RBC Insurance

THE FUNDAMENTAL SERIES®
DISABILITY INCOME PROTECTION
ILLNESS APPLICATION

This application is for illness coverage. Injury coverage must also be applied for or in force in order to qualify for the addition of illness coverage.

If applying to add illness coverage to an existing injury policy, please provide the injury policy number ☐

Requests for changes to existing coverage:
- ***Within 60 days of the coverage effective date – complete the Application for Reissue***
- ***Over 60 days from the coverage effective date – complete the Application for Policy Change or Reinstatement***

1. PROPOSED INSURED

Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other ☐ Specify ☐ Female ☐ Male ☐

First Name ☐ Middle ☐ Last ☐

Date of Birth (dd/mm/yyyy) ☐

Address: Apt # ☐ Number ☐ Street ☐

City ☐ Province ☐ Postal Code ☐

Home Telephone Number ☐ Cell Phone Number ☐

Email ☐

Do you understand English and/or French? Yes ☐ No ☐

If No, please complete and submit a Statement of Understanding in the language of your preference ☐

Quebec Residents Only: Is the insurance you are applying for replacing or modifying any existing or pending Individual disability insurance? Yes ☐ No ☐ If Yes, please complete and submit Disclosure forms.

2. PRE-QUALIFYING QUESTIONS

A) Have you ever had any consultations for, received any advice for, or ever been treated for: Heart attack, stroke, any disease or disorder of the blood vessels of the heart or brain, Parkinson's disease, multiple sclerosis, emphysema, lupus, liver cirrhosis, alcoholic pancreatitis, any disease or disorder of the immune system, paralysis, any brain or nervous system disease or disorder, cerebral palsy, Lou Gehrig's disease (amyotrophic lateral sclerosis [ALS]), Huntington's Chorea, muscular dystrophy, Alzheimer's disease, polycystic kidney disease, cystic fibrosis, schizophrenia or AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex); or have you ever tested positive for the Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐

B) Height ☐ cm ☐ ft/in ☐ Weight ☐ kg ☐ lb ☐

If you answered Yes to question 2A) or your height and weight is less than the minimum, or exceeds the maximum in the Height and Weight Chart for The Fundamental Series, illness coverage is not available.

3. HEALTH AND LIFESTYLE QUESTIONS

Have you ever received any treatment, medical advice, been diagnosed with, required any follow-up for, or had any known indication of:

A) Any disease or disorder of the eyes, ears, nose or throat (including loss of speech)? . . . . . Yes ☐ No ☐

B) Chest pain, angina, irregular pulse, high blood pressure, heart murmur, heart or circulatory problem or disorder? . . . . . Yes ☐ No ☐

C) Blood or sugar in the urine, diabetes, thyroid abnormality, or any disease or disorder of the kidneys, bladder, urinary tract, prostate or genital organs? . . . . . Yes ☐ No ☐

D) Fainting, dizziness, loss of consciousness, seizures, transient ischemic attack (TIA), epilepsy, chronic headaches, migraines, muscle weakness, numbness or tingling of the limbs? . . . . . Yes ☐ No ☐

E) Cancer, any malignant or benign tumour, polyp, cyst, or any disease or disorder of the lymph glands? . . . . . Yes ☐ No ☐

F) Ulcer, internal bleeding, colitis, any disease or disorder of the digestive system including the oesophagus, stomach, pancreas, colon, intestines, liver or gall bladder, or tested positive for hepatitis and/or been told you are a carrier? . . . . Yes ☐ No ☐

G) Any disease or disorder of the back, neck, or any spinal discomfort including pain, sprain, strain, sciatica or disc disease? . . . . . Yes ☐ No ☐

H) Any disease or disorder of the knee, ankle, foot, hip, wrist, elbow, shoulder or any other joint, including amputation or deformities? If Yes, please indicate specific joint. . . . . Yes ☐ No ☐

I) Arthritis, osteoporosis or any disorder or disease of the muscles or bones? . . . . . Yes ☐ No ☐

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3. HEALTH AND LIFESTYLE QUESTIONS (continued)

J) Tuberculosis, bronchitis, asthma, persistent or chronic cough, shortness of breath, sleep apnea or other sleep disorder, or any disease or disorder of the chest or lungs? . . . . . Yes ☐ No ☐

K) Any disease or disorder of the reproductive organs, breast or prostate? . . . . . Yes ☐ No ☐

L) Are you currently under investigation, observation or treatment, therapy, counselling or taking medication? . . . . . Yes ☐ No ☐

M) Have your natural parents, brothers or sisters, whether living or dead, ever had any history of: polycystic kidney disease, Huntington's disease, or any form of hereditary disease? . . . . . Yes ☐ No ☐

If Yes, please complete the table below.

Family Member:		Condition
Father ☐		
Mother ☐		
Brother(s) ☐	Indicate # of brothers with the history ☐	
Sister(s) ☐	Indicate # of sisters with the history ☐	

Within the past 5 years, have you:

N) Been advised about or treated for the use or abuse of alcohol or drugs (prescription or non-prescription), or have you been convicted or charged with any criminal offence or are charges currently pending? . . . . . Yes ☐ No ☐

O) Had any undiagnosed or untreated condition for which tests or examinations are as yet to be completed or are ongoing? Yes ☐ No ☐

P) Had any illness or injury that resulted in missing more than 10 consecutive days of work? . . . . . Yes ☐ No ☐

Q) Please provide your personal doctor's name, address and telephone number (including area code). If none, write "None".

R) Date and reason for your last consultation or visit with a physician. Include the reason, diagnosis, treatment given or recommended, medication prescribed and whether any further follow-up is required:

Details to Yes answers in Section 3

Please give full and accurate details below to any Yes answer in Section 3 – Health and Lifestyle Questions. Include the question #, symptoms, diagnosis, treatment date and duration of each occurrence; indicate if any time was lost from work and whether recovery is complete, and if not, provide details of any ongoing issues, treatment, problems or follow-ups.

Question #	Details

4. ILLNESS COVERAGE APPLIED FOR

Loss of Income – Illness Coverage

Benefit Period: 2 Years ☐ 5 Years ☐ To Age 70 ☐ (Cannot exceed the Injury Benefit Period)

Elimination Period: 30 Days ☐ 90 Days ☐ 120 Days ☐ (Cannot be shorter than the Injury Elimination Period)

Monthly Benefit Requested (Cannot exceed the injury amount) $ _____ (Coverage is available in $100 increments with a minimum required of $500 per month).

Business Overhead Expense – Illness Coverage

Monthly Benefit Requested (Cannot exceed the injury amount) $ _____ (Coverage is available in $100 increments with a minimum required of $500 per month).

The Benefit Period for injury BOE coverage is 12 months and the Elimination Period is 30 days.

5. CONSENTS AND DECLARATIONS

I declare that all statements and answers in all parts of this application are full, complete and true, and agree that:

A) Insurance for Illness will take effect on the monthly anniversary date after the Illness application has been approved by RBC Life Insurance Company (RBC Life), based on the Effective Date of the Injury coverage, provided that:

1) The next Pre-Authorized Debit for the new premium is honoured on presentation by RBC Life; and

2) Any and all conditions for the delivery of the policy have been satisfied completely, including but not limited to, our receipt and approval of all amendments, addendums and exclusions required for the policy, signed by you within the period required by us and;

3) There has been no change to your insurability between the date you signed this Illness application and the date you receive your updated Policy Schedule. If on the date I receive my updated Policy Schedule I would give different answers to the questions in this application, in any tele-interview, in any other questionnaire(s) or in any paramedical exam (as applicable), I will immediately advise RBC Life in writing.

B) I confirm that I have reviewed all of the answers provided in my Injury application, and where any of the information is different, I have submitted the changes in writing to RBC Life with my Illness application. If I have not provided any updates in writing to RBC Life, I certify that all of the information and answers provided in my Injury application are full, complete and true.

C) I have read the "Notice regarding the MIB, Inc." and understand and agree to its terms.

D) If payment is by Pre-Authorized Debit, RBC Life is not required to provide me with notification before the new premium is debited.

E) RBC Life may be entitled to render my policy null and void if there is any misrepresentation or non-disclosure in any part of the application for Illness insurance.

F) No statement made to and no information acquired by a representative of RBC Life shall be attributed to or binding upon RBC Life unless contained in this application. No one other than an Officer of RBC Life may (1) alter or modify the terms of this application or any policy issued or (2) waive any rights or requirements of RBC Life.

G) RBC Life shall not be liable for any claim on account of any Illness benefits applied for, commencing prior to the Effective Date of the Loss of Income Illness coverage. Notwithstanding any interim premium payments, no temporary or conditional insurance is being provided for Illness.

This Application, and any telephone interview, application supplement(s), and/or questionnaire(s) will form part of any insurance contract issued. The contract will be of utmost good faith, based upon the statements contained in this application, and any tele-interview, application supplement(s), and/or questionnaire(s). I am responsible for the accuracy of the statements. Before signing, I have verified that all answers are correct and complete and that I have initialed any changes to those answers. Inaccurate answers to any questions may affect my eligibility for coverage and/or benefits.

Signed at: _____ this _____ day of _____ Year _____
(city/province) (day) (month)

_____ _____
Signature of Proposed Insured Signature of Proposed Owner
(If the owner of the injury policy is not the insured, this application for illness coverage must be signed by that owner)

Note: Any ownership assigned to the injury policy extends to the addition of illness coverage.
If the injury policy is owned by a corporation, this Application must be signed by an Officer of the Company, other than the Proposed Insured.

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AUTHORIZATION

I understand and authorize the Company (RBC Life Insurance Company and its reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me. I understand that the Company will create and maintain files that contain personal information concerning me. I also understand that access to personal information concerning me will be limited to the employees of and other persons engaged by, the Company in performance of their duties or to the persons to whom I have granted access, in writing, or to any other person authorized by law. I further understand that, except when the Company can and does lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information in the possession of the Company, upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and to have any errors in the personal information noted and corrected by formulating a written request to the Company. I authorize and direct the persons, institutions and organizations listed below to disclose and provide to the Company any information, records or other data regarding me, my medical history or treatment or my past and present income or employment that is relevant to this Application that they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other health care practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of health care or treatment; and also the provincial health insurance plan, any insurance or reinsurance company or other financial institution; and also my employer or former employers and also any federal or provincial government department or organization including the federal or provincial income tax authorities and provincial motor vehicle divisions and also the MIB, Inc. and also any other person, agency, credit bureau or institution having information, records or data regarding me. This Authorization to obtain information is valid until revoked by me in writing.

I understand that any information records or data received by the Company pursuant to this Authorization both medical and non-medical, will be used for the assessment of insurance risk for underwriting purposes; for the purpose of evaluating any claim for benefits; assessing the validity of the policy as issued; and, issuing and delivering the policy. Only to the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to the MIB, Inc.; to other insurance companies, or any reinsurer; and, to my Servicing Representative such as my insurance advisor or broker. This Authorization to disclose information as reasonably necessary is valid until revoked by me in writing.

I authorize the Company to disclose to my Servicing Representative material information regarding my health and personal history solely for the purpose of explaining underwriting decisions. This disclosure could include history of mental illness, infectious disease, drug and alcohol use, record of criminal activity, or other facts that have a material effect on the Company's decision to insure me. This Authorizaton to disclose information for this purpose is valid until 60 days after the later of the day: the Company issues a new or amends the existing policy; or the Company notifies me in writing that my Application has been declined, withdrawn, or filed incomplete.

I do not agree to the disclosure of health and personal information to the Servicing Representative: ☐

I also authorize the Company to release to my health care professional any medical information obtained for this insurance Application including the results of any blood or urine test or urine drug screening tests for the purpose of revealing findings that might require further investigation or treatment or for the purpose of explaining any underwriting decision. This Authorization to disclose medical information is valid until revoked by me in writing. A photocopy of this Authorization, as executed by me, will be as valid as the original. Any alteration of this Authorization will render it null and void.

Dated at _____ this _____ day of _____ Year _____

(City / Province) (day) (month)

_____

Signature of Proposed Insured

Notice regarding the MIB, Inc.

Information regarding your insurability will be treated as confidential. RBC Life Insurance Company or its reinsurers may, however, make a brief report to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB, and seek a correction. The address of the MIB, Inc.'s information office is:

MIB, Inc., 330 University Avenue, Toronto, Ontario, CANADA M5G 1R7
Telephone: 416-597-0590.
Web site: www.mib.com

RBC Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Personal History Interview (PHI)

As part of the underwriting process, you may be asked to respond to a telephone interview. This Personal History Interview (PHI) is conducted by specially trained interviewers. The interview will take approximately 10-15 minutes.

The questions asked by the interviewer amplify the information on your application for insurance. These questions relate to personal, financial and medical aspects of insurability. We also use the PHI process to gather information which may be omitted or only partially explained.

Any information obtained during the PHI will be kept strictly confidential and will not be released to anyone without your written consent.

Your co-operation in this process is greatly appreciated and enables us to provide you with the best quality underwriting.

RBC Life Insurance Company
Tower 1, 6880 Financial Drive
Mississauga, ON L5N 7Y5

ADVISOR'S REPORT

1. Required only if the Illness application is not being submitted at the same time as the Injury application. If you are submitting an injury application at the same time as this illness application, you may leave this report blank, provided you have completed the Loss of Income Injury Coverage Application advisor's report.

2. Advisor's Declaration:

I have clearly explained the provisions and limitations of the Illness coverage being applied for to the Proposed Insured. All of the questions in the application were clearly asked of, or read by, the Proposed Insured. To the best of my knowledge, all of the answers and statements on the application have been fully and accurately recorded. I am not aware of any pertinent information about the Proposed Insured that has not been disclosed on the application. If Illness coverage is issued, I will deliver the new Policy Schedule only after obtaining confirmation that all conditions for delivery have been completely satisfied and there has been no change in the insurability of the Proposed Insured. I understand that I cannot modify the application or the terms of the Illness coverage, if issued. I have complied with my duties and obligations in regard to Advisor Disclosure, including providing an Advisor Disclosure Statement in writing to the Proposed Insured.

Date				
Advisor's Signature				
Advisor's Name				
Advisor's Company Name				
Marketing Office/MGA				
Share	☐ %	Servicing Advisor Code: ☐	☐ %	Advisor Code: ☐