RBC Insurance

THE FUNDAMENTAL SERIES®
DISABILITY INCOME PROTECTION
INJURY APPLICATION

This application is for injury coverage only. If applying for illness coverage, please also complete the Fundamental Series Illness Insurance Application form.

To be used for NEW policies ONLY.

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.

1.1 Is this application part of the ***Student Savings Program?*** . . . . Yes ☐ No ☐

If Yes, the maximum monthly benefit is $2,000.

1.2 If Yes to 1.1, are you registered with a certified college and/or regulatory body for your vocation? . . . . . Yes ☐ No ☐

If Yes, Pre-Qualifying Question #2b may be answered No without impacting coverage availability.

If No, coverage under the Student Savings Program is not available.

2. Is this application part of an employer paid ***Wage Loss Replacement Plan?*** . . . . Yes ☐ No ☐

If Yes, submit a Wage Loss Replacement Plan Amendment A694 and complete the Ownership section of this application.

Please use the exact occupation wording as stated in the Rate Guide.

Do you work in any other occupation more than 15% of your time? . . . . Yes ☐ No ☐

If Yes, please also provide the secondary occupation.

Primary Occupation ______ Secondary Occupation ______

What percentage of time is spent in your primary occupation? ______ What percentage of time is spent in your secondary occupation? ______

Describe your duties ______ Describe your duties ______

If you are a driver (primary or secondary occupation), please complete the following section.

What type of driver are you? ______ What is your cargo? ______

What percentage of your occupation consists of manual duties? Less than 15% ☐ More than 15% ☐

If there is more than one occupation indicated above, please use the lower of the occupational ratings. (Class 1 is the highest.)

Occupational Rating[1]: Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ Class 5 ☐ Class 6 ☐

Are you covered by any worker's compensation plan? Yes ☐ No ☐ If No, 24 hour coverage is mandatory. If Yes, you may wish to consider non-occupational coverage only.

2. PRE-QUALIFYING QUESTIONS

a) Do you have any ongoing restrictions or limitations to your bodily movements or daily activities as a result of an injury or other condition? . . . . Yes ☐ No ☐

b) Are you currently working a minimum of 20 hours per week, 35 weeks per year? . . . . Yes ☐ No ☐

c) Are you a Canadian citizen or have you been granted Permanent Resident (landed immigrant) status by the Canadian government? . . . . Yes ☐ No ☐

If you answered Yes to question 2A) or No to question 2B) or question 2C), coverage is not available.

[1] See the Feature Summary for more information on these terms.

3. LOSS OF INCOME CALCULATION (Complete only if applying for Loss of Income coverage. If applying for coverage under the **Student Savings Program**, completion of line (A) is not required.)

Employees Enter your annual Employment Income[1]: (A) $

Self-Employed Enter either your annual Business Income[1] plus your annual Employment Income[1] from the business or 50% of your annual Gross Revenue[1]: (A) $

Enter the Maximum Eligible Monthly Benefit from the Benefit Determination Chart based on the amount listed in (A):

(If applying as part of an employer paid Wage Loss Replacement Plan, use the Taxable Benefit Determination Chart.)

(If applying under the Student Savings Program, the maximum monthly benefit is $2,000). (B) $

Enter the monthly amount of any disability insurance that you are maintaining from all sources: (C) $

Total maximum Monthly Benefit (B subtract C): (D) $

4. BUSINESS OVERHEAD EXPENSE (BOE) CALCULATION (Complete only if applying for Business Overhead Expense coverage)

		Monthly Amounts
Lease Payments		$
Property Rent		$
Professional and Accounting Fees		$
Insurance Premiums		$
Utilities		$
Other Fixed Expenses (Please list)		$
		$
		$

Total Monthly BOE Expenses (E) $

Enter the monthly amount of any business overhead disability insurance that you are maintaining from all sources: (F) $

Total maximum Monthly BOE Benefit (E subtract F): (G) $

5. INJURY COVERAGE APPLIED FOR

Loss of Income – Injury Coverage

Coverage Type: 24 Hour ☐ Non-Occupational ☐

Benefit Period: 5 Years ☐ To Age 70 ☐

Elimination Period: 0 Days ☐ 30 Days ☐ 90 Days ☐ 120 Days ☐

Monthly Benefit Requested: (Cannot exceed the lesser of the class maximum issue limit or the amount in (D) above) $

Coverage is available in $100 increments with a minimum required of $500 per month.

Accidental Death and Dismemberment (AD&D)

Coverage Type: With AMER[2] ☐ Without AMER ☐

Benefit Requested: $100,000 ☐ $200,000 ☐ $300,000 ☐ $400,000 ☐ $500,000 ☐

Beneficiary of the Accidental Death and Dismemberment benefit (only required if applying for AD&D coverage). If no beneficiary designation is provided, benefits will be payable to the estate of the insured.

Beneficiary Name Relationship to Proposed Insured

All designations are revocable, except in Quebec, where the designation of a legally married spouse is irrevocable unless expressly stated to be revocable by checking the following box: Revocable ☐

Except in the Province of Quebec, if you have designated a beneficiary who is a minor (under the age of 18), a trustee should be named in order to avoid payment of the proceeds into court. In Quebec, benefits payable to minors are paid to the surviving parent(s) as tutor(s).

Name of Trustee Relationship to Proposed Insured

Business Overhead Expense – Injury Coverage

Monthly Benefit Requested: (Cannot exceed the lesser of the class maximum issue limit or the amount in (G) above, plus 25%) $

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.

[1] See the Feature Summary for more information on these terms.
[2] Accidental Medical Expense Reimbursement Benefit.

OWNERSHIP ***Complete if the owner is not the Proposed Insured. This must be completed if Wage Loss Replacement Plan is selected.***

Print legal name of Proposed Owner — Address

Print legal name of Contingent Owner — Address

To Whom should correspondence be sent?

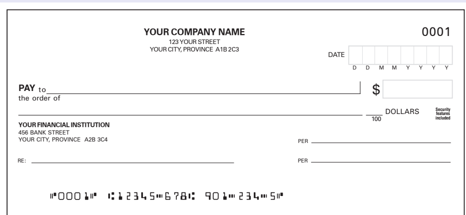
6. PREMIUM PAYMENT – PRE-AUTHORIZED DEBIT (PAD)

Please select payment frequency: Monthly (PAD) ☐ or Annual (PAD) ☐

I/we hereby request and authorize RBC Life Insurance Company (RBC Life) to debit my/our account provided below to pay the premiums, pursuant to the Pre-Authorized Debit Agreement as outlined in the Feature Summary. I authorize RBC Life to withdraw the initial premium required to place the coverage into effect, immediately on the receipt of the application by RBC Life. Thereafter, RBC Life will withdraw the premiums on the date the premiums are due, or the date I/we have selected below. The names and signatures of all persons required to authorize withdrawals from the account are indicated below.

Special Withdrawal Date **(Only applies to Monthly (PAD) payment frequency)**: Instead of withdrawing the monthly premiums on the date they are due, after the initial premium has been paid, please withdraw the premiums on the ______ of each month (limited to 1-28).

Bank Information (Please attach a cheque marked "VOID" – A line of credit account cannot be used.)



Transit Number — Bank Number — Account Number

Please use the banking information:

☐ From the attached void cheque, or

☐ From the information below

Name of Bank or Financial Institution	Transit Number (5 digits)	Bank Number (3 digits)	Account Number

Print Name of Payor (Account Holder) — Print Name of Second Payor (Account Holder) (if any)

Signature of Payor — Signature of Second Payor (if any)

7. 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 will take effect on the date of this application (the 1st of the following month in which the application was signed if the application was signed on the 29th, 30th or 31st of the month) provided that the first premium payment is honoured on presentation by RBC Life Insurance Company (RBC Life).

B) I acknowledge having received and been advised to read the Feature Summary, which contains some of the key definitions, exclusions and limitations applicable to the coverage being applied for, as well as the "Collection and Use of Personal Information" privacy statement outlining the collection, use and disclosure of my personal information. I have also been advised to carefully review my policy contract when issued for a complete understanding of the terms, conditions, definitions, exclusions and limitations of the policy.

C) The actual amount that RBC Life will issue will be based on the maximum amount I qualify for, based on the income declared in this application, any other disability coverage in force or pending that is not being replaced or cancelled and RBC Life Issue and Participation Limits. RBC Life is not required to specifically notify me if the amount I have applied for and the amount issued are different. Acceptance of the contract as issued will constitute approval of any changes.

D) I understand that when RBC Life determines the amount of insurance coverage that it will issue, they will rely on the information I have given about any existing individual or business overhead expense disability coverage that I intend to keep, including any existing coverage with RBC Life. I understand that this policy integrates the benefits provided by other disability insurance policies, and I acknowledge that if I have not disclosed all existing coverage, the benefits payable under this policy may be reduced.

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 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 (a) alter or modify the terms of this application or any policy issued or (b) waive any rights or requirements of RBC Life.

G) The policy and all related documents have been expressly requested to be in the English language. (Il a été expressément demandé que le contrat et tous les documents qui s'y rapportent soit rédigés en anglais.)

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

Signature of Proposed Insured — Signature of Proposed Owner

Note: If policy is to be owned by a corporation, this Application must be signed by an Officer of the Company, other than the Proposed Insured.

® / ™ Trademark(s) of Royal Bank of Canada. Used under licence.

ADVISOR'S REPORT

1. The Proposed Insured is an employee of RBC and qualifies for the Colleagues as Clients Discount. ☐
2. **Advisor's Declaration:**

   I have clearly explained the provisions and limitations of the policy being applied for to the Proposed Insured and provided details of the coverage applied for in the Premium Receipt and Information Notice. 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 a policy is issued, I will deliver it only after obtaining confirmation that all conditions for delivery have been completely satisfied, and if Illness coverage is issued, that there has been no change in the insurability of the Proposed Insured between the date of the Illness application and the delivery date of the policy. I understand that I cannot modify the application or the terms of the policy, 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 Owner.

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