MM-DD)	Personal SRF Number
Address		City or Town	Province	Postal Code
Cause of Death			Date of Death (YYYY-MM-DD)	Life Insurance Amount

Section 2 - Physician's Statement

Deceased's Name	Date Last Illness Began (YYYY-MM-DD)	Date of Death (YYYY-MM-DD)
Place of Death	Immediate Cause of Death	Contributory Cause of Death

Was death due to
☐ Natural Causes ☐ Suicide ☐ Accident ☐ Homicide

If death is other than natural causes, please provide details along with a copy of the Police, Fire or Coroner's reports.

To the best of your knowledge, has the deceased ever used any tobacco products?
☐ Yes ☐ No ☐ Yes, but stopped on YYYY-MM-DD

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Did you treat or advise the deceased during the 3 year period preceding death? If **yes,** please provide details (dates, illness/injury):

☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last **3 years** from any other physician, Health practitioner, or in any hospital or institution? If **yes,** please provide details. ☐ Yes ☐ No

Date	Name of physician/hospital	Address	Details

Name of Attending Physician		Telephone Number	Fax Number
Mailing address (Number and Street)	City or Town	Province	Postal Code

To the best of my knowledge and belief, the above statements are true and complete.

Signature of Physician

Name:

Date: YYYY MM DD

Section 3 - Next of Kin's Statement

Relationship to the Deceased

To the best of your knowledge, has the deceased ever used any tobacco products?

☐ Yes ☐ No ☐ Yes, but stopped on

What date did the deceased first complain of, or consult a physician for, his/her last illness? (YYYY-MM-DD)

YYYY-MM-DD

Names and addresses of attending physicians of the deceased and hospitals where deceased was treated during the **3 years** prior to death.

Print Name	Address	Date (YYYY-MM-DD)	Medical Condition

I declare the questions answered on this statement are complete and true to the best of my knowledge.

I authorize RBC Life Insurance Company, the plan administrator(s), and their advisors and service providers to collect, use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage relating to _____ (the life insured). I authorize any company or public/private organization, law enforcement agency, fire protection or fire investigation official(s), Federal or Provincial Government Department, health care professional, health or social service establishment, insurance company, the Medical Information Bureau holding personal/medical information concerning the deceased, particularly medical information, to supply this information or statements to RBC Life Insurance Company, and/or its service provider or authorized agents. I hereby consent to the disclosure of such information to RBC Life Insurance Company, and/or its service provider or authorized agents, and to other sources as may be required to adjudicate this claim or assess the validity of the insurance as issued.

I understand this claim may be subject to review and investigation.

I understand that, if I refuse to provide this authorization, RBC Life Insurance Company and/or its service provider will be unable to adjudicate this claim or assess the validity of the insurance as issued.

A photocopy of the signed authorization to obtain this information will be as legally valid as the original. This authorization will be valid until revoked by written notice to RBC Life Insurance Company.

Signature of Next of Kin

Name:

Date: YYYY MM DD

Signature of Witness

Name:

Date: YYYY MM DD