What to expect if you need to submit a claim

Insurance

RBC®

Your income protection coverage

We at RBC Insurance® recognize that a disabling illness or injury can create emotional, physical and financial challenges. We want you to feel confident knowing that you have disability income protection insurance from RBC Insurance.

Your RBC Insurance benefits are intended to help support you and your family while you are unable to work. Our commitment to you, however, extends beyond the amount of your benefit payment. Our unique claims

management process is based on the types of injuries or illnesses you might encounter, and on the expected length of your time away from work. Our Customer Care professionals work in dedicated teams — orthopedic, psychiatric and general medical — and are trained in the conditions handled by their team. It is this unique claims management process that sets us apart. Your Customer Care team will work hard to understand your specific needs and to help you in any way that is appropriate.

How do I submit a claim?

To notify us of a disability income protection claim, you will need to submit a claim form. If your insurance is provided through your employer, you may obtain a claim form from your human resources department. If you purchased an individual disability income protection policy, you may call us for a claim form or obtain a claim form from the insurance advisor who helped you buy your policy.

The claim form includes information for you to complete, sections for your physician and your employer to complete and an authorization form that enables us to

We are committed to providing specialized expertise and responsive service when you are preparing to make a claim and during the claim process.

gather additional information as it becomes necessary. Submitting your completed claim form early in the defined elimination period may result in a more timely decision and can enhance overall service.

Please note that although it is your responsibility to pay for any cost incurred to complete the Attending Physician's Statement (APS), we do reimburse up to $50 to assist with these costs when complete copies of medical files are requested and provided.

Who will review my claim?

Once we receive your completed claim form, our goal is to acknowledge receipt of your claim within one business day and let you know the name of your Customer Care Specialist, who will contact you within 10 business days. They will personally handle your case. We will also set up a telephone interview at a convenient time for you. The telephone interview is an opportunity for your Customer Care Specialist to get to know you. They will take the time to listen. It also gives you the chance to provide further clarification about your claim and elaborate on information within the claim form.

Your Customer Care Specialist has training in your specific type of disability or illness. They will evaluate the full nature of your condition and potential length of your time away from work, arrange payment of the financial benefits for which you qualify and begin working with you toward your recovery and return-to-work goals, as appropriate.

Is anyone else involved in the review process?

Your Customer Care Specialist may call your employer and your attending physician to better understand your claim and your potential for returning to work. What's more, your Customer Care Specialist has access to a team of experts to ensure a thorough and accurate assessment of your claim. This includes doctors, clinical specialists, rehabilitation specialists and their managers. This team works together to ensure we have all the information we need to make an accurate assessment of your claim.

When will a decision be made about my claim?

With some medical conditions, such as a recovery following a routine surgery, your benefits may begin almost immediately after all the policy provisions are met. If your claim is more complicated, your benefits decision could take longer as we may require additional information to better understand your claim, such as details regarding your financial, medical or employment history. In such a case, your Customer Care Specialist will provide you with a written update on the status of your claim every 30 days until a decision is made. Our goal is always to provide a decision as quickly as possible. Your prompt response to requests for information about your claim will help us serve you better and help ensure that you receive the benefits for which you qualify in a timely manner.

What if I have questions about my claim?

If you have questions or concerns about your claim, you can speak with your Customer Care Specialist using a direct, toll-free phone number. One of the advantages of having a single point of contact assigned to your needs is that you will be able to speak with someone who is familiar with all the key details and issues surrounding your claim.

What assistance do you provide to help me return to work?

Because most disabilities are not permanent in nature, we may offer you return-to-work support in addition to providing you with financial benefits. Return-to-work potential is part of your claim evaluation from the start. When needed, we will work with you and/or your employer on transitional work schedules, modification of your workspace or an investment in additional training that will enable you to return to the workforce. At the appropriate time, a rehabilitation specialist may be assigned to assist in your transition back to work.

What can I expect if I can't go back to work for a long time?

If your claim is, or becomes, long term, your Customer Care Specialist will stay in contact with you, your physician and your employer, as needed, and will continue to monitor the progress of your medical condition. Periodically, depending upon the specific circumstances of your claim, we will reassess your eligibility for benefits. This may involve asking for additional medical information from you or your doctor, setting up face-to-face visits, requesting an independent assessment or co-ordinating with government benefits.

What happens if I disagree with the decision on my claim?

Our claim process is designed to ensure that your claim receives a thorough, fair and objective evaluation. In addition, safeguards are in place throughout the process to ensure the integrity of decisions that result from our evaluation. If we determine that you do not qualify for a benefit, you will receive a letter clearly outlining the reasons for this decision. You have the right to appeal the decision, and the appeal process will be clearly outlined in the letter.

If you have coverage through your employer, you can also contact your human resources department. If you have an individual disability income protection policy, you may contact the insurance advisor who helped you purchase your policy.

For more information,
please call 1-877-519-9501 (toll-free)

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