RBC Insurance®

CLAIMANT SUPPLEMENTARY STATEMENT

Name: _____ Policy No(s): _____
Last First Middle

Address: _____
Apt. Street City Province Postal Code

Telephone No.: Home: ( ) _____ Work: ( ) _____

INFORMATION ABOUT YOUR CLAIM

1. a) Since your last Statement, have you returned to work? ❑ Yes ❑ No If "Yes," to the same job? ❑ Yes ❑ No

Indicate: _____ _____ _____ _____ If not the same job, where? _____
Full-time (MM/DD/YYYY) # hours/wk Part-time (MM/DD/YYYY) # hours/wk

b) If you have not returned to work, have you made any effort or investigation about attempting to return to work? ❑ Yes ❑ No

If "Yes," provide details: _____

c) Have you been able to engage in any volunteer work since the last Statement? ❑ Yes ❑ No If "Yes," explain: _____

d) If you are currently working, have your regular duties been modified due to your condition? ❑ Yes ❑ No

If "Yes," describe: _____

2. Describe your current symptoms preventing you from working full-time: _____

3. Describe any change in your condition, and any new restrictions or limitations that have been recommended by your attending physician:

4. Describe your current activities and how your condition has impacted these activities: _____

5. Have you applied for, or are you receiving, an income, or benefits from any of the following:

	Yes/No	Policy No.	Amount	Date filed	Date Payments Began
Workers' Compensation Board benefits					
Canada / Quebec Pension Plan benefits					
Automobile or Disability Insurance					
Other: specify _____					

(Please provide copies of all correspondence received)

TREATMENT

6. Primary Physician's Name: _____ Last consultation: _____ (MM/DD/YYYY)

7. a) List other Physicians and/or Therapists consulted:

Name & Specialty	Address	Telephone No.	Date(s) seen (MM/DD/YYYY)

b) Do you feel that the treatment has helped, or is likely to be helpful? _____

8. Have you been hospitalized since your last Statement? ❑ Yes ❑ No If "Yes," from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

Reason: _____

Hospital name and address: _____

FRAUD NOTICE

Any person who knowingly files a Statement containing false or misleading information may be subject to criminal and civil penalties.

I, _____ , verify that items no. 1 - 8, inclusive, are true and complete to the best of
(print name)

my knowledge and belief.

Date _____ Signature of Claimant _____
(MM/DD/YYYY)

AUTHORIZATION

I understand and authorize the Company (the Company refers to and includes RBC Life Insurance Company, and its participating 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, which 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 the performance of their duties, or 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 have any errors in the personal information noted and corrected by formulating a written request to the Company mailed to the employee who is handling my claim.

Your Authorization to Disclose Personal Information

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, employment, education or training, 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 or workers' compensation; and also any federal or provincial government department or organization, including the workers' compensation board, the CPP/QPP disability /retirement authorities, and the federal or provincial income tax authorities; and also to any other person, agency, credit bureau or institution having information, records or data regarding me, my medical history or treatment, or my past and present income, employment, education or training.

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 purpose of evaluating my claim for benefits, my ability to return to work or for the purpose of administering the policy under which my claim is made. To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to other insurance companies or any reinsurer; or to my employer and their insurance brokers or advisors or their benefit plan administrators; or to my physicians or health care providers; or to any other person or firm (including physicians, health care practitioners, rehabilitation workers, vocational evaluators) employed or engaged by the Company.

I also authorize the Company to use my Social Insurance Number for my insurance file identification, any tax reporting purposes, and all other matters relating to my insurance claim or entitlement to benefits.

This authorization does not have any expiry date. It will remain valid for as long as I am claiming benefits or service from the Company. A photocopy of this authorization, as executed by me, will be as valid as the original.

X _____ Date: _____
Signature of Claimant (MM/DD/YYYY)

_____ Social Insurance Number: | | | | | | | | | |
Name of Claimant (Please Print)

X _____ Date: _____
Signature of Witness (MM/DD/YYYY)

_____
Name of Witness (Please Print)

MAIL THE COMPLETED FORM TO:

RBC Life Insurance Company, Life and Health Claims Department

P.O.Box 4435, Station A, Toronto, ON M5W 5Y8 **or fax to:** 1-800-714-8861

If you have any questions, call toll free 1-877-519-9501 or 416-643-4700

COLLECTION AND USE OF PERSONAL INFORMATION

Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about you such as:

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

We may collect information from you, 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, motor vehicle reports, and your employer.

Using your personal information

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

- to verify your identity and investigate your personal background;
- to issue and maintain insurance products and services you may request;
- to evaluate insurance risk and manage claims;
- to better understand your insurance situation;
- to determine your eligibility for insurance products and services we offer;
- to help us better understand the current and future needs of our clients;
- to communicate to you any benefit, feature and other information about products and services you have with us;
- to help us better manage our business and your relationship with us; 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, (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, and (iii) to let RBC companies know your choices under "Other uses of your personal information" for the sole purpose of honouring your choices.

If we have your social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

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

Other uses of your personal information

› We may use this information to promote our products and services, and promote products and services of third parties we select, which may be of interest to you. We may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided.

› We may also, where not prohibited by law, share this information with RBC companies for the purpose of referring you to them or promoting to you products and services which may be of interest to you. We and RBC companies may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided. You acknowledge that as a result of such sharing they may advise us of those products or services provided.

› If you also deal with RBC companies, we may, where not prohibited by law, consolidate this information with information they have about you to allow us and any of them to manage your relationship with RBC companies and our business.

You understand that we and RBC companies are separate, affiliated corporations. RBC companies include our affiliates which are engaged in the business of providing any one or more of the following services to the public: deposits, loans and other personal financial services; credit, charge and payment card services; trust and custodial services; securities and brokerage services; and insurance services.

You may choose not to have this information shared or used for any of these "Other uses" by contacting us as set out below, and in this event, you will not be refused insurance products or services just for that reason. We will never use or share your health information for these purposes. We will respect your choices and, as mentioned above, we may share your choices with RBC companies for the sole purpose of honouring your choices regarding "*Other uses of your personal information*".

Your right to access your personal information

You may obtain access to the information we hold about you 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, to ask questions about our privacy policies or to request that the information not be used for any or all of the purposes outlined in "Other uses of your personal information" you 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 "Straight Talk®" brochure about privacy, by calling us at the toll free number shown above or by visiting our web site at www.rbc.com/privacy

83740 (09/2008)