Disability Claim Form
Employer Section

Insurance

Client's Name: _____

Policy No(s): _____

Employer Name: _____

COMPLETING THE FORM:

We want to make sure the claim is processed accurately and quickly. To make the process as timely as possible, we have designed this Disability Claim form to collect as much necessary information as possible from you at the beginning of the process. The information we have requested will help us determine the benefits receivable according to the contract with us.

THE COMPLETED FORMS MUST REACH RBC LIFE INSURANCE COMPANY
WITHIN 90 DAYS OF THE CLAIMED DISABILITY DATE.

Send the completed form and documents to our office by email: intake@rbc.com

You can also fax the information to: RBC Life Insurance Company, Life and Health Claims Department, 1-800-714-8861.

If you have any questions, call toll free 1-877-519-9501 or 416-643-4700.
RBC Life Insurance Company, Life and Health Claims Department, P.O. Box 4435, Station A, Toronto ON, M5W 5Y8
www.rbcinsurance.com

Insurance

EMPLOYER'S STATEMENT OF DISABILITY

EMPLOYER

Company Name

Policy Number

Name of Benefits Administrator who should be contacted regarding this claim, if applicable

(_____) _____ Telephone No.

(_____) _____ Fax No.

Address (Street / City / Province / Postal Code)

Email address

Language Preference: ☐ English ☐ French

Name of employee's direct manager

(_____) _____ Telephone No.

(_____) _____ Fax No.

Address (Street / City / Province / Postal Code)

Email address

Name of Third Party Administrator (TPA), if applicable

(_____) _____ Telephone No.

(_____) _____ Fax No.

Address (Street / City / Province / Postal Code)

Email address

EMPLOYEE

Legal Name (Last, First, Middle)

Address (Street / City / Province / Postal Code)

Email Address

(_____) _____
Telephone No.

Date of Birth (DD/MM/YYYY)

Address of employee's work location (Street / City / Province / Postal Code)

Employee Reporting Department

Employee ID Number

Employee Division Number

Employee Class Number

EMPLOYMENT

1. a) Date employee was hired (DD/MM/YYYY)

   Date employee became insured under this plan (DD/MM/YYYY)

   b) Last date employee worked (DD/MM/YYYY)

   Date employee would have next worked if absence from work had not begun (DD/MM/YYYY)

2. Position/Job title on last date worked

   Length of time in that position

3. Was coverage added for this employee on the first date that they were eligible? Yes ☐ No ☐
   If "No," provide details:
4. Has the employee's coverage been continuous since first insured under this plan? Yes ☐ No ☐
   If "No," provide details:
5. Has coverage under this policy terminated for this employee? Yes ☐ No ☐
   If "Yes," provide details:
6. Has the employee returned to work for any period of time since the last date worked? Yes ☐ No ☐
   If "Yes," provide details:

Insurance

EMPLOYER'S STATEMENT OF DISABILITY

EMPLOYMENT (Cont'd)

7. Is the employee: ☐ Permanent ☐ Part-time ☐ Temporary/Contract ☐ Other (specify) _____

8. Please indicate one complete work week or shift cycle by showing the number of hours worked per day:

Day of Week	S	M	T	W	T	F	S

Does this cycle repeat? Yes ☐ No ☐

Number of hours worked per week: _____

9. Is the work subject to:
Seasonal Changes Yes ☐ No ☐ Business Cycles Yes ☐ No ☐ Layoffs Yes ☐ No ☐

10. Were there any recent changes to the employee's responsibilities or hours prior to ceasing work? Yes ☐ No ☐
If "Yes," what were the changes and when were they made?

_____

11. Can the position be performed on a modified or part-time basis? Yes ☐ No ☐
If "No," explain: _____

EMPLOYEE'S SALARY

1. Prior to the last date worked: $ _____ (Hourly Wage) $ _____ (Annual Salary) _____ (Pay Period (i.e. Bi-weekly, Monthly))

2. In the 12 months prior to the last date worked (or the period of employment, if less than 12 months), what was the amount paid?

$ _____ (Salary) $ _____ (Commission) $ _____ (Bonuses) $ _____ (Overtime)

EMPLOYEE'S OTHER INCOME REPLACEMENT AND INSURANCE COVERAGE

1. Is this also an application for: Group Life Waiver Yes ☐ No ☐ Disability Yes ☐ No ☐

2. Did the employee receive any other income during the disability period? Yes ☐ No ☐

If "Yes," please select one of the following and indicate amount and period below:

☐ Vacation ☐ Maternity Leave ☐ Employment Insurance ☐ Sick Days ☐ Statutory Holidays ☐ STD

Amount: $ _____ From: _____ To: _____

3. Has the employee submitted a claim to the following governing bodies?

☐ CPP ☐ QPP (RRQ) ☐ WCB / WSIB / CSST ☐ Auto Insurer

4. Do you consider the employee's condition to be work-related? Yes ☐ No ☐
If "Yes," provide details: _____

RETURN TO WORK

1. Does your company have a return-to-work program? Yes ☐ No ☐
If "Yes," what type of accommodations can be provided: _____

2. Is there an anticipated return-to-work date known? Yes ☐ No ☐
If "Yes," please provide date: _____

DOCUMENTS REQUIRED

Please attach the following documents with this Statement:

☐ Copy of the last pay-stub/payroll record just prior to the last day of work.
☐ Copy of attendance records for the past six months.
☐ Copy of the job description and minimum qualifications, licenses/certifications and resume.
☐ Initial report of injury and decision notices relating to Worker's Compensation Claim (WCB, WSIB, CSST), if applicable.

SIGNATURE OF PERSON COMPLETING THIS STATEMENT

I declare that the above statements are true and complete to the best of my knowledge and belief.

Signature of Preparer: _____ Date: _____ (DD/MM/YYYY)

Print Name: _____ Title: _____

Address: _____
(Street / City / Province / Postal Code)

Telephone No.: (_____) _____