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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

Important information about

Claiming Critical Illness benefits

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.)



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).

LoanProtector® HomeProtector®

Critical Illness Benefit Claim Form

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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:

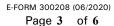
RBC Insurance Services Inc. Insurance Service Centre P.O. Box 53, Postal Station A Mississauga, ON L5A 2Y9

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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.

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Critical lilliess Claimani	illionilation - Must be Cor	inpleted by the Clai	illiant or a	n Authoriz	eu nep	resentative	.		
Name of Claimant - Last Name		First Name				Initial(s)			
Maiden Name (if applicable)			Date of Birth (YY			Y/MM/DD)			
Mailing Address (number and str	City or Town								
Province	Postal Code	Code Telephone No.			Email Address (if applicable)				
Tell us about the physi	cians that you have consul	ted in the past five	years						
Current family physician's name		Telephone No.	Fax No. Email Address						
Current family physician's addres	City or Town Pr		Province	ovince Postal Code					
Name of treating physician (other	Specialty	Approximate dates of visits From: yyyy / mm / dd To:			: yyyy/ mm	/ dd			
Treating physician's address (nu	•	City or Town Pr			ovince	Postal Code			
Telephone No.	Fax No.	Email Address							
Name of treating physician (other	Specialty	Approximate dates of visits From: yyyy / mm / dd			то: уууу /	mm / dd			
Treating physician's address (nu		City or	Town		Province	Postal Code			
Telephone No.	Fax No.	Email Address							





Client Card #	

Critical Illness Benefit Claim Form

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.

Signature of Claimant or Authorized Representative

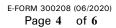
You understand that your personal information is needed by Canada Life to investigate, assess and administer your critical illness claim. You acknowledge that your consent enables Canada Life to process your claim and that refusing to consent may result in delay in decision or denial of the claim.

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.

X							
	year/ month / day						
Section 2 – Authorization Form to Release Personal Inform	mation – Must be co	ompleted by the claimant					
Claimant Authorization Form to Release Personal Information	tion:						
If you wish to authorize someone other than yourself (such as a Assurance Company (Canada Life) on your behalf with respect to Communication will be limited to matters related to the claim for of the claim for benefits or until otherwise revoked by you. A reg	o your claim, please co r benefits. This authori	omplete this Authorization Form. zation shall remain valid for the duration					
I authorize Canada Life to benefits with:	o communicate persona	al information that relates to my claim for					
Name of the appointed person who is authorized to communicate on you	our behalf	Relationship to the appointed person					
Address of the appointed person Telephone No.							
Please select one option: Excluding medical information	Including medical inf	Tormation					
**If no option is selected, medical information will not	t be released by Canada I	Life to the authorized appointed person.					
Signature of Claimant/Insured	Date (year/month	n/day)					

Date





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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 Author	rized Kepresen	tative					
Name of Claimant - Surname			First Name				Initial(s)	
Email Address <i>(If applicable)</i>						Date of I	Birth (YYYY/MM/DD)	
Mailing Address (number and street)		City or Town				Province	Postal Code	
Telephone No.	Mobile N	Mobile No. Business No.			ss No.			
Signature of Claimant or Authorized By signing here, the claimant auth Insurer and policyholder. You acknow	orizes his o	r her attending						
Signature of claimant or X				Date	· ———			
Authorized Representative						year / mo	onth / day	
Part 2 - Attending Physician's St	atement							
Patient Information					Т	1		
Last Name		First Name		Initial(s)		Da	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 sy	mptoms, date	of diagnosis, duration	on, etc yyyy/ mm/ da	1)				
Has the patient been hospitalized? If your real Yes No From		gth of stay <i>(year/ m</i>	•					
Hospital Name			Hospital Telephon	e No.	No. Hospital Fax N		x No.	
Hospital Address (number and street)			City or Town		Province	Postal Code		
We require copies of all specialist co For the following conditions, please of Heart Attack: ECG's from the day of eve	ensure attac	ched documenta	tion includes but	t is not	limited to) :		
Stroke: Diagnostic evidence supporting s	troke diagnos	sis and current ne	urological deficits	that hav	re been pre	esent for o	ver 30 days.	
Cancer: Diagnostic evidence to confirm u	ıncontrolled g	growth and spread	l of malignant neop	plasm in	cluding ini	tial and fin	al biopsy/pathology r	
Please tell us any additional information which	n would help u	s assess this claim:						

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Critical Illness Benefit Claim Form

Name and Addres	s of Attending Pl	nysicia	an						
Attending Physician - Surname			First Name	First Name			Specialty		
Name of Facility/Clinic (F	Hospital, Medical Centre)		1						
Mailing Address (Number	r and Street)			City			ty or Town		
Province	Postal Code		Business Telep	ohone No.		Fax No.			
Email Address	I		-1						
Names and addresses	of other treating phy	sicians							
Surname, First Name				Specialty					
Mailing Address (Number	r and Street)			City or Town			Province	Postal Code	
Telephone No.		Fa	ax No.		Email Address		1		
Surname, First Name				Specialty					
Mailing Address (Number	r and Street)			City or Town			Province	Postal Code	
Telephone No.		Fa	ax No.		Email Address				
		ı							
Signature of Physici	ian								
By signing here, you acknowledge that the answers given above are true and complete to the best of your knowledge. Signature of Physician When you have completed this form, please give it to the claimant					D - –	ate year / mor	nth / day		
or mail it to: RBC Insurance Serv Insurance Service C									

P.O. Box 53, Postal Station A Mississauga, ON L5A 2Y9



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Critical Illness Benefit Claim Form

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:	
	(Appointed Person who is authorized to comm	municate on your behalf)
Please s	select one option:	
	Excluding medical information	
	☐ Including medical information	
	If no option is selected, medical info	rmation will not be released to the authorized appointed person.
	Signature	