LoanProtector®
HomeProtector®
Disability Benefit Claim Form

Important information about claiming disability insurance benefits

LoanProtector® Group
Policy Number H28445
HomeProtector® Group
Policy Number H60101

How to claim for benefits:

To claim for disability insurance benefits on an insured Royal Credit Line® account, personal loan or mortgage, **fully complete** the **attached Disability Benefit Claim Form, Employer Statement** and have the 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 **or** fax to: 1-800-864-6102
P.O. Box 53, Postal Station A
Mississauga, ON L5A 2Y9

Important:

- As there is a 60 day waiting period to qualify for benefits, do not submit your claim until you know that your disability will last for more than 60 consecutive days.
- 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 Attending Physician's Statement
  - A completed and signed Disability Benefit Claim form
  - Any additional information that you think is relevant to your claim
- You will be advised in writing if additional information is required to process the claim (e.g., additional medical information, accident report, etc.)
- If a claim is made within the first two years of the date of application, Canada Life may be required to obtain additional medical history from your physician.
- **IT IS IMPORTANT NOT TO CLOSE OR REFINANCE YOUR LOAN/MORTGAGE OR INCREASE YOUR ROYAL CREDIT LINE LIMIT TO GREATER THAN $100,000, WHILE THE CLAIM IS BEING PROCESSED. TO DO SO MAY INVALIDATE YOUR CLAIM.**
- It is your responsibility to keep the mortgage, loan or Royal Credit Line® payments 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.
- A disability claim must be sent to the Insurer within 150 days from the day your disability started, otherwise claims will be denied. For any consideration of exception appeal to this limitation, you must submit all medical information required to support your late claim from date of disability to date of claim submission.

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

If a claim is approved or denied, Canada Life will advise you in writing.

If you are an RBC Royal Bank® Online Banking client, you will receive automatic updates on the status of 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 distribution guide 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 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 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.

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- 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 RBC Royal Bank® 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, 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.

General Information - Must be Completed by the Claimant

Client Card No.

Branch Telephone No.

Branch Transit No.

Type of Loan

☐ Mortgage
☐ Personal Loan
☐ Royal Credit Line® (RCL)

Type of Insurance

☐ HomeProtector®
☐ LoanProtector®

Disability Claimant Information - Must be Completed by the Claimant

Name of Claimant – Surname. | First Name | Initial(s)

Maiden Name *(if applicable)*

Date of Birth m m m / d d / y y y y

Gender: ☐ Male ☐ Female

Mailing Address *(number and street)*

City or Town

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

Occupation at date of Disability/Unemployment

Self-employed? ☐Yes ☐No

Employment type? ☐Full-time ☐Part-time ☐Seasonal ☐Temporary

Name of employer at time of Disability *(please print)*

Start date of employment m m m / d d / y y y y

If seasonal, regular months of employment *(mmm/dd/yyyy)* From: To:

Employer's Address *(number and street)*

City or Town

Province | Postal Code | Business Telephone No. | Name of supervisor or contact person

Brief job description

Tell us about your most recent employment history

Employer	Duration *(mmm/dd/yyyy)*	Total hours worked each week	Name of supervisor or contact person	Contact telephone
	From: To:			
Employer	Duration *(mmm/dd/yyyy)*	Total hours worked each week	Name of supervisor or contact person	Contact telephone
	From: To:			

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Disability Claimant Information Continued

Last day worked before disability m m m / d d / y y y y

Are you still disabled? ☐Yes ☐No

Date returned to work m m m / d d / y y y y

Expected to return to work m m m / d d / y y y y

Cause of disability? ☐Accident ☐Illness

If accident, date of accident m m m / d d / y y y y

If MVA (motor vehicle accident, include the **Police Report**) ☐Driver ☐Passenger

Location of accident? ☐Home ☐Work ☐Other *(please specify)*_____

How did the accident happen/ Cause of Disability

When did the illness begin? m m m / d d / y y y y

Nature of illness or injury

Present treatment *(medication, diets, physiotherapy, etc.)*

Have you been hospitalized for this condition? ☐Yes ☐No

If Yes, From when m m m / d d / y y y y To m m m / d d / y y y y

At which hospital?

Hospital Telephone No.

Have you ever had same or similar condition? ☐Yes ☐No

If Yes, From when m m m / d d / y y y y To m m m / d d / y y y y

Describe the previous condition(s)

Are you entitled to any other disability benefits? ☐Yes ☐No

If yes, check the appropriate box(es) below

☐Worker's Compensation ☐Group disability coverage at work ☐Automobile insurance

☐Canada or Quebec Pension Plan ☐Other government plan ☐Private plan

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

Current family physician's name *(please print)*

Telephone No.

Fax No.

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: m m m / d d / y y y y To: m m m / d d / y y y y

Telephone No.

Treating 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: m m m / d d / y y y y To: m m m / d d / y y y y

Telephone No.

Treating physician's address *(number and street)*

City or Town

Province

Postal Code

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Section 1 - Signature and Authorization - Must be completed by the claimant

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 disability 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

_____

Date

_____/_____/_____
(month) (day) (year)

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) and RBC Insurance Services Inc. 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 and RBC Insurance Services Inc. 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. RBC Insurance Services Inc. does not have access to medical information

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

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EMPLOYER STATEMENT - Must be completed by your current Employer

Name of Employer		Name of Claimant		
Employer's mailing address *(Number and Street)*		City or Town	Province	Postal Code
Commencement date of employment *(month/day/year)*	Date last worked *(month/day/year)*		Reason for discontinuing work	
If layoff, date employee notified *(month/day/year)*	Date expected to return to work *(month/day/year)* ☐ Full-time ☐ Part-time **OR**		Date returned to work *(month/day/year)* ☐ Full-time ☐ Part-time	
Did employee receive severance? ☐ Yes ☐ No If Yes, date severance ends *(month/day/year)*		Occupation as of last day worked		

Type of position

☐ Full-time ☐ Part-time **Specify number of hours worked per week:**	Seasonal, provide inclusive dates of employment: *(month/day/year)*	
	From:	To:

For a disability claim, brief outline of job duties and physical requirements *(e.g.: amount of standing, bending, lifting, sitting, etc.)* Please attach a copy of job description.

Has a claim been submitted to Workers Compensation? ☐ Yes ☐ No
If Yes, indicate the office address.

Physical Demands of the occupation at the time of disability

Please circle the appropriate numbers below for each Job requirement:

0 - never performed
1 - sometimes performed
2 - performed occasionally, less than 1 hour per day
3 - frequent and/or repetitious for 1-3 hours daily
4 - maximum job requirement for over 3 hours per day

Sitting	0	1	2	3	4	Gripping	0	1	2	3	4
Standing	0	1	2	3	4	Typing	0	1	2	3	4
Walking	0	1	2	3	4	Climbing	0	1	2	3	4
Bending	0	1	2	3	4	Lifting	0	1	2	3	4
Kneeling	0	1	2	3	4	Pulling	0	1	2	3	4
Carrying	0	1	2	3	4	Pushing	0	1	2	3	4
Reaching:						Lifting, Carrying, Pushing, Pulling:					
Below Shoulder	0	1	2	3	4	0 to 10lbs	0	1	2	3	4
Above Shoulder	0	1	2	3	4	10 to 25lbs	0	1	2	3	4
						25 to 50lbs	0	1	2	3	4
						over 50lbs	0	1	2	3	4

Name of insurance company *(other than Worker's Compensation)* providing group disability coverage for your employees. Please include Policy Number and contact person.

Insurance Company	Contact Person	Telephone No.

I certify that according to the records of this organization the above information is correct.

Name of authorized officer *(please print)*	Title	Telephone No.
Signature of authorized officer	Date *(day, month, year)*	

Please return to your employee.

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Attending Physician's Statement

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 or 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

Name of Claimant - Surname | First Name | Initial(s)

Client Card No. | Date of Birth

Gender: ☐ Male ☐ Female

m m m / d d / y y y y

Mailing Address *(number and street)* | Telephone No. | Email Address *(if applicable)*

City or Town | Province | Postal Code

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

History

Date of Diagnosis for the Disabling condition *(month/day/year)*	Date patient became disabled *(month/day/year)*	Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No ☐ Unknown
Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown If Yes, state when and describe	Is condition considered chronic? ☐ Yes ☐ No	What precipitated absence from work?

How long has Claimant been your patient? Years: Months:

Names and addresses of other treating physicians

Name	Specialty	Telephone No.	
Mailing address *(Number and Street)*	City or Town	Province	Postal Code
Name	Specialty	Telephone No.	
Mailing address *(Number and Street)*	City or Town	Province	Postal Code

Cause of Disability

Primary Diagnosis - what is the primary cause of disability? *(including any complications)*

Secondary Diagnosis *(if applicable)*

Are there any additional conditions or complications which might affect duration of absence from work? ☐ 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)*

Subjective symptoms

Objective signs *(including results of current x-rays, EKG'S, MRI'S, CATSCANS or laboratory data and any relevant clinical findings).* Please provide copies.

Is the patient receiving or in need of treatment for the use of alcohol or drugs? ☐ Yes ☐ No
If yes, please advise all details of the rehabilitation program.

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

Cont'd...

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Current Functional Limitations

1. **Function**	Degree of limitation						Degree of limitation				
	None	Slight	Moderate	Severe	Don't Know		None	Slight	Moderate	Severe	Don't Know
Cognition	☐	☐	☐	☐	☐	Dexterity	☐	☐	☐	☐	☐
Psychological	☐	☐	☐	☐	☐	Vision	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐						
Walking	☐	☐	☐	☐	☐	Please add any other functions limited by the illness or injury:					
Standing	☐	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐						
Bending	☐	☐	☐	☐	☐	Please indicate max. recommended weight _____			☐ lb		☐ kg
Lifting	☐	☐	☐	☐	☐						

2. Describe any functional limitations, physical or psychological, which you consider to be major obstacles to the person's ability to work.

3. Were any functional capacity evaluations performed? ☐ Yes ☐ No
If yes, state type

When *(month/day/year)*

Treatment

Date of first visit for the disabling condition *(month/day/year)*

Date of latest visit for the disabling condition *(month/day/year)*

Frequency of visits
☐ Weekly ☐ Monthly ☐ Other *(specify)*

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

To your knowledge is patient following recommended treatment program? ☐ Yes ☐ No
If No, please comment:

Progress

Has patient ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed
Please comment:

Prognosis

Is patient now **totally disabled** from own occupation?

☐ Yes,
State date you think patient will be able to resume work *(month/day/year)*

☐ No,
State date patient was able to work *(month/day/year)*

If indefinite, estimate:
☐ 1 - 3 months ☐ 4 - 6 months
☐ Over 6 months ☐ Never

Is patient a suitable candidate for some trial employment or rehabilitation? ☐ Yes ☐ No
If Yes, state date *(month/day/year)*

Has patient been referred to another doctor? ☐ Yes ☐ No
If No, date referred *(month/day/year)*

Name	Specialty	Telephone No.	
Mailing address *(Number and Street)*	City or Town	Province	Postal Code

Remarks

Name and address of attending physician

Name of Attending Physician *(please print)*	Specialty	Telephone No.	
Name of Facility/Clinic *(Hospital, Medical Center)*			
Mailing address *(Number and Street)*	City or Town	Province	Postal Code

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 _____ / _____ / _____ (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