

# Group Insurance Evidence of Insurability Form



Insurance

Please answer all applicable questions; all subsequent changes must be initialed by the Employee. On completion, the form must be signed and dated to be accepted.

## IMPORTANT:

The Employee must be a permanent resident of Canada with Canadian Citizenship or Permanent Resident status, and must be an eligible employee of the Policyholder in Active Employment as defined in the Group Insurance Policy on the date this Evidence of Insurability Form is signed.

## SECTION 1: EMPLOYER INFORMATION *(to be completed by authorized Plan Administrator)*

### REASON FOR SUBMISSION OF EVIDENCE OF INSURABILITY BY EMPLOYEE:

- New Employee – Eligible for an amount exceeding Non-Evidence Maximum       Optional Life       Add Dependant  
 Current Employee – Eligible for increase over Non-Evidence Maximum       Late Application       Other:

Name of Company:  Group Policy No:

Head Office Mailing Address:  City:  Prov:  Postal Code:

Company Phone No:  Authorized Personnel:

Billing Type:     Insurer-Billed     Self-Billed     TPA – Name of TPA:

## SECTION 2: EMPLOYEE INFORMATION *(to be completed by Employee)*

Language Preference:     English     French

Full Legal Name:    First:     Initial:     Last:

Date of Birth:     Gender:  M     F  
(day/month/year)

Employee Home Address:  City:  Prov:  Postal Code:

Date of Hire:     Occupation:     Annual Earnings: \$   
(day/month/year)

Name and Address of Personal Physician:    Name:   
Address:

Please provide the date, reason and results of your last consult with any physician:

### Eligible Dependent Spouse

Full Legal Name:    First:     Initial:     Last:

Date of Birth:     Gender:  M     F  
(day/month/year)

Name and Address of Personal Physician  
(if different from Employee):    Name:   
Address:

**RBC Life Insurance Company**  
6880 Financial Drive, Tower 1, Eighth Floor  
Mississauga, Ontario L5N 7Y5

Please provide the date, reason and results of your last consult with any physician:

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**Eligible Dependent Child(ren)**

First Name <small>(also indicate last name if different from Employee)</small>	Gender	Date of Birth <small>(day/month/year)</small>

**SECTION 3: COVERAGE** *(Check all that apply)*

**Employee**

Basic Life:  
Applying for: \$

Optional Life:  
Applying for: \$

Extended Health Care

Dental Care

Short Term Disability:  
Applying for: \$

Long Term Disability:  
Applying for: \$

**Dependant**

Basic Dependent Life:  
Applying for: Spouse: \$  Child: \$

Optional Life:  
Applying for: Spouse: \$  Child: \$

Extended Health Care

Dental Care

**SECTION 4: HEALTH AND LIFESTYLE QUESTIONS**

The following questions must be answered by the applicable Employee and/or Spouse. **ALL QUESTIONS MUST BE ANSWERED.** If the answer is "Yes" to any of the following questions, please circle the condition and provide full details in the space provided on page 4, including dates, duration, treatment, result and name of attending physician.

When answering the questions on this form, DO NOT provide information about any genetic test you have taken or plan to take. A genetic test is a type of medical test which analyzes DNA, RNA, or chromosomes. DO provide information about other types of medical tests.

		Employee	Spouse <small>(if applicable)</small>
<b>1</b>	Have you ever had any indication of, been told you have, or have you ever received treatment or advice for:		
<b>a</b>	Abnormal blood pressure, chest pain, heart attack, phlebitis, or any other disease or disorder of the heart or blood vessels? If yes to abnormal blood pressure, please complete the following: Date first advised of blood pressure: _____ Treatment: <input type="checkbox"/> Diet <input type="checkbox"/> Medicine <input type="checkbox"/> Other How long on treatment? _____ Still in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No In the past two (2) years, have special tests been done? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give type of tests, dates and results: _____ Do you have recent readings? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give readings: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

		Employee	Spouse (if applicable)
<b>b</b>	Gastrointestinal disorder, ulcer, jaundice, chronic diarrhoea, gall bladder, hepatitis or liver disease/ disorder, or any other disease or disorder of the stomach, intestines or rectum? If yes, complete the following: <input type="checkbox"/> Ulcer <input type="checkbox"/> Other: _____ Date of first attack: _____ No. of attacks: _____ Treatment: <input type="checkbox"/> Medicine – Give name: _____ <input type="checkbox"/> Operation – Give date: _____ Do you now have symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>c</b>	Asthma, bronchitis, emphysema, tuberculosis or any other respiratory disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>d</b>	Abnormal urine, venereal disease, or any disease or disorder of the kidneys, bladder, prostate or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>e</b>	Back or neck pain, whiplash, or any other disease or disorder, injury or deformity of the spine? If you answer yes to this question, please complete the "Back and Neck Disorder Questionnaire" on page 5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>f</b>	Arthritis, amputation, or any disease or disorder of the hip, knee, or other joints, bones or muscles, including fibrositis or fibromyalgia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>g</b>	Epilepsy, paralysis, stroke, recurrent headaches, or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>h</b>	Nervous disorder, anxiety, depression or any stress related illness? If Yes, please complete the "Mental Health Questionnaire" on page 7.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>i</b>	Diabetes, thyroid or other glandular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>j</b>	Cancer, cyst, tumour or skin disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>k</b>	Anaemia, leukaemia, or any other disease or disorder of the blood or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>l</b>	Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2</b>	Have you ever had any indication of, been told you have, or have you ever received treatment or advice for AIDS (acquired immune deficiency syndrome), ARC (aids related complex), or any immunological disorder; or had a positive blood test for antibodies to HIV (human immunodeficiency virus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3</b>	<b>a</b> In the last five (5) years, have you been examined by or consulted a physician or other health care professional, received advice, treatment or medication, or been hospitalized for any disease or disorder not included in Question #1, on pages 2 and 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>b</b> Have you ever been advised to undergo investigation or have treatment, testing or consultation which has not yet been completed, or are you aware of any symptom, complaint or health-related disorder for which you have not yet sought treatment or consulted a health care professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>c</b> In the last two (2) years, have you had any illness or injury which resulted in your absence from work for ten (10) consecutive days or more?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>d</b> Are you currently receiving any medical advice, treatment or medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4</b>	Do you currently participate in any hazardous activities such as auto racing, hang gliding, rock climbing, aircraft flying or SCUBA diving below 50 feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5</b>	<b>Height and Weight:</b> Employee's Current Height: _____ <input type="checkbox"/> ft/in <input type="checkbox"/> cm Employee's Current Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg If any change in weight of more than 15 lb/7 kg in the past 12 months, state amount and reason: _____  Spouse's Current Height: _____ <input type="checkbox"/> ft/in <input type="checkbox"/> cm Spouse's Current Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg If any change in weight of more than 15 lb/7 kg in the past 12 months, state amount and reason: _____		



# Back and Neck Disorder Questionnaire

If you answered Yes to question 1e, please complete this questionnaire.

<b>1</b>	Have you ever had any type of back or neck pain or discomfort or any other neck or back related symptom or complaint or have you ever had any indication of or been treated for any disease or disorder of the back or neck? <b>If yes, please answer all questions below.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2</b>	Specify area involved: <input type="checkbox"/> Neck (cervical) <input type="checkbox"/> Upper/middle (thoracic) <input type="checkbox"/> Low (lumbar – waist and below) <b>If more than one area is involved, please complete a separate questionnaire for each area affected.</b>		
The following details relate to the <input type="checkbox"/> Neck (cervical) <input type="checkbox"/> Upper/middle (thoracic) <input type="checkbox"/> Low (lumbar – waist & below)			
<b>3</b>	<b>a</b>	How many episodes of back or neck pain or discomfort or related symptoms have you had?	
	<b>b</b>	Date of first episode:	
	<b>c</b>	Describe symptoms of the first episode:	
	<b>d</b>	How long did the symptoms of the first episode last?	
	<b>e</b>	What was the final diagnosis?	
	<b>f</b>	Date of the last episode:	
	<b>g</b>	Describe the symptoms of the last episode:	
	<b>h</b>	How long did the symptoms of the last episode last?	
	<b>i</b>	What was the final diagnosis for the last episode?	
	<b>j</b>	What was the longest duration of symptoms for all episodes?	
<b>4</b>	Have you ever had any back or neck related numbness or tingling or radiation of pain to other parts of your body? <b>If yes, indicate date(s) and area(s) involved:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5</b>	<b>a</b>	Have any diagnostic tests been completed? <b>If yes, specify type(s), date(s), and results:</b> <input type="checkbox"/> X-ray studies <input type="checkbox"/> CT scan <input type="checkbox"/> MRI <input type="checkbox"/> Bone scan <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>b</b>	Have any tests or investigations been recommended? <b>If yes, specify nature of test(s) or investigation(s) and date(s) scheduled:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6</b>	<b>a</b>	Have you ever had epidural steroid injections or treatment at a pain clinic? <b>If yes, indicate date(s) and name(s) and address(es) of doctor(s) or medical facility(ies):</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>b</b>	Have you ever had chiropractic manipulation or treatment? <b>If yes, provide details:</b> 1. Date(s), frequency and duration of treatment: _____ 2. Date of last chiropractic consultation: _____ 3. Name and address of chiropractor(s): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>c</b>	Have you ever had physical therapy or any other form of treatment for this condition? <b>If yes, indicate type(s), date(s) and duration of treatment, name(s) and address(es) of provider(s):</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

(continued on following page)

## Back and Neck Disorder Questionnaire, continued

7	<p>Have you ever been prescribed medication for any back or neck condition or symptom?</p> <p><b>If yes</b>, provide details including name(s) of medication(s) and date(s) prescribed:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	<p>Have you ever been hospitalized for any back or neck condition or symptom?</p> <p><b>If yes</b>, indicate date(s), duration, reason, name and address of hospital(s):</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	<p>Have you been told you may need surgery at some time in the future?</p> <p><b>If yes</b>:</p> <p>a) Specify type of surgery: _____</p> <p>b) Has surgery been scheduled? If so specify date: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	<p>Have you ever lost any time from work due to back or neck related symptoms?</p> <p><b>If yes</b>, provide details including dates and duration of time off work:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	<p>Have your job duties or daily activities ever been restricted or modified in any way because of this condition?</p> <p><b>If yes</b>, describe restrictions, modifications or limitations:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	<p>Do you have any ongoing symptoms?</p> <p><b>If yes</b>, describe symptoms:</p> <p><b>If no</b>, how long have you been completely free of any neck or back related symptoms? _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
13	<p>Other than those already declared, please provide the full names and addresses of all doctors, health care professionals, hospitals or health care facilities consulted for this condition and the dates of consultations:</p>	

# Mental Health Questionnaire

If you answered Yes to question 1h, please complete this questionnaire.

<p><b>1</b></p>	<p>Please specify/describe all current and past symptoms, history or diagnosis of (tick off appropriate boxes):</p> <table border="0"> <tr> <td><input type="checkbox"/> Stress</td> <td><input type="checkbox"/> Fatigue, exhaustion</td> <td><input type="checkbox"/> Marriage/family counselling</td> <td><input type="checkbox"/> Bipolar disorder</td> </tr> <tr> <td><input type="checkbox"/> Anxiety</td> <td><input type="checkbox"/> Chronic fatigue</td> <td><input type="checkbox"/> Attention deficit disorder</td> <td><input type="checkbox"/> Suicidal thoughts or attempts</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Major depression</td> <td><input type="checkbox"/> Concentration problems</td> <td><input type="checkbox"/> Psychosis/hallucinations</td> </tr> <tr> <td><input type="checkbox"/> Burn out</td> <td><input type="checkbox"/> Panic attack(s)</td> <td><input type="checkbox"/> Memory problems</td> <td><input type="checkbox"/> Anger management problems</td> </tr> <tr> <td><input type="checkbox"/> Insomnia</td> <td><input type="checkbox"/> Adjustment disorder</td> <td><input type="checkbox"/> Agoraphobia</td> <td><input type="checkbox"/> Seasonal affective disorder</td> </tr> <tr> <td><input type="checkbox"/> Dysthymia</td> <td><input type="checkbox"/> Bulimia</td> <td><input type="checkbox"/> Post traumatic stress</td> <td><input type="checkbox"/> Generalized anxiety disorder</td> </tr> <tr> <td><input type="checkbox"/> Phobia(s)</td> <td><input type="checkbox"/> Anorexia nervosa</td> <td></td> <td></td> </tr> </table> <p><input type="checkbox"/> Counselling for (specify): _____</p> <p><input type="checkbox"/> Other (describe): _____</p>	<input type="checkbox"/> Stress	<input type="checkbox"/> Fatigue, exhaustion	<input type="checkbox"/> Marriage/family counselling	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Attention deficit disorder	<input type="checkbox"/> Suicidal thoughts or attempts	<input type="checkbox"/> Depression	<input type="checkbox"/> Major depression	<input type="checkbox"/> Concentration problems	<input type="checkbox"/> Psychosis/hallucinations	<input type="checkbox"/> Burn out	<input type="checkbox"/> Panic attack(s)	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Anger management problems	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Adjustment disorder	<input type="checkbox"/> Agoraphobia	<input type="checkbox"/> Seasonal affective disorder	<input type="checkbox"/> Dysthymia	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Post traumatic stress	<input type="checkbox"/> Generalized anxiety disorder	<input type="checkbox"/> Phobia(s)	<input type="checkbox"/> Anorexia nervosa		
<input type="checkbox"/> Stress	<input type="checkbox"/> Fatigue, exhaustion	<input type="checkbox"/> Marriage/family counselling	<input type="checkbox"/> Bipolar disorder																										
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<input type="checkbox"/> Phobia(s)	<input type="checkbox"/> Anorexia nervosa																												
<p><b>2</b></p>	<p>Have you experienced any symptoms within the last 12 months? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>If yes</b>, describe all symptoms: _____</p> <p><b>If no</b>, how long have you been completely symptom-free? _____</p>																												
<p><b>3</b></p>	<p>a) Date of onset of your initial symptoms: _____</p> <p>b) Cause(s) of symptoms _____</p> <p>c) How many separate occurrences or episodes of symptoms have you had? _____</p> <p>d) What was the duration of each occurrence or episode? _____</p>																												
<p><b>4</b></p>	<p>Has your physician given you a diagnosis? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>If yes</b>, provide full details, including the date a diagnosis was given: _____</p>																												
<p><b>5</b></p>	<p>Have you taken medication, prescribed or non-prescribed, or received treatment in the past 12 months? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>If yes</b>, provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment and the date treatment was first recommended: _____</p>																												
<p><b>6</b></p>	<p>What other medication(s) or treatment has been prescribed in the past? Provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment, the date treatment was first recommended, and the date and reason medication(s) or treatment was discontinued: _____</p>																												
<p><b>7</b></p>	<p>Have you been referred to a psychiatrist or psychologist for this condition? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>If yes</b>, provide full name(s) and address(es) of those consulted, date of first consultation, frequency of follow-up visits and date of the last consultation: _____</p>																												
<p><b>8</b></p>	<p>Have you ever consulted an emergency room or been hospitalized for this condition? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>If yes</b>, provide date(s), reason(s) and name and address of hospital(s): _____</p>																												

(continued on following page)

## Mental Health Questionnaire, continued

<b>9</b>	Have you ever had any suicidal thoughts or attempts? <b>If yes</b> , provide dates and details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>10</b>	Have you ever lost any time from work due to this condition? <b>If yes</b> , provide details including dates and duration of time off work:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>11</b>	Have your job duties or daily activities ever been restricted or modified in any way because of this condition? <b>If yes</b> , describe restrictions, modifications or limitations:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>12</b>	Other than those already declared, please provide the names and addresses of all physicians, psychiatrists, psychologists, counsellors, mental health care providers, other health care practitioners, hospitals or facilities consulted for this condition and include details and duration of treatment:	



## SECTION 5: DECLARATION

### EMPLOYEE STATEMENT

I hereby declare that the above answers and statements that I have given in this Evidence of Insurability Form are, to the best of my knowledge and belief, full, complete and true as of this date, and that any misstatements or failure to report information may be used as the basis for a rescission of my insurance. I understand and agree that they are material to the risk and form part of the Application and consideration for the insurance I am applying for. I further understand that if the insurance applied for becomes effective, it will be subject to the terms and conditions of the group policy.

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### SPOUSE STATEMENT (if applicable)

I hereby declare that the above answers and statements that I have given in this Evidence of Insurability Form are, to the best of my knowledge and belief, full, complete and true as of this date, and that any misstatements or failure to report information may be used as the basis for a rescission of my insurance. I understand and agree that they are material to the risk and form part of the Application and consideration for the insurance I am applying for. I further understand that if the insurance applied for becomes effective, it will be subject to the terms and conditions of the group policy.

**Signature of Employee's Spouse:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## SECTION 6: AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand and authorize RBC Life Insurance Company and its reinsurers (hereinafter collectively referred to as "RBC Life") to gather personal information concerning me and to disclose, as necessary, to third parties the fact that I am seeking insurance coverage from RBC Life.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to RBC Life any information, records or other data regarding me and my medical history or treatment, or my past and present income or employment, which they have in their possession or control.

Persons to whom this Authorization applies: Any physician, nurse, counselor, psychologist, 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 company or other financial institution or insurance broker or administrator; and also my employer or former employers and any of their agents performing services relating to any employee benefits; and also any federal or provincial government department or organization, including the Workers' Compensation Board/Workplace Safety and Insurance Board and the federal or provincial income tax authorities; and also to any other organization, institution or person having information, records or data regarding me, my medical history or treatment or my past and present income and employment.

I understand that any information, records or data received by RBC Life pursuant to this authorization will be used for the purpose of determining eligibility for coverage under group insurance offered by my employer (underwriting), for the purpose of administering the group insurance policy(ies) arranged through my employer or for the evaluation of any claim for benefits.

To the extent reasonably necessary for this purpose, I authorize RBC Life to disclose any of the said information, records or data received to other insurance companies or any reinsurer; or to my employer and its insurance brokers or advisors or its benefit plan administrators; or to any other person or firm employed or engaged by RBC Life.

If this application is being made on behalf of my dependant(s), I am authorized to disclose information about them, for the purposes of underwriting, administration or adjudication of claims. I confirm that RBC Life is authorized to disclose information about this application to me, for the purposes of assessing this application and managing my group benefits plan.

A photocopy of this authorization, as executed by me, shall be as valid as the original and shall continue to have effect throughout the duration of my coverage under the group coverage offered by my employer.

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Employee's Spouse (if applying):** \_\_\_\_\_ **Date:** \_\_\_\_\_

## SECTION 6: AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand and authorize RBC Life Insurance Company and its reinsurers (hereinafter collectively referred to as "RBC Life") to gather personal information concerning me and to disclose, as necessary, to third parties the fact that I am seeking insurance coverage from RBC Life.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to RBC Life any information, records or other data regarding me and my medical history or treatment, or my past and present income or employment, which they have in their possession or control.

Persons to whom this Authorization applies: Any physician, nurse, counsellor, psychologist, 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 company or other financial institution or insurance broker or administrator; and also my employer or former employers and any of their agents performing services relating to any employee benefits; and also any federal or provincial government department or organization, including the Workers' Compensation Board/Workplace Safety and Insurance Board and the federal or provincial income tax authorities; and also to any other organization, institution or person having information, records or data regarding me, my medical history or treatment or my past and present income and employment.

I understand that any information, records or data received by RBC Life pursuant to this authorization will be used for the purpose of determining eligibility for coverage under group insurance offered by my employer (underwriting), for the purpose of administering the group insurance policy(ies) arranged through my employer or for the evaluation of any claim for benefits.

To the extent reasonably necessary for this purpose, I authorize RBC Life to disclose any of the said information, records or data received to other insurance companies or any reinsurer; or to my employer and its insurance brokers or advisors or its benefit plan administrators; or to any other person or firm employed or engaged by RBC Life.

If this application is being made on behalf of my dependant(s), I am authorized to disclose information about them, for the purposes of underwriting, administration or adjudication of claims. I confirm that RBC Life is authorized to disclose information about this application to me, for the purposes of assessing this application and managing my group benefits plan.

A photocopy of this authorization, as executed by me, shall be as valid as the original and shall continue to have effect throughout the duration of my coverage under the group coverage offered by my employer.

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Employee's Spouse (if applying):** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please send the completed form using one of the following options:

Email: [MedicalUnderwritingSupport@rbc.com](mailto:MedicalUnderwritingSupport@rbc.com)

Mail: Please place in an envelope marked "Private and Confidential" and retain a copy for your records.

RBC Life Insurance Company  
Tower 1, 8th Floor, 6880 Financial Drive  
Mississauga ON L5N 7Y5

## COLLECTION AND USE OF PERSONAL INFORMATION

### Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about the employer and the employees (collectively "clients") such as:

- information establishing identity (for example, name, address, phone number, date of birth, etc.) and personal background;
- information related to or arising from the relationship with and through us;
- information provided through the application and claim process for any insurance products and services; and
- information for the provision of products and services.

We may collect information from the employer or the employee, either directly or through representatives. We may collect and confirm this information during the course of our relationship. We may also obtain this information from a variety of sources including hospitals, doctors and other health care providers, the MIB, Inc., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions and motor vehicle reports. Health information will not be shared with the employer without the consent of the employee.

### Using personal information

This information may be used from time to time for the following purposes:

- to verify the identity and investigate the background of the employer and employee;
- to issue and maintain insurance products and services that may be requested;
- to evaluate insurance risk and manage claims;
- to better understand the insurance situation of our clients;
- to determine eligibility for RBC insurance® products and services;
- to help us better understand the current and future needs of our clients;
- to communicate to our clients any benefit, feature and other information about RBC® products and services maintained with us;
- to help us better manage our business and the relationship with our clients; and
- as required or permitted by law.

For these purposes, we may make this information available to our employees, our agents and service providers, and third parties, who are required to maintain the confidentiality of this information. If you are insured under a group insurance policy obtained through your employer, we may also share your information with your employer when necessary for the services we provide to you. Your health information will not be shared with your employer without your consent.

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, Inc., and financial institutions.

We may also use this information and share it with RBC companies (i) to manage our risks and operations and those of RBC companies and (ii) to comply with valid requests for information about you from regulators, government agencies, public bodies or other entities who have a right to issue such requests.

**If we have a client's social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.**

### Right to access of personal information

Our clients may obtain access to the information we hold about them at any time and review its content and accuracy, and have it amended as appropriate; however, access may be restricted as permitted or required by law. To request access to such information or to ask questions about our privacy policies, the employee may do so now or at any time in the future by contacting us at:

**RBC Life Insurance Company**  
**P.O. Box 515, Station A,**  
**Mississauga, Ontario**  
**L5A 4M3**  
**Telephone: 1-800-663-0417**  
**Facsimile: 905-813-4816**

### Our privacy policies

You may obtain more information about our privacy policies by asking for a copy of our "Financial fraud prevention and privacy protection" brochure, by calling us at the toll free number shown above or by visiting our web site at [www.rbc.com/privacysecurity](http://www.rbc.com/privacysecurity).