RBC Insurance

ROYAL RECOVERASSIST®
HOSPITAL BENEFIT CLAIM FORM

Instructions for completing this form

This form should be completed by the Client (Insured Certificate holder) and the Attending Physician.

Please follow these instructions for completing the form:

Client's Statement
- Client completes 1, 2, 3 and 4.
- Hospitalized Insured Person 16 years of age or older (if different from client) completes 2, 3 and 4.

Attending Physician's Statement
- Physician completes.

We will accept copy of driver's license or passport as proof of age.

Please note that any charges incurred for completion of this form are at the expense of the client.

You must include a fully itemized statement of account from the hospital showing the date(s) of your confinement. Your claim will not be processed without this document.

Send the completed original claim form and all other required documents to:

RBC Life Insurance Company
P.O. Box 4435, Station A
Toronto, Ontario
M5W 5Y8

Telephone: 416-643-4700
Toll free: 1-877-519-9501
Fax: 1-800-714-8861

Incomplete claim forms will be returned for completion.

Please allow 10-15 days for your claim to be processed.

1 Personal information

Insured person's name (last, first, initial)

Insured's date of birth (DD/MM/YYYY)
(provide copy of birth certificate)

Client's name (last, first, initial)

Client's date of birth (DD/MM/YYYY)
(provide copy of birth certificate)

Certificate number

Relationship to client: ☐ Self ☐ Spouse ☐ Child*

* If child is 19 years or older, are they: ☐ Disabled ☐ Full-time student**

** If full-time student, please provide proof of enrollment at an accredited institute of learning.

Client's address (number, street and apt. number)

City Province Postal code

Client's residence telephone number
(_____) _____

Client's business telephone number
(_____) _____

2 Details of hospital stay

Were you confined to a hospital for your present condition? ☐ Yes* ☐ No

* If "Yes," please provide the period of confinement: From (DD/MM/YYYY) To (DD/MM/YYYY)

Hospital name Hospital address

Indicate the type of hospital stay:

☐ Out-patient ☐ In-patient ☐ Day surgery ☐ Other (specify)

In what unit(s) of the hospital were you confined?

☐ Intensive care ☐ Intensive coronary care ☐ Coronary care ☐ Palliative care
☐ Rehabilitative care ☐ Convalescent care ☐ Chronic care ☐ Emergency

When was surgery or hospitalization first discussed with your doctor? (DD/MM/YYYY)

When was the hospital room booked? (DD/MM/YYYY)

Was surgery performed for cosmetic reasons? ☐ Yes ☐ No

Details of condition Nature of condition

Specify the reason for your hospital stay: ☐ Sickness ☐ Injury

Diagnosis/nature of condition

Date symptoms of this condition were first noticed (DD/MM/YYYY)

If sickness

Date of first medical treatment or advice for this condition (DD/MM/YYYY)

If injury

Date of injury (DD/MM/YYYY) Describe injury

If you were injured in a motor vehicle accident

Name of the driver of the vehicle in which you were travelling

Name and address/division of the police officer notified

Was a police report prepared? ☐ Yes* ☐ No * If "Yes," please attach a copy of the report.

1 Hospital admission details

Patient's name (last, first, initial) _____ Date of birth (DD/MM/YYYY) _____

Certificate number _____

Date of hospital inpatient admission (DD/MM/YYYY) _____ Date of hospital discharge (DD/MM/YYYY) _____

Date of surgery (DD/MM/YYYY) _____

Nature of surgery _____

Diagnosis most responsible for this hospital admission

Primary condition _____

Secondary condition (if applicable) _____

If due to sickness (directly or indirectly)

Was sickness a contributing cause of this admission? ☐ Yes ☐ No

Date of first consultation for any manifestation of this condition (DD/MM/YYYY) _____ Date the diagnosis was first made (DD/MM/YYYY) _____

Has patient ever had the same or similar condition? ☐ Yes* ☐ No

* If "Yes," please state when and describe.

If due to injury

Is the condition primarily due to an accident? ☐ Yes* ☐ No Date of accident (DD/MM/YYYY) _____

* If "Yes," please specify: ☐ Motor vehicle accident ☐ Work-related incident ☐ Other

Please provide details of the accident.

Medical care

Are you actively treating the patient? ☐ Yes ☐ No Date of last consultation (DD/MM/YYYY) _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify)

If the patient is pregnant, please provide the expected date of confinement. (DD/MM/YYYY) _____

Describe any pathological complications of pregnancy.

Previous medical care

Give details of prior visits by the patient for the current disabling condition (include dates, the presenting signs and symptoms, the diagnostic findings, and treatments).

If the patient was referred to you, please indicate name of the referring physician. _____

Doctors consulted in the past

Have you ever had this or a similar condition before? ☐ Yes* ☐ No

* If "Yes," give details including name, address and telephone number(s) of doctor(s) and dates of treatments.

Family physician's name

Address

Telephone number

(_____) _____

List the names, addresses and telephone numbers of ALL other doctors you have consulted during the past five years.

3 Declaration

Did you smoke during the 12 months prior to the date of hospitalization? ☐ Yes* ☐ No

* If "Yes," please specify: ☐ Cigarettes ☐ Pipe ☐ Cigars

I understand that this declaration is a material statement and the Company will rely upon its truth in assessing the claim.

Client's signature

Date signed (DD/MM/YYYY)

Witness's signature

Date signed (DD/MM/YYYY)

Confidentiality

- All information requested will be for the purpose of processing and adjudicating your claims and will be treated as confidential.
- To protect the confidentiality of this information, RBC Insurance® will establish a "Claim File" from which this information will be used to process your claims.
- Access to this file will be restricted to RBC Insurance's employees, service providers and representatives who are responsible for the investigation of claims and to any other person you authorize or who is authorized by law.
- Your file is secured and will be kept in the offices of RBC Insurance and its service providers.

4 Authorization

I certify that the information in the form is true and complete to the best of my knowledge.

- I understand that RBC Insurance, its service providers and representatives may investigate this claim.
- I authorize any licensed physician, medical practitioner, health care professional, hospital, health care institution, medical organization, clinic and any medically related facility, insurance company, the Medical Information Bureau, corporation, organization, institution, association or person to release and exchange with RBC Insurance, its service providers and representatives any medical or benefit payment information, or any other information or records that may be requested by RBC Insurance, its service providers and representatives to establish or review the validity of this claim.
- I agree that a photocopy of this authorization shall be as valid as the original.

Client's name

Client's signature

Date signed (DD/MM/YYYY)

Insured's name (if different from above)

Insured's signature

Date signed (DD/MM/YYYY)

Did your patient smoke during the 12 months prior to the date of hospitalization? ☐ Yes* ☐ No ☐ Unknown

* If "Yes," please specify: ☐ Cigarettes ☐ Pipe ☐ Cigars

Additional remarks regarding your patient's condition

Attending physician's name (please print) Specialty

Address (number, street and suite number)

City Province Postal code

Telephone number
(_____)_____

Fax number
(_____)_____

Signature of physician

Date signed (DD/MM/YYYY)

Fee: The patient is responsible for securing this form and for charges made for its completion.

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