Disability Insurance Application

Use this application for all disability insurance products except the Fundamental Series®

RBC Insurance

FINANCIAL REQUIREMENTS FOR ALL APPLICANTS

Business/Employment Status	Applied for and in Force for Less Than $10,000	Applied for and in Force for $10,000 or More
If applicant is:	**Then include with application:**	**Then include with application:**
Employee, no ownership share of the business	No financial documents required	T4 and T1*
Employee with business expense deductions or commissioned employee with expense deductions	T1*	T4 and T1*
Owner/shareholder of incorporated business	T1* and Income Statement of business	T4 and T1* and complete Business Financial Statements***
Unincorporated professional, business owner or partner	T1* and T2125**	T1* and T2125**
Incorporated farmer	T1* and Balance Sheet, Income Statement and Schedule 8 (Capital Cost Allowance) from the last financial statements of the corporation; and T2 Schedule 1 (Net Income (Loss) for Income Tax Purposes) from the most recent T2 Corporate Tax Return	
Unincorporated farmer	T1* and all pages of form T2042 (Statement of Farming Activities); or T1* and form T1163 (Statement A) and Form T1175 (Farming – Calculation of Capital Allowance)	

4A Executive – Part of a Multi-Life Sale of 3 or More Individuals	All Amounts
If applicant is:	**Then include with application:**
Employee, no ownership share of the business	Census or letter on company letterhead, signed and dated by the appropriate company official, with their title. Document must include clear breakdown of all applicants' salaries, bonuses and any other compensation for the last two years. If original document is not available or not submitted, census can be submitted as an email from the appropriate company official, not from the producer or applicant.
Corporate owner/shareholder	Same requirement as for "Employee, no ownership share of business" plus complete Business Financial Statements*** of the business for the last complete fiscal year

Disability Buy Sell Coverage Business Structure	All Amounts
If applicant is:	**Then include with application:**
Owner/shareholder of an incorporated business	T1* or T4 and complete Business Financial Statements*** for the past two years
Unincorporated professional, business owner or partner	T1* and complete Business Financial Statements*** for the past two years

Business Overhead Expense Coverage+	All Amounts
All applicants	**Include with application:** Business Overhead Expense Coverage supplement. No financial documents required.

Business Loan Protector Coverage+	All Amounts
All applicants	**Include with application:** Business Loan Protector Supplement. No financial documents required.

* **T1 means all pages up to and including line 26000 of the most recent T1 General federal tax return.**

** **Statement of Business or Professional Activities**

*** **The Business Financial Statements include the Income Statement (profit & loss statement), balance sheet, and notes for the last complete fiscal year.**

+ **There are no routine financial requirements for Business Overhead Expense applications provided the financial documentation is not required for any other type of coverage applied for concurrently. Proof of earnings and expenses is required at claim time.**

+ **There are no routine financial requirements for Business Loan Protector applications provided the financial documentation is not required for any other type of coverage applied for concurrently. Proof of loan is required at claim time.**

DETACH AND GIVE TO PROPOSED INSURED

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, LLC, 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.

In the event our service provider is located outside 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, LLC 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.

DETACH AND GIVE TO PROPOSED INSURED

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 calling us at the toll free number shown above or by visiting our website at www.rbc.com/privacysecurity.

DETACH AND GIVE TO PROPOSED INSURED

CONSUMER FACT SHEET
PRE-NOTICE

Information regarding your insurability and claims will be treated as confidential. RBC Life Insurance Company (RBC Life) or its reinsurer(s) may, however, make a brief report thereon to the MIB, LLC, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com, calling 1-866-692-6901 or write to:

MIB, LLC,
50 Braintree Hill Park, Suite 400,
Braintree, MA
USA, 02184-8734
Telephone: 1-866-692-6901
Website: www.mib.com

RBC Life or its reinsurer(s) 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.

PERSONAL HISTORY INTERVIEW (PHI)

As part of the underwriting process, you may be asked to respond to a telephone interview. The Personal History Interview (PHI) is conducted by specially trained interviewers. The interview will take approximately 20 minutes.

The questions asked by the interviewer amplify the information on your application for insurance. We also use the PHI process to gather information which may have been omitted or only partially explained in the application. These questions relate to personal, financial and medical aspects of insurability and must be answered truthfully and completely. The answers contained in the Personal History Interview and/or supplementary questionnaire(s) completed by you during a telephone interview will form part of your application for insurance and the contract. Because of the nature of the information obtained, the PHI will only be conducted directly with you.

Any information obtained during the PHI will be kept strictly confidential and will not be released to anyone without your written consent.

Your co-operation in this process is greatly appreciated and enables us to provide you with the best quality underwriting.

This page has been left
blank intentionally.

PART 1 (You/Your refers to the Proposed Insured)

PROPOSED INSURED (Check one) Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐

1. Print name as legally known:
   a. Last
   b. First & Middle
   c. Birthdate: Day Month Year
   d. Birthplace: Country
   e. Sex: M ☐ F ☐
   f. Do You understand English or French? Yes ☐ No ☐

If No, please ensure a Statement of Understanding is signed by the Proposed Insured and the Proposed Owner(s) and submitted with this application.

   g. Is a French language policy requested? Yes ☐ No ☐

   h. Canadian Citizen ☐ Permanent Resident ☐
   Other (Specify) ☐
   i. How long have You resided in Canada? yrs

2. a. Home Address: Number
   b. Street
   c. City
   d. Province e. Postal Code
   f. Email Address
   g. Home Phone No. ( )
   Work Phone No. ( )
   Mobile Phone No. ( )
   h. Premium notices to be sent to:
   Residence ☐ Business ☐

▶▶ If premium notices are to be sent to someone other than the Owner/Insured, please complete **Part 3, question 2.**

3. If additional information is required, I may be contacted at the following telephone number:

☐ Home ☐ Work ☐ Mobile

EMPLOYMENT INFORMATION

4. a. Occupation
   b. Professional Designation(s) or Degree(s)
   c. Breakdown of Duties:

Office		% time spent
Supervision in an office		% time spent
Supervision on-site		% time spent
Manual		% time spent
Driving		% time spent
Other		% time spent

Total = 100%

Details of "Manual" and "Other" Duties

   d. How many hours per week do You work?
   e. What % of this time is spent working in Your home?

   f. Is employment seasonal? Yes ☐ No ☐
   g. If Yes, how many weeks worked per year?

5. a. Do You have any part-time or other full-time jobs?
   Yes ☐ No ☐
   b. If Yes, describe exact duties, number of hours worked per week and income.

PART 1

6. a. Business/Employer Name

b. Business/Employer Address: Suite No. c. Street

d. City e. Province f. Postal Code

g. Phone No. ( )

h. Describe the nature of the business.

i. Number of years with present employer? j. Number of years in this type of business?

k. Are You a commissioned salesperson? Yes ☐ No ☐

If You are self-employed, provide the following details:

l. How long have You been self-employed? (years)

m. Number of full-time employees excluding owners?

n. Organization of Business: ☐ Sole Owner ☐ Partnership ☐ Corporation

o. If incorporated, what is your percentage voting ownership of the common shares? %

p. Do you income split to your spouse/children in the form of a salary or management fee for tax purposes? Yes ☐ No ☐

q. If Yes, what amount do You income split? $

COVERAGE APPLIED FOR

Include Illustration with submitted application.
If the Illustration has been signed by the client, there is no need to complete this section.

7. Select the product and occupation class:						8. Select additional benefits applied for:	
☐ The Professional Series®	☐ 4A	☐ 3A	☐ 2A			☐ Future Income Option →	$ Amount
☐ The Foundation Series™	☐ 4A	☐ 3A	☐ 2A	☐ A	☐ B	☐ Short Term Partial Disability →	Number of Months
☐ The Bridge Series®	☐ 4A	☐ 3A	☐ 2A	☐ A	☐ B	☐ Cost Of Living Adjustment	
☐ Quantum®	☐ 4A	☐ 3A	☐ 2A			☐ Enhanced Definition of Disability	
☐ Business Overhead Expense	☐ 4A	☐ 3A	☐ 2A	☐ A		☐ Own Occupation	
☐ Disability Buy Sell	☐ 4A	☐ 3A	☐ 2A			☐ Healthcare Profession Rider	
☐ Key Person Protector	☐ 4A	☐ 3A	☐ 2A			☐ Family Compassionate Care Rider (spouse and children)	
☐ Retirement Protector	☐ 4A	☐ 3A	☐ 2A	☐ A	☐ B	If not listed above, provide details:	
☐ Business Loan Protector	☐ 4A	☐ 3A	☐ 2A	☐ A (periodic pay)			

Product Name(s) (from list above)						
Monthly Indemnity	BASE $	AMI* $	BASE $	AMI* $	BASE $	AMI* $
Elimination Period						
Benefit Period						

* Additional Monthly Indemnity

COVERAGE APPLIED FOR, (continued)

9. Is this application part of a Wage Loss Replacement Plan? Yes ☐ No ☐
If Yes, complete Wage Loss Replacement Plan Amendment Form (page 24).

10. a) Is the Student Savings Program requested? Yes ☐ No ☐

b) Expected date of Graduation

c) Date of first year of Practice

11. Large Case Discount ☐ # 5% ☐ 10% ☐ 15% ☐

12. Existing group? Yes ☐ No ☐ If Yes, specify group name

13. Select/Risk or Salary Allotment/Maximizer/Performer ☐ #

▶▶ List members in the space provided under Advisor's Report on page 31.

EXISTING AND PENDING COVERAGES (Must be answered in all cases)

14. Describe all coverages in force and pending, including any with RBC. Include life, critical illness and disability coverage under (A) Individual, (B) Association, (C) Group STD &/or LTD, (D) Salary Continuation or Employer Sick Pay Disability Income Coverage, (E) Overhead Expense, (F) Buy Sell, (G) Key Person, (H) Business Loan, (J) Accident Only, (K) Government Plans, or (O) Other.

Specify (O) Other

If none, write "None."

Name of Insurance Company	Amount and Type of Insurance (Life, CI or Disability) (A, B, C, D, etc.)	Year and Month Issued	DI Only: Elimination Period	DI Only: Benefit Period	DI Only: Taxable Yes	DI Only: Taxable No	Policy listed is to be:
	$ Type Policy #				☐	☐	☐ Continued ☐ Replaced by this Policy
	$ Type Policy #				☐	☐	☐ Continued ☐ Replaced by this Policy
	$ Type Policy #				☐	☐	☐ Continued ☐ Replaced by this Policy
	$ Type Policy #				☐	☐	☐ Continued ☐ Replaced by this Policy

15. Have You applied for insurance concurrently or within the past six months with any other company? Yes ☐ No ☐

If Yes, indicate details. ▶▶

Type of Coverage Applied for	Insurer

BENEFICIARY

▶▶ The beneficiary designation applies **only** to disability policies that contain the Survivor Benefit and/or the Accidental Death and Dismemberment Benefit rider. **Do not complete if You are applying for Business Loan Protector, Buy Sell, or Key Person.**

16.

Beneficiary	Equally or Survivors (if any)	Relationship	Birthdate (dd/mm/yyyy)

All Beneficiary designations are revocable except in Quebec where the designation of a legally married spouse of the owner is irrevocable unless expressly stated to be revocable by checking the following box: ☐ Revocable.

OWNERSHIP

▶▶ **Complete if the Owner is not the Proposed Insured. This must be completed for Disability Buy Sell, Business Loan Protector, and Key Person Insurance, or if Wage Loss Replacement Plan is selected.**

17.

Print legal name of Proposed Owner

Address

Email Address

Print legal name of Proposed Owner

Address

Email Address

Do You understand English or French? Yes ☐ No ☐ ▶▶ If No, please ensure a Statement of Understanding is signed by the Proposed Insured and the Proposed Owner(s) and submitted with this application.

To whom should correspondence be sent?

FINANCIAL INFORMATION (Refer to requirements on the inside of the cover page)

Net earned income is Your income after all business expenses, before personal taxes. Do not include other sources of income such as EI benefits, retirement benefits, family allowance or any income which is not dependent on Your ability to work. Do NOT include PERKS. They will be included in the calculations at our office if the Proposed Insured is eligible.

18. a) What was Your net annual earned income as declared on Your federal income tax return for the last **TWO** calendar years?

Calendar Year	Amount
	$
	$

b) If You are a shareholder of the Corporation You work in, what was Your share of the net income for the last **TWO** fiscal years?

Calendar Year	Amount
	$
	$

c) If You are an employee, what is Your current annual salary? $

19. Does Your annual unearned income exceed $30,000? Yes ☐ No ☐

If Yes, indicate total annual unearned income. $

20. Does Your liquid net worth exceed $6,000,000? Yes ☐ No ☐

If Yes, indicate net worth. $

21. Have You ever declared personal or corporate bankruptcy or filed any form of Proposal? Yes ☐ No ☐

If Yes, provide the discharge date and complete details below.

Date of Discharge or Proposal	Complete Details

22. Are You eligible for:

a. Employment Insurance? . . . . . Yes ☐ No ☐

b. Workers' compensation benefits (e.g. WSIB/WCB, CNESST)? . . . . . Yes ☐ No ☐

c. CCQ for Disability Coverage? . . . . . Yes ☐ No ☐

ADDITIONAL INFORMATION

23. Have You collected Employment Insurance (EI), disability benefits, workers' compensation benefits (WC), CPP or QPP disability benefits, income replacement benefits, maternity/parental leave, or any form of social assistance in the past 12 months? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide details.**

Date Started	Date Ended	EI	WC	Maternity/ parental	Other
		☐	☐	☐	Describe
		☐	☐	☐	Describe
		☐	☐	☐	Describe

24. Have You within the past 24 months piloted a plane, ultralight or glider, or do You have any intention of doing so in the future?. . . . . Yes ☐ No ☐

▶▶ **If Yes, please complete the Aviation Questionnaire.**

25. In the past 12 months, have You traveled outside Canada or the United States of America, or do You intend to do so within the next 12 months? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide full details, including countries and cities, length of stay in each country, and the reason for the visit; or complete the Travel Questionnaire.**

Details

26. In the past 24 months, have You engaged in any hazardous or contact sports or activities, including but not limited to racing, scuba diving deeper than 100ft (30m), skydiving, heli-skiing or back-country skiing, or do You intend to do so? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide details or complete the appropriate questionnaire.**

Hazardous Sport or Activity Type	Dates, Frequency, Professional/Amateur, Recreational/Commercial

27. Have You ever had life, disability or critical illness insurance rated, modified, rejected, rescinded, or have You been denied renewal or reinstatement? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide details.**

Indicate Type of Insurance	Rated	Modified	Rejected	Rescinded	Denied Renewal or Reinstatement	Insurer	Reason
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		

28. Have You ever received disciplinary action from Your licensing body and/or been found guilty of a criminal offence, or are criminal charges pending? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide details.**

Date of Incident	Details Including Outcome

29. Have You within the past 10 years been convicted of any driving offences or violations, including impaired driving, and/or have You had a driver's license revoked or suspended, or are any such charges pending? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide the driver's license number and complete details below, including dates, offence type, how many km/h over the limit.**

Driver's License Number	Details, Dates, Offence Type(s), km/h Over Limit

PART 2: MEDICAL INFORMATION (You/Your refers to the Proposed Insured)

When answering the questions on this form, DO NOT provide information about any genetic test You have taken or plan to take. A genetic test is a type of medical test which analyzes DNA, RNA, or chromosomes. DO provide information about other types of medical tests.

Legal Name of Proposed Insured

1. Current Height cm ☐ ft/in ☐ Current Weight kg ☐ lb ☐

2. Have You lost 10lb/5kg or more within the past year? Yes ☐ No ☐

▶▶ **If Yes**

Reason	Amount Lost
	kg ☐ lb ☐

3. Are You presently under medical observation or investigation, treatment, therapy, counselling, or **taking medication**? . . . . . Yes ☐ No ☐

Details

Name of Medication	Dose Amount	Frequency Taken	Date Started

4. Have You had any symptoms or complaints regarding Your health for which You have not yet consulted a physician or received treatment? . . . . . Yes ☐ No ☐

Details

5. Who is Your family physician or regular healthcare provider or clinic? **(If none, write "None.")** Provide the full address and phone number.

6. Provide the name of the healthcare provider who has Your most recent health record **if different from Your regular healthcare provider or clinic**.

7. Provide the date and reason for Your last consultation with **ANY** physician or healthcare provider, the name of the provider, and the outcome/results.

8. **In the past 24 months** have You used cigarettes, e-cigarettes, vaping products, cigars, water pipes, betel nut, smoking cessation products or nicotine or tobacco in any form? . . . . . Yes ☐ No ☐

Details/Product Type (cigars, cigarettes, vaping, etc.)	Quantity & Frequency of use	Date Last Used

Details of Smoking Cessation Therapy (type, date last used)

9. Have You used marijuana and/or hashish **within the past 5 years**? . . . . . Yes ☐ No ☐

▶▶ **If Yes, indicate the quantity and frequency of use, and date last used.**

10. Do You consume alcoholic beverages? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide details.**

	Amount		Day	Week	Month	Year
Beer		cans/bottles	☐	☐	☐	☐
Wine		glasses	☐	☐	☐	☐
Liquor		ml/oz	☐	☐	☐	☐

Have **You:**

11. Ever sought or received advice or treatment relating to alcohol use, or used alcohol excessively? . . . . . Yes ☐ No ☐

▶▶ **If Yes, please complete the Alcohol Use Questionnaire.**

12. Ever used cocaine, barbiturates, crack, or any other narcotic drug, or ever sought or received advice or treatment for the use of drugs, prescribed or non-prescribed? . . . . . Yes ☐ No ☐

▶▶ **If Yes, please complete the Drug Use Questionnaire.**

13. Ever been absent from work for 15 consecutive days or more for any injury and/or illness? . . . . . Yes ☐ No ☐

Details

Have You ever had any known indication of or been treated for:

14. a. Acquired immune deficiency syndrome, AIDS related complex, AIDS related conditions; or have You tested positive for antibodies to the AIDS virus or HIV? . . . . . Yes ☐ No ☐

Details

b. Any disease or disorder of the eyes, ears, nose or throat (including loss of speech)? . . . . . Yes ☐ No ☐

Details

c. Sleep apnea, chronic insomnia, or any other sleep disorder? . . . . . Yes ☐ No ☐

Details

d. Chest pain, heart attack, angina, abnormal ECG, irregular pulse, heart murmur, high blood pressure, high cholesterol, peripheral vascular disease or any disease or disorder of the heart or circulatory system? . . . . . Yes ☐ No ☐

Details

e. Stroke, transient ischemic attack (TIA), headaches, cognitive impairment, memory disorder, Parkinson's disease, Alzheimer's disease, motor neuron disease, Huntington's disease, fainting spells, dizziness, seizures, epilepsy, paralysis, multiple sclerosis, muscle weakness, numbness or tingling of the limbs, or any disease or disorder of the brain or nervous system? . . . . . Yes ☐ No ☐

Details

Have You ever had any known indication of or been treated for:

f. Protein, albumin, blood, or sugar in the urine, abnormal prostate test, kidney stones, or any disease or disorder of the kidneys, urinary tract, bladder, prostate, or reproductive organs? . . . . . Yes ☐ No ☐

Details

g. Anxiety, depression, nervousness, stress, fatigue, burnout, eating disorder, other emotional disorder, psychiatric disorder, mental disorder or psychosis; or have You ever attempted suicide?. . . . . Yes ☐ No ☐

▶▶ **If Yes, please provide details or complete the Mental Health Questionnaire.**

Details

h. Chronic fatigue, chronic fatigue syndrome, Epstein-Barr virus, fibromyalgia, or chronic pain? . . . . . Yes ☐ No ☐

Details

i. Cancer, dysplastic nevi, tumour, cyst, mass, lesion, lump, nodule, polyp or other growth, any disorder of the skin or lymph glands, blood disorder or any form of malignant disease? . . . . . Yes ☐ No ☐

Details

j. Diabetes, elevated blood sugar, thyroid disease, rheumatism, rheumatic fever, lupus, gout, or syphilis? . . . . . Yes ☐ No ☐

Details

k. Work-related allergies, environmental hypersensitivity or illness, or non-seasonal allergies? . . . . . Yes ☐ No ☐

Details

l. Any disease or disorder of the breast, including lumps, cysts or other masses, other physical changes, abnormal mammogram findings or any biopsy? . . . . . Yes ☐ No ☐

Details

m. Any amputation or deformity, hernia or rupture, deep vein thrombosis or varicose veins? .. . . . . Yes ☐ No ☐

Details

n. Any arthritis, disease or disorder of the hip, ankle, knee, wrist, elbow, shoulder, hands, feet or any other joint? . . . . . Yes ☐ No ☐

▶▶ **If Yes, which joint(s)?** ☐ Right ☐ Left ☐ Both

Details

o. Any type of back or spinal trouble (includes neck area) including sprain, strain, or disc disease or disorder? . . . Yes ☐ No ☐

▶▶ **If Yes, please provide details or complete the Back and Neck Disorder Questionnaire.**

Details

p. Any type of asthma, emphysema, bronchitis, pleurisy, tuberculosis, or any disease or disorder of the chest or lungs? . . . . . Yes ☐ No ☐

Details

Have You ever had any known indication of or been treated for:

q. Any type of peptic ulcer, indigestion, colitis, or any disease or disorder of the stomach, colon or intestines, gall bladder, liver, pancreas; or have You tested positive for hepatitis and/or been told You are a carrier? . . . . Yes ☐ No ☐

Details

Other than the information provided in Part 2, questions 1-14, have You in the last <u>10 years:</u>

15. a. Been examined by or consulted a physician, chiropractor, psychologist, physiotherapist, osteopath, homeopath, or other practitioner? . . . . . Yes ☐ No ☐

Details

b. Been under observation or treatment in any hospital or other institution or facility, or been advised to be admitted? . . . . . Yes ☐ No ☐

Details

c. Had an X-ray, ECG, CT scan, MRI, blood or urine test, or other diagnostic tests? . . . . . Yes ☐ No ☐

Details

d. Had any surgical operation, treatment, special diet, or any illness, ailment, abnormality or injury? . . . . . Yes ☐ No ☐

Details

e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? . . . . . Yes ☐ No ☐

Details

16. Have Your natural parents, brothers or sisters, either living or dead, ever suffered from any of the following conditions: heart disease, polycystic kidney disease, high blood pressure, a stroke, diabetes, cancer, multiple sclerosis, Alzheimer's disease, Huntington's disease, Parkinson's disease, motor neuron disease or any form of hereditary disease? . . . . . Yes ☐ No ☐

▶▶ **If Yes, complete the chart below.**

Condition	Mother	Age at Onset	Father	Age at Onset	Sister	Age at Onset	Brother	Age at Onset
	☐		☐		☐		☐	
	☐		☐		☐		☐	
	☐		☐		☐		☐	
	☐		☐		☐		☐	

Female Applicants Only

17. Are You currently pregnant? . . . . . Yes ☐ No ☐

▶▶ **If Yes,**

a. What is the due date?

b. Have You experienced any complications with this pregnancy or any past pregnancy? . . . . . Yes ☐ No ☐

▶▶ **If Yes, provide details.**

Details

CONDITIONAL DISABILITY INSURANCE AGREEMENT (CIA)

If either of the following questions is answered Yes or left blank, the Proposed Insured is not eligible for CIA.

1. Has the **Proposed Insured**, within the past two years, been treated for heart trouble, a stroke or cancer, or had treatment recommended? . . . . . Yes ☐ No ☐

2. Has the **Proposed Insured**, within the past 90 days, been admitted to a hospital or a medical facility, or been advised to be admitted? . . . . . Yes ☐ No ☐

As needed, provide additional details below to any Yes answers from Part 2.

Question Number	Conditions, Symptoms, Duration, Results and Treatment	Date of Onset	Name of Healthcare Provider	Date of Recovery

This page has been left
blank intentionally.

Insurance

RBC LIFE INSURANCE COMPANY

IF APPLICABLE, DETACH AND GIVE TO PROPOSED INSURED

CONDITIONAL DISABILITY INSURANCE AGREEMENT (CIA) RECEIPT

(applicable only if CIA is applied for)

Received a payment of $ _____ on _____ with the Application for insurance on behalf of
Date (dd/mm/yyyy)

_____ (the Proposed Insured).

DEFINITIONS

For the purpose of this Conditional Insurance Agreement:
"You" means the Proposed Insured on the Application.
"We", "Us" and "Our" mean the Company.
"Minimum Payment" means an initial deposit of one month's premium for the monthly premium mode and 10% of the annual premium for all other modes.
"Effective Date" means the later of the following:

(a) The date We receive the Minimum Payment; or
(b) The date of completion of the Application and all medical examinations and supplementary tests which We may require according to Our underwriting guidelines and practices; or
(c) The date of issue requested by the Proposed Owner at the time of the Application.

CONDITIONAL INSURANCE

We accept this payment and will insure You commencing on the Effective Date subject to all of the following:

CONDITIONS PRECEDENT

(a) The amount of the payment is equal to or greater than the Minimum Payment; and
(b) You have completed the Application and all medical examinations and supplementary tests which We may require according to Our underwriting guidelines and practices; and
(c) You are insurable according to Our underwriting guidelines and practices under any policy currently offered by Us; and
(d) The Advisor's Declaration has been signed by a licensed advisor.

We will not insure You under this Agreement, in any event, if:

(a) Either question 1 or 2 of the CIA is answered Yes or left blank; or
(b) There is any material misrepresentation on the Application; or
(c) Death is by suicide; or
(d) You are not insurable according to Our underwriting guidelines and practices under any policy currently offered by Us.

If conditional insurance becomes effective, it will be exactly as applied for only if, according to Our underwriting guidelines and practices, You are insurable for the Policy and amount exactly as applied for, at our standard rate of premium, with no exclusions, limitations, reductions or other modifications. Otherwise, the conditional insurance will be the modified policy under which You would have been insurable on the Effective Date according to Our underwriting guidelines and practices.

However, in no event will We be liable under this Agreement for accidental death benefits, including any insurance currently in force or pending with Us, in excess of $100,000.

TERMINATION

If conditional insurance becomes effective, it will terminate on the earliest of the following:

(a) The date that any policy issued as a result of the Application is delivered to You and comes into effect; or
(b) 90 days from the Effective Date; or
(c) The date that We write to advise that We are unable to approve the issuance of a policy.

RETURN OF PAYMENT

If conditional insurance does not become effective, Our liability will be limited to the return of the payment tendered with this Agreement.

This page has been left
blank intentionally.

PART 3: PREMIUM AND PAYMENT INFORMATION

If either question 1 or 2 on the Conditional Disability Insurance Agreement (CIA) (page 16 of the application package) is answered Yes or left blank, the advisor may not accept an initial deposit with the application, and the CIA is void.

1. a. Method of Payment: Monthly ☐ Annually ☐

   b. Pre-Authorized Debit Plan (PAD) (Complete the PAD authorization form) ☐ OR Direct Bill ☐

   c. Initial deposit collected? Yes ☐ No (COD) ☐

If initial deposit is collected, it is in exchange for the Receipt and CIA (page 18 of the application package).

   d. Conditional Insurance Agreement (CIA) premium to be withdrawn by PAD? Yes ☐ No ☐

   If No, make cheque payable to **RBC Life Insurance Company**.

   e. Complete the following. Provide deposit amount for each product requested.

Product	Deposit	Product	Deposit	Product	Deposit	Product	Deposit
	$		$		$		$

   If deposit cheque is for more than one applicant, please provide the legal name(s).

2. **PREMIUM NOTICES AUTHORIZATION AND AGREEMENT** **(Complete only if this Policy is to be part of a List Bill and if premium notices are to be sent to someone other than the Owner/Insured.)**

_____ , owner of the insurance policy, hereby authorizes the Company to
Signature of Owner

send all premium notices, premium lapse notices, or pay any premium refunds to and accept premium payments from

Premium Payor Legal Name and Address

Mandatory for ALL applications

3. **Have you detached and given to the applicant**

   ☐ MIB, LLC, Pre-Notice

   ☐ CIA Receipt (page 18 of the application package; if deposit collected)

   ☐ Supplementary Questionnaires (if required)

4. **Have you attached to the application**

   ☐ Notice of Replacement of Insurance (Quebec only, if applicable)

   ☐ Payment for the First Month **or** Blank CIA (if deposit not collected)

   ☐ A Void Cheque with Legible Banking Codes (if using PAD)

   ☐ Statement of Understanding Signed by the Proposed Insured and the Proposed Owner(s), if English or French is not understood

   ☐ Illustration

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Ensure You read and understand the section entitled "Collection and Use of Personal Information."

The Payor(s) named below agrees that:

1. (a) RBC Life Insurance Company (RBC Life) is authorized to make scheduled monthly withdrawals against the account at the financial institution below or any other financial institution that the Payor(s) may later designate to pay the premium in accordance with the premium schedule set out in this Policy/these policies, including the initial premium and/or the Conditional Insurance Agreement premium, if requested in this application.

   (b) **RBC Life is not required to provide notification before the Conditional Insurance Agreement premium and/or the initial premium is debited, or if the amount of the withdrawal should vary.**

   (c) Unless otherwise indicated in the Special Requests section below, such withdrawals shall be dated on the day of the month on which the premium is due under the Policy or, if more than one policy is included in this Agreement, the withdrawals shall be dated to coincide with the existing policy/policies.

   (d) The financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Life to withdraw premiums or fees from the account indicated below, which may include a redraw within 30 days should any withdrawal not clear the account.

   (e) Notification of any change to the information provided below shall be given to RBC Life by the Payor(s) a minimum of 5 days prior to the next scheduled withdrawal. The Payor(s) agrees that from time to time they may authorize RBC Life to deduct such payments from another account upon the Payor's oral or written instructions.

   (f) This Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Life or by the Payor(s). The Payor(s) may obtain further information on their right to cancel a PAD agreement by visiting the Payments Canada website at www.payments.ca.

   (g) In the event that a PAD is disputed, the Payor(s) agrees to contact RBC Life. For recourse purposes, this PAD is considered a Personal PAD.

   The Payor(s) has certain recourse rights if any debits do not comply with this agreement. For example, the Payor(s) has the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on recourse rights, the Payor(s) may contact their financial institution or visit www.payments.ca.

   (h) The names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

2. Add to existing PAD with policy number(s) _____

3. Special Requests (Withdrawals are limited between the 1st – 28th of the month) _____

Bank Information

Please attach a specimen cheque marked "Void" (a line of credit account cannot be used).

Name of Bank or Financial Institution	Transit Number	Bank Number	Account Number

Address _____

City _____ Province _____ Postal Code _____

Signed at _____ (City/Province) this _____ day of _____ (Month/Year)

Print Legal Name of Payor (Account Holder) _____

Print Legal Name of Second Payor (Account Holder) (if any) _____

Signature of Payor _____

Signature of Second Payer (if any) _____

BUSINESS OVERHEAD EXPENSE SUPPLEMENT

Complete if applying for a Business Overhead Expense Policy

Use Your actual current monthly average expenses. If Your expenses are shared, include only Your portion of the expenses. Exclude any payments to Yourself or to any other member of Your occupation. Only those expenses which qualify as tax deductions for income tax purposes may be considered as reimbursable for this product.

1. **Are Your office expenses shared with anyone else?** Yes ☐ No ☐

   If yes, what is Your share? ____ %

2. **Do You employ any other members of Your profession or a related profession, any person who performs Your duties or any person directly responsible for the generation of income for Your business?** Yes ☐ No ☐

   If yes: How many? ____

3. **Are any members of Your family actively working at least 20 hours per week in Your business?** Yes ☐ No ☐

   If yes: Provide name(s), relationship, duties and annual salary:

Name(s)	Relationship	Duties	Annual Salary

4. **Please provide a list of all employee positions, duties and monthly remuneration:**

Position(s)	# of Employees	Duties	Average Monthly Remuneration

5. **Please provide a breakdown of Your monthly overhead expenses:**

Rent or mortgage	$	Telephone & other utilities	$
Employee wages*	$	Principal & interest on business loans	$
Employee benefits*	$	Business liability insurance premiums	$
Leased equipment	$	Malpractice insurance premiums	$
Rental equipment	$	Professional dues & memberships	$
Office supplies	$	Depreciation/capital cost allowance	$

* Do not include any payments to/for Yourself or any other member of Your occupation.

Other fixed, monthly and necessary expenses**: $ ____

** Give full details if amount is over 10% of the total monthly expense:

____

BUSINESS LOAN PROTECTOR SUPPLEMENT

Complete if applying for Business Loan Protector Policy or submit letter from lender

BUSINESS DETAILS

1. a. Business Name:

b. Organization of Business: Sole Owner ☐ Partnership ☐ Corporation ☐

c. Your Ownership Share (% of common voting shares): %

d. Number of Years in Business:

e. Have all Partners/Shareholders been affiliated for at least 3 years? Yes ☐ No ☐

f. Net Worth of Business: $

LOAN DETAILS

Loan #1:

2. a. Amount of Loan: $ b. Interest Rate: %

c. Term (if applicable): months d. Monthly Payment (if applicable): $

e. Purpose of Loan:

f. Name of Lender (recognized financial institution):

g. Is the interest on this loan tax deductible for this business? Yes ☐ No ☐

Loan #2 (if applicable):

3. a. Amount of Loan: $ b. Interest Rate: %

c. Term (if applicable): months d. Monthly Payment (if applicable): $

e. Purpose of Loan:

f. Name of Lender (recognized financial institution):

g. Is the interest on this loan tax deductible for this business? Yes ☐ No ☐

Loan #3 (if applicable):

4. a. Amount of Loan: $ b. Interest Rate: %

c. Term (if applicable): months d. Monthly Payment (if applicable): $

e. Purpose of Loan:

f. Name of Lender (recognized financial institution):

g. Is the interest on this loan tax deductible for this business? Yes ☐ No ☐

WAGE LOSS REPLACEMENT PLAN AMENDMENT FORM

(Not to be used for Bridge Series)

Proposed Insured

The Owner and the Insured hereby acknowledge and agree that the individual disability insurance policy for which they are applying, or have applied for, is intended to form part of a "Wage Loss Replacement Plan" which either already exists or will be established immediately by the Owner of the Policy. All premiums will be paid solely and directly by the Owner. Any claim benefits (other than waiver of premium) will be paid to the Insured as taxable claim benefits.

The Owner and the Insured acknowledge and understand that in the event that a valid Wage Loss Replacement Plan acceptable to Canada Revenue Agency is not established and maintained:

(a) The premiums paid by the Owner may be disallowed retroactively by Canada Revenue Agency as a tax deductible expense; and

(b) Canada Revenue Agency may require the Insured, retroactively, to include the amount of the premiums as a taxable payroll benefit in calculating his or her personal income taxes.

The Owner and the Insured specifically acknowledge and agree that they alone shall be solely and completely responsible for establishing and continuing to maintain a valid Wage Loss Replacement Plan acceptable to Canada Revenue Agency. The Owner and the Insured acknowledge and agree that they do not rely upon any tax or other advice whatsoever from the Company or its employees regarding the validity of the Wage Loss Replacement Plan. The Owner and the Insured specifically agree that the Company and its employees shall not be liable in any way for tax or other advice received from any broker, or for tax arrears or otherwise resulting from termination or invalidity of the Wage Loss Replacement Plan.

The Owner and the Insured specifically agree that, in the event that a valid Wage Loss Replacement Plan is not established or, if established, it terminates or ceases to be valid or acceptable to Canada Revenue Agency, or in the event that the Insured ceases for any reason to be a member of the Plan:

(a) The Owner and the Insured immediately will notify the Company, in writing, at its office, located at 6880 Financial Drive, Mississauga, Ontario L5N 7Y5;

(b) Effective as of the date of termination or invalidity of the Plan or the date that the Insured ceases to be a member, whichever occurs earlier, the monthly benefit provided by the Policy shall be reduced to the amount for which the Insured would have qualified based upon the Company's non-taxable issue limits including eligibility for EI disability benefits that are currently in effect or that were in effect on the Date of Issue of the Policy, whichever is more favourable to the Insured;

(c) The Insured immediately shall repay to the Company any and all excess claim benefits paid by the Company prior to its receipt of notification that a valid Plan was not established or terminated or ceased to be valid or that the Insured ceased to be a member, whichever occurred earlier; and

(d) The Policy premium will be reduced to the amount that the Company would have required for the reduced monthly benefit referred to in (b) above. The Company will refund to the Owner any excess premiums paid by the Owner.

The Amendment will apply notwithstanding any Policy provision to the contrary. All other provisions of the Policy will remain the same.

This Amendment will form part of the Policy. The effective date of this Amendment shall be the same as the Date of Issue of the Policy.

I agree to this Amendment:

Insured Signature _____ Owner Signature _____

Signed at _____ (City/Province) this _____ day of _____ (Month/Year)

AGREEMENT

In this Agreement, RBC Life Insurance Company is referred to as the "Company", any policy issued as a result of this application is referred to as the "Policy", and the Proposed Owner and Proposed Insured, if different from the Proposed Owner, are each referred to as "I", "me" and "my".

It is understood and agreed as follows:

1. I have read the statements and answers recorded on this application and any supplemental forms required to support this application. They are true, complete, and correctly recorded. In order to obtain additional evidence of insurability, the Company may arrange a paramedical or medical examination or telephone interview. During the examination or interview, I will answer all questions honestly and completely. I am responsible for verifying the accuracy and completeness of the information provided in this application, any supplemental forms or questionnaires required to support this application, any paramedical or medical examination, and any documented telephone interview. The Company is entitled to rely on that information. I understand that providing inaccurate or incomplete information may compromise eligibility for coverage and/or benefits, and may mean that there will be no coverage.
2. Upon delivery of this Policy, the Proposed Owner will ensure that the Proposed Insured reviews the statements and answers contained in any paramedical or medical examination, documented telephone interview, or other questionnaire and verifies that they were correctly recorded. The Proposed Owner will immediately advise the Company if any of them were not. The Proposed Owner will also immediately advise the Company if, between the date they were provided and the date this Policy is delivered, there have been any changes to the statements and answers in this application, any paramedical or medical examination, documented telephone interview, or other questionnaire (as applicable).
3. The entire Contract of Insurance shall be the Policy, any attached endorsements, exclusions, amendments, addendums or documents, including documented paramedical or medical examinations and documented telephone interviews, and all completed parts of this application, application supplement(s) and questionnaire(s). No statement made to and no information acquired by a representative of the Company, an examiner, or an interviewer shall be attributed to or binding upon the Company unless contained in the Contract of Insurance. No one other than an officer of the Company may a) alter or modify the terms of this Policy or b) waive any rights or requirements of the Company. Acceptance of the Policy will constitute agreement to its terms and to any changes specified by the Company in the Policy.
4. In Quebec, insurance under the Policy shall only take effect when:
   a. the full initial premium has been paid; and
   b. the Company accepts the application without modification.

   In all provinces other than Quebec, and in Quebec if the Company accepts the application with modification, insurance under the Policy shall only take effect when:
   a. the full initial premium has been paid; and
   b. the Policy has been delivered to the Proposed Owner and all conditions for delivery of the Policy have been completely satisfied, including but not limited to the Company's receipt and approval of all amendments, addendums and exclusions required for the Policy to take effect, signed by the Proposed Owner and the Proposed Insured, if different from the Proposed Owner, within the period required by the Company; and
   c. there has been no change in the health or insurability of the Proposed Insured between the time of the application and delivery of the Policy.
5. A failure to disclose existing and pending coverage, including any coverage with the Company, may compromise eligibility for coverage, and may mean that there will be no coverage. If this application indicates that an existing or pending policy will be replaced by this Policy, the Proposed Owner must discontinue that existing or pending policy as soon as this Policy is delivered. The discontinuance of that existing or pending policy is a condition of delivery, and this Policy will not take effect unless that existing or pending policy is discontinued.
6. This Policy will not provide coverage for any disability that is due to a) an accidental bodily injury sustained before this Policy is delivered, or b) a disease or sickness that first manifests itself before this Policy is delivered. However, this Policy will provide coverage for such disability if the Proposed Insured has, before this Policy is delivered, fully disclosed to the Company, on this application or otherwise in writing, all information known or reasonably available to the Proposed Insured regarding the injury, disease or sickness, including all signs, symptoms or other manifestations, and the Company has chosen not to exclude the injury, sickness or disease.
7. I have received satisfactory information about the product(s) being applied for.
8. A copy of the "Consumer Fact Sheet Pre-Notice" has been received and read.
9. I have read the section entitled "Collection and Use of Personal Information' appearing in this Application and understand and agree to its terms.

I have read, understood and agree with the terms of the Conditional Disability Insurance Agreement (CIA) Receipt (applicable only if the Minimum Payment has been properly made and the Receipt properly detached from this application).

Signed at _____ (City/Province)

Date _____ (DD/MM/YYYY)

Proposed Insured (Signature)

Proposed Owner (Signature)

Note: If the Policy is to be owned by a corporation, this Application must be signed by an Officer of the corporation other than the Proposed Insured (unless the Proposed Insured is the sole Officer of the corporation).

CONSENT FORM FOR ELECTRONIC DELIVERY OF CONTRACT

This form is **only applicable for New Business**.

Delivery of Policy: If you are the proposed policy owner, **you will need to create an Online Insurance Account**. When the policy documents are ready to be delivered, you will receive an email at the email address you provide below. The email will explain how to create an Online Insurance Account so that you can accept electronic delivery of the policy documents.

PROPOSED POLICY OWNER NAME	**PREFERRED EMAIL** *If you have enrolled for Online Insurance, that email address will be used.*	**MOBILE NUMBER** *Used only for verification purposes*

☐ I consent to the electronic delivery of my policy contract and any associated documents to my Online Insurance Account.

SIGNATURE OF PROPOSED OWNER

DATE (DD/MM/YYYY)

PROPOSED JOINT POLICY OWNER NAME *If any*	**PREFERRED EMAIL** *If you have enrolled for Online Insurance, that email address will be used.*	**MOBILE NUMBER** *Used only for verification purposes*

☐ I consent to the electronic delivery of my policy contract and any associated documents to my Online Insurance Account.

SIGNATURE OF JOINT PROPOSED OWNER

DATE (DD/MM/YYYY)

PROPOSED INSURED CONSENT (MUST BE COMPLETED IF THE INSURED AND OWNER ARE DIFFERENT)

Authorization: I understand that the policy owner has selected electronic delivery of the policy and associated documents and will have electronic access to all of the information (including but not limited to health/medical information) that I have provided to RBC Life Insurance Company in the application process. I hereby consent to the owner having access to all of this information.

If you do not want the policy owner to have access to the information you have provided, please do not sign this form and discuss your concern with the advisor.

SIGNATURE OF PROPOSED INSURED

DATE (DD/MM/YYYY)

This page has been left
blank intentionally.

AUTHORIZATION

I understand and authorize the Company (RBC Life Insurance Company and its 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 that 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 performance of their duties, or to 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 to have any errors in the personal information noted and corrected by formulating a written request to the Company. 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 or employment that is relevant to this Application that they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other healthcare 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 or reinsurance company or other financial institution; and also my employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also the MIB, LLC; and also any other person, agency, credit bureau or institution having information, records or data regarding me. This Authorization to obtain information is valid until revoked by me in writing. If I choose to revoke this Authorization to obtain information, consequences may include termination of the underwriting process and/or the policy, if one has been issued.

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 assessment of insurance risk for underwriting purposes; for the purpose of evaluating any claim for benefits, assessing the validity of the Policy as issued, and issuing and delivering the Policy. Only to the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received to the MIB, LLC; to other insurance companies or any reinsurer; and to my Servicing Advisor, such as my insurance advisor or broker; and to other third parties, who are required to maintain the confidentiality of this information (ex: the managing general agency with which my Servicing Advisor is associated (if applicable)). This Authorization to disclose information as reasonably necessary is valid until revoked by me in writing.

I authorize the Company to release to my healthcare professional any medical information obtained for this insurance Application, including the results of any blood or urine test or urine drug screening tests for the purpose of revealing findings that might require further investigation or treatment or for the purpose of explaining any underwriting decision. This Authorization to disclose medical information is valid until revoked by me in writing. A photocopy of this Authorization, as executed by me, will be as valid as the original. Any alteration of this Authorization will render it null and void.

I authorize the Company to disclose to my Servicing Advisor material information regarding my health and personal history solely for the purpose of explaining underwriting decisions. This disclosure could include history of mental illness, infectious disease, drug and alcohol use, record of criminal activity, or other facts that have a material effect on the Company's decision to insure me. This Authorization to disclose information for this purpose is valid until 60 days after the later of the day the Company issues a new or amends the existing policy; or the day the Company notifies me in writing that my Application has been declined, withdrawn, or filed incomplete.

I do not agree to the disclosure of health and personal information to the Servicing Advisor ☐

Signed at _____ this _____ day of _____

(City/Province) (Month/Year)

Proposed Insured (Signature) _____

This page has been left
blank intentionally.

ADVISOR'S REPORT

1. Who initiated this request for insurance? You ☐ Proposed Owner(s) ☐ Proposed Insured ☐

2. Have you collected money? Yes ☐ No ☐

   If Yes, indicate amount collected: $ _____ Date Received (dd/mm/yyyy) _____

3. Special Date Required? _____

4. Evidence: The following requirements have been ordered:

   Blood Profile ☐ MVR ☐ Paramedical ☐ Urine-HIV ☐ Other (Specify) _____

   ☐ Para-Medical Company Used _____

5. **Advisor's Declaration:**

I have clearly explained the provisions and limitations of the Policy being applied for and, if applicable, the Conditional Insurance Agreement to the Proposed Insured and the Proposed Owner(s). All of the questions in the application were clearly asked of, or read by, the Proposed Insured and the Proposed Owner(s). To the best of my knowledge, they understood all of the questions. To the best of my knowledge, all of the answers and statements on the application have been fully and accurately recorded. I am not aware of any pertinent information about the Proposed Insured that has not been disclosed on the application. If a policy is issued, I will deliver it to the Proposed Owner(s) only after obtaining confirmation that all conditions for delivery have been completely satisfied and there has been no change in the insurability of the Proposed Insured. I understand that I cannot modify the application, the Conditional Insurance Agreement or the terms of the Policy, if issued. I have complied with my duties and obligations in regard to Advisor Disclosure, including providing an Advisor Disclosure Statement in writing to the Proposed Owner(s).

Date (dd/mm/yyyy)				
Advisor's Signature				
Advisor's Name				
Advisor's Company Name				
Marketing Office				
Share of Commission	____ %	Servicing Advisor Code _____	____ %	Advisor Code _____

RBC Insurance

Please use this space for any special instructions or additional information which would be helpful in the underwriting of this risk.

Insurance

VPS 110134

83568 & (09/2022)