

Long Term Care Application (Short) - Form number 89606

The current version of this application is dated 10/2004.

Please destroy all applications that do not have this date.



Long Term Care Insurance

Application

IMPORTANT GUIDELINES

- Print legibly in ink, preferably black for photocopy purposes. DO NOT use ditto marks.
- DO NOT make erasures or use liquid paper. Strike out any error and have the applicant initial it.
- After the application has been signed, have additions initialed by the applicant. The application is a legal document forming part of the policy contract.
- Ensure the latest version of the MAX illustration software is used as a reference.

Your Privacy Matters To Us

At RBC Insurance®, we're committed to protecting your privacy. We respect your privacy and want you to understand how we safeguard your personal information.

How we collect your information

We collect and keep information about you, which is needed to provide the products and services you request. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, the Medical Information Bureau, the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

How we use your information

We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage claims. We may also share your information with others who work for RBC Insurance or other RBC Financial Group™ companies, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, financial institutions, third party administrators, and any references you provide.

We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business.

If you have given us your social insurance number, we will use it for taxation purposes and to help identify you with Citizenship and Immigration Canada, when necessary.

Please note that this paragraph is not applicable if this application is submitted by an independent representative or a representative who is attached to a firm other than RBC Insurance.

Other ways we use your information

When you request products and services directly from RBC Insurance, there are other ways we may use your information. For example, we may use or share some of your information to help you find out about other products and services from RBC Insurance and other companies of the RBC Financial Group. However, we will never use or share your health information for these purposes. To better manage your relationship with other companies of RBC Financial Group, and where the law allows us, we may consolidate the information we have about you with information held by the other member companies.

If, at any time, you decide that you do not want us to use your information as described here, under "Other ways we may use your information," please let us know by calling us at 1-800-663-0417.

Your right to access your information

You have a right to access the personal information that we have about you in your file. If we have information that is not correct, you can have it corrected.

To access your information or to ask us to correct information, you can contact us at:

RBC Life Insurance Company

P.O. Box 515, Station A,

Mississauga, Ontario

L5A 4M3

Telephone: (800) 663-0417

Facsimile: (905) 813-4816

If you would like more information about client privacy

RBC Financial Group publishes a brochure on client privacy. If you would like a copy of the brochure, you can contact us and we would be pleased to send one to you.

APPLICATION FOR LONG TERM CARE INSURANCE TO RBC LIFE INSURANCE COMPANY**1. PROPOSED INSURED**

NAME First Middle Last **SEX** (Check one) M F

DATE OF BIRTH D | | M | | Y | | | | **AGE**^{nearest} **SOCIAL INSURANCE NUMBER** | | | | | | | | | | | | | | | |

Smoker **Non-Smoker** **Place of Birth** _____

RESIDENCE ADDRESS

Street Name Apartment/Unit Number

City Province Postal Code Telephone Number

OCCUPATION/DAILY ACTIVITIES/HOBBIES**CONFIRMATION OF IDENTITY** (Check One)

DRIVER'S LICENSE **LANDED IMMIGRANT STATUS** **PASSPORT** **CANADIAN CITIZENSHIP CARD** **BIRTH CERTIFICATE**

DOCUMENT NUMBER

2. EMPLOYMENT INFORMATION

NAME OF EMPLOYER

OFFICE ADDRESS

Street Name Suite/Unit Number

City Province Postal Code Telephone Number

3. OWNER - IF OTHER THAN PROPOSED INSURED

NAME First Middle Last

DATE OF BIRTH D | | M | | Y | | | | **RELATIONSHIP**

BILLING ADDRESS

Street Name Apartment/Unit Number

City Province Postal Code

CONFIRMATION OF IDENTITY (Check One)

DRIVER'S LICENSE **LANDED IMMIGRANT STATUS** **PASSPORT** **CANADIAN CITIZENSHIP CARD** **BIRTH CERTIFICATE**

DOCUMENT NUMBER

4. POWER OF ATTORNEY OR MANDATE

Do you have a Power of Attorney/Mandate for Personal Care? Yes No

If yes, provide the name _____

Street Name Apartment/Unit Number

City Province Postal Code

Are you currently exercising your Power of Attorney/Mandate? Yes No

5. PLAN OF INSURANCE: LONG TERM CARE INSURANCE

INSURANCE	AMOUNT	BENEFIT PERIOD	WAITING PERIOD	ANNUAL PREMIUM
Facility Care	\$			\$
Home Care	\$			\$
Return of Premium	\$			\$
Future Purchase Option	\$			\$
COLA	\$			\$
Other	\$			\$

MONTHLY PRE-AUTHORIZED CHEQUE PREMIUM: \$

6. BENEFICIARY: For Return of Premium

All beneficiaries are revocable unless otherwise stated, except in Quebec where the designation of a legally married spouse of the owner is irrevocable unless expressly stated to be revocable. An irrevocable beneficiary cannot be changed without the written consent of the designated irrevocable beneficiary.

NAME First	Middle	Last	Relationship
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Revocable Irrevocable

7. Do you now have any pending insurance application or inforce coverage for Long Term Care, Life, Disability, or Critical Illness? If yes, please complete the following information: YES NO

Product Type	Company	Benefit Amount Applied For	Coverage Inforce	Are you Replacing?

PRE-AUTHORIZED CHEQUING ACCOUNT INFORMATION (PAC)

Account for PAC (must have chequing privileges and 7 or more digits):

(attach an encoded cheque sample marked "VOID")

Name of Financial Institution, Transit No. and Branch Address:

Special Withdrawal date if required: _____

	YES	NO
8. Are you presently:		
a) Confined to a hospital or nursing home?	<input type="checkbox"/>	<input type="checkbox"/>
b) Bedridden, wheelchair confined or in need of home nursing or health aid services?	<input type="checkbox"/>	<input type="checkbox"/>
c) Receiving physical, speech, or inhalation therapy, or kidney dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you presently being treated, or within the past 5 years have you been treated or advised to be treated for:		
a) Multiple Sclerosis, leukemia or liver cirrhosis?	<input type="checkbox"/>	<input type="checkbox"/>
b) Senility, dementia, brain disease or disorder, Alzheimer's, Parkinson's or Lou Gehrig's Disease?	<input type="checkbox"/>	<input type="checkbox"/>
c) A lung disorder which requires the use of oxygen or a mechanical device to help you breathe?	<input type="checkbox"/>	<input type="checkbox"/>
d) Insulin dependent diabetes mellitus, retinopathy, stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
e) Acquired Immune Deficiency Syndrome (AIDS), or other immune system disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you:		
a) Been advised to have joint replacement or other surgery which has not been done?	<input type="checkbox"/>	<input type="checkbox"/>
b) Been advised you need hospitalization, nursing home care, home health care or kidney dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
c) Had, or been advised to have an amputation because of a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you currently need, or within the past 5 years have you required another person's help in performing any activities of daily living such as bathing, dressing, toileting, eating, transferring from bed to chair, controlling bladder or bowel function?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU HAVE ANSWERED "YES" TO ANY OF QUESTIONS 8-11, YOU ARE *NOT* ELIGIBLE FOR COVERAGE. ANY APPLICANT WHO HAS ANSWERED "NO" TO QUESTIONS 8-11 MAY CONTINUE.

PLEASE PROVIDE DETAILS FOR ALL "YES" ANSWERS TO QUESTIONS 12-16 IN THE AREA PROVIDED IN QUESTION #17.

	YES	NO
12. Height _____ in/cm Weight _____ lbs/kgs Gain _____ Loss _____ lbs/kgs Any weight changes in the last year? Reason? _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had, or been told you had, or received treatment or advice for:		
a) Disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
b) Dizziness, fainting, weakness, convulsions, headache, speech defect, epilepsy paralysis, stroke, transient ischemic attack (TIA), or other neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c) Anxiety or depression, chronic fatigue, suicidal thought or any other emotional, behavioural, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d) Shortness of breath, hoarseness or cough, blood spitting, bronchitis, pleurisy, tuberculosis, asthma, emphysema or other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e) Chest pain, palpitation, high blood pressure, elevated cholesterol, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
f) Jaundice, intestinal bleeding, ulcer, colitis, diverticulitis, hepatitis or hepatitis carrier state or other disorder of the stomach, intestines pancreas, liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>
g) Sugar, albumin, blood or pus in urine, sexually transmitted disease, stone or other disorder of the kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
h) Rheumatism, arthritis, fibrositis, fibromyalgia, chronic pain disorder, gout or disorder of the muscles or bones, including the spine, back, neck or joints?	<input type="checkbox"/>	<input type="checkbox"/>
i) Deformity, lameness, amputation?	<input type="checkbox"/>	<input type="checkbox"/>
j) Cancer, tumour, cyst or disorder of the skin?	<input type="checkbox"/>	<input type="checkbox"/>
k) Allergies, anemia or other disorders of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
l) Diabetes, thyroid, pituitary, or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
m) Enlargement of the lymph nodes (glands), chronic diarrhea, skin lesions, unexplained infections or tested positive for antibodies to the HIV (AIDS) virus?	<input type="checkbox"/>	<input type="checkbox"/>
n) A breast disorder (male or female)?	<input type="checkbox"/>	<input type="checkbox"/>

18. Please give name, address and phone number of the health practitioner with the most complete record of your health history.

19. Please give name, address and phone number of the most recently seen health practitioner, date last consulted, reason for your visit, diagnosis or specified treatment, if any.

20. Family history: Diabetes, cancer, high blood pressure, colon polyps, heart or kidney disease, stroke or Huntington's chorea?

	Condition or cause of death	Age at onset	Age if living	Age at death
Father				
Mother				
Brothers				
Sisters				

Smoker Status:

21. Do you currently use tobacco? Yes No

a) Form of tobacco _____

b) Quantity/Frequency _____

22. Have you used tobacco in the past? Yes No

a) Date Quit _____

b) Form of tobacco _____

c) Quantity/Frequency _____

23. Do you have any intention to reside or travel outside of North America? If yes, provide details including places, dates and purposes of travel:

CONDITIONAL INSURANCE AGREEMENT

1. Insurance is provided under this conditional agreement only if all of the following conditions are first satisfied: a) The full, initial premium has been paid at time of application; b) RBC Life Insurance Company decides that the Proposed Insured is approved as applied for; c) the applicant otherwise complied with all the provisions of the insurance policy (including eligibility requirements, conditions and exclusions for which the applicant is submitting this application).
2. If all the conditions that are set out in paragraph #1 are first satisfied, the conditional insurance coverage shall take effect on the latest of: a) the date of the application; b) the date of completion of the latest of all medical examinations and/or cognitive impairment assessment or nursing assessment whether conducted by telephone or otherwise, as requested by RBC Life Insurance Company; or c) the date when RBC Life Insurance Company receives all other evidence of insurability that RBC Life Insurance Company has requested.
3. If a material misrepresentation or fraud is made in the application or at any time prior to the issuance of the insurance for which the application is being submitted, then no insurance of any kind, whatsoever (whether under this conditional insurance agreement or otherwise) is provided.
4. For Long Term Care insurance, RBC Life Insurance Company's liability (if any) under this conditional agreement prior to issuance of the insurance policy applied for shall be limited to the lesser of: a) the amount of benefit provided under the policy applied for, taking into account other benefits and other coverage in force; b) benefits in the amount of \$100 per day from all sources for a maximum of 180 days; or c) the difference between the amount applied for and the amount of Long Term Care insurance which the Insured is eligible to receive under any other individual and/or group Long Term Care plan.
5. If the initial premium payment submitted at the time of application, by cheque, is not paid according to its tenor, this conditional agreement will be null and void.
6. Any insurance coverage that is provided under this conditional insurance agreement ends on the earliest of the following: a) the date when the applicant requests a refund of premium before the issuance of the policy applied for or a cancellation of the application; b) the date when RBC Life Insurance Company rejects the application; c) the 90th day after the date when the applicant signed the application if RBC Life Insurance Company has not yet issued the insurance policy as applied for; or d) the date when RBC Life Insurance Company approves the application as applied for and issues the insurance policy applied for.
7. No benefits of any kind whatsoever are payable under this conditional agreement if the loss results, in whole or in part, from self-inflicted injury or loss, while sane or insane.

RBC Life Insurance Company acknowledges the receipt of \$ _____ (by cheque) as full payment of the initial premium(s) for insurance coverage regarding _____, the Proposed Insured in the application bearing the same number as this agreement.

SIGNATURE OF REPRESENTATIVE

SIGNATURE

DATE

The agent is a contracted representative of RBC Life Insurance Company and is paid by commission. The commission is shared, where applicable with _____.

DECLARATION/AGREEMENT/ACKNOWLEDGEMENT/AUTHORIZATION

IT IS AGREED that: (1) Insurance under any policy issued will become effective, only when the first premium has been paid in full and the policy has been delivered, provided that at the time of delivery no change has taken place in the insurability of any life to be insured between the time the application was completed and the time the policy is delivered. (2) Acceptance of the policy will constitute agreement to its terms and ratification of any changes specified by the Company in the policy.

I/We hereby certify that the statements and answers recorded on this application are true and complete.

I/We acknowledge that RBC Life Insurance Company will be entitled to render this policy and any Conditional Insurance Agreement null and void if I/We or the insured have made a misrepresentation in any part of the application for insurance, medical examinations, or any questionnaire completed in connection with this application that is material to the insurance risk, provided that RBC Life Insurance Company cannot contest any statement made by me/us or an insured, other than fraudulent statements, once the insurance coverage has been effective during the lifetime of the insured for two years following the later of:

- the policy or coverage effective date; or
- the effective date of any reinstatement; or
- the effective date of any addition or increased amount in coverage.

However, the policy will remain contestable if disability or critical illness arose before the end of the two year period.

I/We authorize any health care professional, any health or social service establishment, any insurance company, the Medical Information Bureau, financial institution, personal information agents or security agencies, my employer or any former employer and any public body holding personal information concerning me, particularly medical information, to supply this information to RBC Life Insurance Company and its reinsurers. For the same purpose, I authorize RBC Life Insurance Company, its reinsurers, and the Medical Information Bureau, to exchange the personal information contained in this application with other insurers, market intermediaries, financial institutions, and persons whom I have indicated as references. I also authorize the Underwriting Department of RBC Life Insurance Company to release to my doctor(s) any medical results obtained as a result of my application for insurance for the purpose of assisting in explaining those results.

I understand that if I/we refuse to provide this authorization, RBC Life Insurance Company will be unable to assess insurance risk and therefore unable to issue a policy.

This authorization will be valid until revoked by written notice to RBC Life Insurance Company.

A photocopy of this authorization shall be as valid as the original.

I/We authorize the Medical Information Bureau to provide such information on the same basis. I have read and received the M.I.B. Pre-Notice regarding this Medical Information Bureau.

If the Owner has chosen the monthly mode of payment, I/We authorize RBC Life Insurance Company to make Pre-Authorized Cheque Withdrawals from the owner's bank account for the purpose of paying premiums as they fall due. If premiums change for the insurance policy issued from this Application, I/we authorize RBC Life Insurance Company to amend the amount of the pre-authorized cheque withdrawals. This payment method may be cancelled by providing 10 days written notice to the Head Office of RBC Life Insurance Company or to the financial institution indicated on the Application for Insurance.

Insurance is a contract based on trust. Failure to fully disclose facts material to this application could make the contract void.

The parties thereto have expressly requested this contract and all documents relating thereto to be drawn up in the English language. Les parties aux présentes ont expressément demandé que ce contrat et tous les documents qui s'y rapportent soient rédigés en langue anglaise.

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DECLARATION/AGREEMENT/ACKNOWLEDGEMENT/AUTHORIZATION

SIGNED IN THE CITY OF	IN THE PROVINCE OF
PROPOSED LIFE INSURED Signature	Date
OWNER (s) Signature	Date
PAYOR Signature	Date
WITNESS Signature	Date
WRITING REPRESENTATIVE (print name)	Representative Code No.
AGENCY	Agency Code No.

AUTHORIZATION TO RELEASE INFORMATION

C.E.

I/WE authorize any health care professional, any health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or security agencies, my employer or any former employer and any public body holding personal information concerning me, particularly medical information, to supply this information to RBC Life Insurance Company and its reinsurers. Such information will be provided for the following purposes: (a) assessment of insurance risk for underwriting purposes; and (b) investigations necessary to adjudicate any claim or assess the validity of the policy as issued. I understand that if I/we refuse to provide this authorization, RBC Life Insurance Company will be unable to assess insurance risk and therefore unable to issue a policy. A photocopy of this authorization shall be as valid as the original.

This authorization will be valid until revoked by written notice to RBC Life Insurance Company.

LIFE TO BE INSURED'S SIGNATURE

SIGNATURE	DATE
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AUTHORIZATION TO RELEASE INFORMATION

C.E.

I/WE authorize any health care professional, any health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or security agencies, my employer or any former employer and any public body holding personal information concerning me, particularly medical information, to supply this information to RBC Life Insurance Company and its reinsurers. Such information will be provided for the following purposes: (a) assessment of insurance risk for underwriting purposes; and (b) investigations necessary to adjudicate any claim or assess the validity of the policy as issued. I understand that if I/we refuse to provide this authorization, RBC Life Insurance Company will be unable to assess insurance risk and therefore unable to issue a policy. A photocopy of this authorization shall be as valid as the original.

This authorization will be valid until revoked by written notice to RBC Life Insurance Company.

LIFE TO BE INSURED'S SIGNATURE

SIGNATURE	DATE
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DISCLOSURE STATEMENT FOR THE PROVINCE OF B.C.

(Detach and leave with Proposed Insured)

Pursuant to S.90 of the Financial Institutions Act of British Columbia, the financial product you are being offered is supplied by RBC Life Insurance Company, a company licensed to carry on business in British Columbia, with Head Office at P.O. Box 515, Station A, Mississauga, ON L5A 4M3.

In relation to any application you may make for the acquisition of life insurance annuities or other financial products;

- a) I am acting as a licensed insurance broker on behalf of RBC Life Insurance Company;
- b) I will be entitled to receive commission from RBC Life Insurance Company on successful completion of this transaction. This commission may take the form of an acquisition commission and/or any on-going service commission; and
- c) There is no condition associated with this transaction requiring that you must transact additional or other business with either myself or RBC Life Insurance Company.

REPRESENTATIVE

NAME	SIGNATURE
ADDRESS	

MUST ALWAYS BE LEFT WITH PROPOSED LIFE INSURED**MEDICAL INFORMATION BUREAU**

C.E.

Pre-Notice to Applicants Regarding the Medical Information Bureau

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

Upon receipt of a request from you, the Bureau will arrange a disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information Office is 330 University Avenue, Toronto, Ontario M5G 1R7 - Telephone (416) 597-0590.

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 you submit a claim for benefits.

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