



NOTICE OF FACILITY CARE

CLAIMANT'S STATEMENT (please print)

Full Name _____

Date of Birth _____ Policy Number _____

Home Address _____

Telephone Number _____

Power of Attorney Granted to (please attach proof of Power of Attorney if applicable) _____

Address of Power of Attorney _____

Telephone Number of Power of Attorney _____

Diagnosis _____

Date of Diagnosis _____

Do you currently need another person's help in performing any activities of daily living, such as bathing dressing
 toileting eating walking indoors transferring from bed to chair controlling bladder or bowel functions
 taking medications as prescribed? _____

Name of Facility _____

Date Entered into Facility _____

Address _____

Telephone Number _____

List services provided to residents _____

Does this facility have a provincial license? _____ License Number _____

Do you own Long Term Care coverages of any kind with any other Insurance Company? Yes No If yes, complete below:

Name of Company	Weekly/Monthly Amount of Benefit	Waiting Period for Benefits
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize any health care professional, health or social service establishment, insurance company, the Medical Information Bureau, financial institution, personal information agents or security agencies, my current employer or any former employer and 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 investigations necessary to adjudicate my claim or assess the validity of the policy as issued.

I understand that if I refuse to provide this information, RBC Life Insurance Company will be unable to adjudicate my claim or assess the validity of the policy as issued.

A photocopy of the signed authorization to obtain this information will be as legally valid as the original.

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

DATE

SIGNATURE OF CLAIMANT

SOCIAL INSURANCE NUMBER