Royal Bank of Canada

LoanProtector® HomeProtector®

Disability Benefit Claim Form

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 a licensed doctor complete the **Initial Disability Insurance Medical Statement** (attached), and forward it to the Insurer, The Canada Life Assurance Company (Canada Life), via the Insurance Service Centre.

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 Disability Benefit Claim form
  - A completed Employer Statement
  - A signed Authorization - Sections 1 & 2
  - A completed and signed Initial Disability Insurance Medical Statement
  - 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.)
- 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 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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Disability Benefit Claim Form

Use these **three** 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. Employer Statement. Must be completed by your current employer.

3. Initial Disability Insurance Medical Statement. Section 1 must be completed by claimant. Section 2 must be completed by the licensed physician treating the claimant.

The claimant is responsible for the securing of the Initial Disability Insurance Medical 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.
- 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.

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).

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.** The Insurance Service Centre will assist you to questions related to the Royal Credit Line®, personal loan, or mortgage.

Email Address:
rbcinsurancecentre@rbc.com

Disability Claimant Information – Must be Completed by the Claimant

Name of Claimant	Last Name	Initials	Client Card Number
Maiden Name (If applicable)	Date of Birth		
Mailing Address (number and street)	City or Town	Province	Postal Code
Telephone No.	Mobile 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	Start date of employment (YYYY-MM-DD)	If seasonal, regular months of employment	

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Employer's Address (number and street)	City or Town	Province	Postal Code
Business Telephone No.	Name of supervisor or contact person	Supervisor/Contact person's email address	
Brief job description			

Most Recent Employment History

Employer	Duration (YYYY-MM-DD) From To	Total hours worked each week	Name of supervisor or contact person	Contact telephone
Employer	Duration (YYYY-MM-DD) From To	Total hours worked each week	Name of supervisor or contact person	Contact telephone

Disability Information

Last day worked before disability (YYYY-MM-DD)	Are you still disabled? ☐ Yes ☐ No	Date returned to work (YYYY-MM-DD)	Expected to return to work (YYYY-MM-DD)	Cause of disability?
If accident, date of accident (YYYY-MM-DD)	If MVA (motor vehicle accident, include the Police Report) ☐ Driver ☐ Passenger		Location of accident? ☐ Home ☐ Work ☐ Other _____	
How did the accident happen/ Cause of Disability				
When did the illness begin? (YYYY-MM-DD)	Nature of illness or injury			
Present treatment (medication, diets, physiotherapy, etc.)				
Have you been hospitalized for this condition? ☐ Yes ☐ No	If Yes, specify duration (YYYY-MM-DD) From To		At which hospital?	Hospital Telephone No.
Have you ever had same or similar condition? ☐ Yes ☐ No	If Yes, specify duration (YYYY-MM-DD) From To		Describe the previous condition(s)	
Are you entitled to any other disability benefits? ☐ Yes ☐ No	Are you entitled to any other disability benefits? 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 ☐ Other _____			

Physicians that you have consulted in the past five years

Current family physician's name		Telephone No.	Fax No.	
Current family physician's address	City or Town	Province	Postal Code	Family physician's email address
Name of treating physician (other than family physician)		Specialty	Approximate dates of visits From To	
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 To	

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Telephone No.	Treating physician's address (number and street)	City or Town	Province	Postal Code

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

Name:

Client No:

Date: YYYY MM DD

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

Name:

Date: YYYY MM DD

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Disability Benefit Claim Form

Employer Statement – Must be completed by your current Employer

Name of Employer	Last Name of Claimant	First Name of Claimant		
Employer's mailing address (Number and Street)	City or Town	Province	Postal Code	Employer's email address
Commencement date of employment (YYYY-MM-DD)		Date last worked (YYYY-MM-DD)		Reason for discontinuing work
If layoff, date employee notified (YYYY-MM-DD)	Date expected to return to work (YYYY-MM-DD) ☐ Full-time ☐ Part-time		**OR**	Date returned to work (YYYY-MM-DD) ☐ Full-time ☐ Part-time
Occupation as of last day worked				
Type of position ☐ Full-time ☐ Part-time	Number of hours worked per week		Seasonal, provide inclusive dates of employment (YYYY-MM-DD) 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.

Name of insurance company (other than Worker's Compensation) providing group disability coverage for your employees. Please include Policy Number andcontact 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	Title	Telephone No.
Authorized officer's email address		

Signature of authorized officer

Name:

Date: YYYY MM DD

Please return this form to your employee.

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LoanProtector® HomeProtector®
Disability Benefit Claim Form

Initial Disability Insurance Medical Statement

How to complete the form:

Section 1 must be completed by the claimant.
Section 2 must be completed by the licensed physician treating the claimant.

The claimant is responsible for the securing of the Initial Disability Insurance Medical Statement and any charge for its completion.

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.**The Insurance Service Centre will assist you to questions related to the Royal Credit Line®, personal loan, or mortgage.

Email Address:
rbcinsurancecentre@rbc.com

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The patient is responsible for any fees related to the completion of this form.

Initial Disability Insurance Medical Statement

Section 1 — Patient Information and Consent
TO BE COMPLETED BY THE PATIENT

Patient Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd/mm/yyyy)

Date Last Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.
I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

_____ _____
Patient Signature Date of Consent (dd/mm/yyyy)

Section 2 — Medical Statement
TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify)_____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

_____

Secondary and/or Complications: _____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): Vaginal ☐ C-Section ☐

Is this condition due to:

Occupational Illness Yes ☐ No ☐

Occupational Injury Yes ☐ No ☐

Motor vehicle accident Yes ☐ No ☐

Other accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____

First date of work absence due to condition: (dd/mm/yyyy) _____

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1)**

_____

_____

_____

_____

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

Date of next visit: (dd/mm/yyyy)

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐ Unknown ☐

If yes, date: (dd/mm/yyyy) _____ Treatment Provider: _____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

_____

_____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

Did/will the patient have day surgery? Yes ☐ No ☐

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

- **If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.**
- **For disabilities expected to be greater than 4 weeks, please complete all pages.**

Investigations

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **consultation reports**
- **clinical notes**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) _____ Type of license: _____

Is the patient capable of managing their own affairs? Yes ☐ No ☐

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐

Workplace Issues ☐ Social/Family Issues ☐ Financial/Legal Issues ☐ Personality issues ☐ Addiction ☐ Other ☐

Please elaborate: _____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician/Medical Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)	Specialty and license/registration number	Date Signed (dd/mm/yyyy)

Address (Street, City, Province, Postal Code)	Telephone # (+ area code) Fax # (+ area code) Email address

Signature