- ☐ **All Pages**
- ☐ **Information Page**
- ☐ **Claimant Statement**
- ☐ **Claimant Signature**
- ☐ **Attending Physician's Statement 1**
- ☐ **Attending Physician's Signature 2**
- ☐ **Authorization Form**

LoanProtector
HomeProtector
Critical Illness Benefit Claim Form

Important information about Claiming Critical Illness benefits

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 the doctor complete the Attending Physician's Statement(attached), and forward it to 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

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

Important:

- **The claim will not be forwarded to Canada Life until we receive all the required documentation. Please ensure all information provided 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 Critical Illness Benefit Claim form**
  - **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 informa tion in order to process the claim. You'll 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 your 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?

Canada Life will advise you directly about their claim decision. If the claim is denied, the reason for the denial will be explained. 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) why your claim has been denied.

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 servicing of your 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 of coverage. The certificate of insurance consists of the LoanProtector® or HomeProtector® certificate of insurance 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.)

SRF#

LoanProtector
HomeProtector

Critical Illness Benefit Claim Form

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

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 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 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 when 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.
- 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 the required information about your Royal Credit Line, personal loan, or mortgage and send the package on to the Insurer.

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

Client Card No.

Branch Transit No.

Branch Telephone No.

Type of Loan

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

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

Your Name and Address
☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**

First Name **Initial** **Last Name**

Maiden Name (If applicable)

Sex
☐ Male ☐ Female

Mailing Address (street and number)

City or Town **Province** **Postal Code**

Date of Birth (month/day/year) **Telephone Contact No.** **Fax No. (If applicable)** **Email Address**

Tell us about the physicians that you have consulted in the past five years:
Name of your family physician

Street Address and city or town **Office Telephone No.** **Office Fax No.**

Name of treating physician (other than family physician)

Street address and city or town **Office Telephone No.** **Office Fax No.**

Name of treating physician (other than family physician)

SRF#

LoanProtector
HomeProtector
Critical Illness Benefit Claim Form

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

Street address and city or town **Office Telephone No.** **Office Fax No.**

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

Signature of Claimant or Authorized Representative _____ **Date (month/day/year)** / /

SRF#

SRF#

LoanProtector
HomeProtector

Attending Physician's Statement

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

How to complete the form:

Part 1 - Must be completed by the claimant or an Authorized Representative
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 (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 - Authorization of Claimant or Authorized Representative

Personal information about the claimant

Client Card No. **First Name** **Initial** **Last Name**

Maiden Name (if applicable)

Sex
☐ Male ☐ Female

Mailing Address (street and number)

City or Town **Province** **Postal Code**

Date of Birth (month/day/year) **Telephone Contact No.** **Fax No. (if applicable)** **Email Address (if applicable)**

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 or Authorized Representative _____ **Date (month/day/year)** / /

Part 2 - Attending Physician's Statement

Tell us about the patient's Diagnosis:

Diagnosis: _____

Exact date of first diagnosis **(month/day/year)** _____ /_____ /_____

Date symptoms first appeared **(month/day/year)** _____ /_____ /_____

Has the patient ever had a similar Condition? ☐ **Yes** ☐ **No** **If Yes, please give details (i.e. date of first symptoms, date of diagnosis, etc.)**

Has the patient been hospitalized? ☐ **Yes** ☐ **No** **Length of stay:** _____ to _____ **(month/day/year)**

Name of Hospital _____ **Hospital telephone no.:** (____) ____-_____

We require copies of all specialist consultation notes and 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:

_____

_____

LoanProtector
HomeProtector
Attending Physician's Statement

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

SRF#

Name and address of attending physician

First Name **Initial** **Last Name**

Mailing Address (street and number)

City or Town **Province** **Postal Code**

Business Telephone No.: (____) _____-_____ **Fax No.:** (____) _____-_____

Email Address

Specialty

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 Attending Physician _____ **Date (month/day/year)** / /

When you have completed this form, please give it to the claimant or Authorized Representative or send it to:

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

LoanProtector
HomeProtector

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

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 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