



**RBC
Insurance**

Life

Insurance Application

YOUR PRIVACY MATTERS TO US

At RBC Life Insurance Company (RBC Insurance), we are committed to protecting your privacy. We respect your privacy and want you to understand how we safeguard your personal information.

How we collect your information

We collect and keep information about you, which is needed to provide the products and services you request from RBC Insurance. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, the Medical Information Bureau, the government and other governmental agencies including government health insurance plans, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

How we use your information

We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage claims. We may also share your information with others who work for RBC Insurance or other RBC Financial Group[®] companies, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, financial institutions, third party administrators and any other parties authorized by you.

We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business.

If you have given us your social insurance number, we will use it for taxation purposes and to help identify you with Citizenship and Immigration Canada when necessary.

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

Other ways we may use your information

When you request products and services directly from RBC Insurance, there are other ways we may use your information. For example, we may use or share some of your information to help you find out about other products and services from RBC Insurance and other RBC Financial Group companies. However, we will never use or share your health information for these purposes. To better manage your relationship with other RBC Financial Group companies, and where the law allows us, we may consolidate the information we have about you with information held by the other companies.

If at any time, you decide that you do not want us to use your information as described here, under "Other ways we may use your information", please let us know by calling us at 1-800-663-0417.

Protecting your information

RBC Insurance will not use any information collected for the purpose of providing this product or service other than as described above (except when you have provided us with your express consent).

Information that we collect from you will be protected by security safeguards appropriate to the sensitivity of the information.

Your right to access your information

You have a right to access the personal information that we have about you in your file. If we have information that is not correct, you can have it corrected.

To access your information or to ask us to correct information, you can contact us at:

RBC Life Insurance Company
P.O. Box 515, Station A
Mississauga, Ontario L5A 4M3

Phone: 1-800-663-0417
Fax: 905-813-4816

If you would like more information about client privacy

RBC Financial Group publishes a brochure on client privacy. If you would like a copy of the brochure, you can contact us and we would be pleased to send one to you.

Guidelines for Completion of Application

- Print legibly in blue or black ink.
- Do not make erasures or use liquid paper. Do not use ditto marks. Stroke out an error and have the applicant initial it. The application is a legal document forming part of the policy contract.
- Ensure the latest version of the MAX illustration software is used as a reference.
- This application is for life insurance and available benefits and riders only. Depending on the product, a critical illness, long term care and disability rider may be added to the life component.
- If the Proposed Life Insured is not fluent in English, a Statement of Understanding, available on MAX, in the Proposed Life Insured's language of choice must be submitted with the application and is an underwriting requirement.

Other Standalone Products

- For standalone disability and/or critical illness insurance, complete the Disability and Critical Illness Insurance Application #83530.
- For standalone long term care, complete the Long Term Care Application #89606.

TRIAL Applications

- Identify TRIAL on the cover of the application. Do not give out a Temporary Life Insurance Agreement (TIA) or order any underwriting requirements.

Lives Insured

- Two lives and up to 4 children may be written on this application. In a joint situation, should privacy be an issue, please complete separate applications cross referencing them in the Representative's Report.

Separate Quebec applications

- If this application is being written in Quebec or if the insured or applicant lives in Quebec, ensure you are using the correct application, #81642 for Quebec English, #81643 for the Quebec French version.

Social Insurance Number

- This information is required for tax purposes. It need not be collected for Term policies.

Policy Ownership

- Minimum legal age is 16 years except in Quebec where it is 18 years.
- Joint ownership will be set up with right of survivorship. This will ensure that upon the death of a joint owner, ownership will pass to the surviving owner(s).

Minor Beneficiaries

- If the beneficiary is a minor, we recommend that a trustee be appointed by completing the Appointment of Trustee form available on MAX. This will avoid having to pay any proceeds into court.

Revocable/Irrevocable Beneficiaries

- All beneficiaries are revocable unless the irrevocable box has been checked. Naming a minor as an irrevocable beneficiary should be avoided as the authorization of an irrevocable beneficiary is required for any change which impacts the value of the policy and a minor cannot give that authorization.

Payor Waiver Benefit

- Complete the following sections under Proposed Life Insured B or in a separate application if this is to be a joint policy: Proposed Life Insured #s 1 – 4; Personal Information; Financial Information; Tobacco Usage; Medical History and Authorization.

Replacements

- If this new policy will result in the termination, modification or reduction in benefits of an existing policy within six months of this application, the Comparison Disclosure Statement must be submitted with the application and is an underwriting requirement.

Travel

- In the Personal Information section, if the Proposed Life Insured has travelled within the last 2 years or has plans to travel outside Canada or the United States, the Travel Questionnaire must be completed. This can be printed from MAX software. Given the mobility of today's population, it is a good idea to carry this form with you.

Temporary Life Insurance Agreement (TIA) Limits

- Temporary Life Insurance is only available up to \$1,000,000 coverage. If applying for coverage over \$1,000,000 and the applicant would like temporary insurance, a life insurance application for \$1,000,000 must be submitted plus a separate, optional life insurance application for the higher amount with no money and no TIA. TIA is not available on TRIAL applications.
- TIA is only available if the Proposed Life Insured is at least 15 days old and not older than 65 years as of last birthday.

Collecting the Initial Premium

- Money can only be collected at the time of application completion or upon delivery of the policy. The application, TIA receipt and any payment must all be dated the same.

Illustrations and Investment Allocation Forms

- If the plan is universal life, a signed illustration and an investment allocation form should accompany the application.



Proposed Life Insured A

1. First Name	Middle Name	Last Name	Prefix
2. Female <input type="checkbox"/>	Country of Birth	Social Insurance Number	Date of Birth (dd/mmm/yy)
Male <input type="checkbox"/>			Age as of Nearest Birthday
3. Canadian Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Other (please specify) <input type="checkbox"/>			
4. Home Address			
City	Province	Postal Code	Phone Number
5. Employer Name	Employer Address	Phone Number	
Nature of Business	How long with this Employer?	Professional Designation/Degree	
Current Occupation	Number of Years at this Occupation	Former Occupation (if at current occupation less than 2 years)	

Beneficiary – Proposed Life Insured A

If the Beneficiary is a minor, we strongly advise the appointment of a trustee. Complete the Appointment of Trustee form. Ensure total shares equal 100%.

6. Primary Beneficiary			
First Name	Middle Name	Last Name	Revocable <input type="checkbox"/>
			Irrevocable <input type="checkbox"/>
Relationship to Applicant/Owner			% Share
First Name	Middle Name	Last Name	Revocable <input type="checkbox"/>
			Irrevocable <input type="checkbox"/>
Relationship to Applicant/Owner			% Share
First Name	Middle Name	Last Name	Revocable <input type="checkbox"/>
			Irrevocable <input type="checkbox"/>
Relationship to Applicant/Owner			% Share
7. Contingent Beneficiary – If all Beneficiaries predecease the Life Insured(s), the proceeds are payable to the Contingent Beneficiary if any, otherwise to the estate of the Owner.			
First Name	Middle Name	Last Name	
Relationship to Applicant/Owner			

Proposed Life Insured B

8. First Name | Middle Name | Last Name | Prefix

9. Female Country of Birth | Social Insurance Number | Date of Birth (dd/mmm/yy) | Age as of Nearest Birthday
 Male

10. Canadian Citizen Permanent Resident U.S. Citizen Other (please specify)

11. Is the home address the same as Proposed Life Insured A? Yes No If no, please complete address section below.
 Home Address

City | Province | Postal Code | Phone Number

12. Employer Name | Employer Address | Phone Number

Nature of Business | How long with this Employer? | Professional Designation/Degree

Current Occupation | Number of Years at this Occupation | Former Occupation (if at current occupation less than 2 years)

Beneficiary – Proposed Life Insured B

If the Beneficiary is a minor, we strongly advise the appointment of a trustee. Complete the Appointment of Trustee form. Ensure total shares equal 100%.

13. Primary Beneficiary

First Name | Middle Name | Last Name | Revocable
 Irrevocable
 Relationship to Applicant/Owner | % Share

First Name | Middle Name | Last Name | Revocable
 Irrevocable
 Relationship to Applicant/Owner | % Share

First Name | Middle Name | Last Name | Revocable
 Irrevocable
 Relationship to Applicant/Owner | % Share

14. Contingent Beneficiary – If all Beneficiaries predecease the Life Insured(s), the proceeds are payable to the Contingent Beneficiary if any, otherwise to the estate of the Owner.

First Name | Middle Name | Last Name
 Relationship to Applicant/Owner

Applicant/Owner

15. Proposed Life Insured A Proposed Life Insured B Proposed Life Insureds A and B jointly
Other If other, please complete below.

First or Company Name | Middle Name | Last Name | Prefix

S.I.N or Business Number | Relationship to Proposed Life Insured A and B (if any)

Mailing address (for billings, notices etc.)

City | Province | Postal Code | Attention

Joint Applicant/Owner other than Proposed Life Insured A and B, if any

If Joint Owners, ownership is to be with right of survivorship unless otherwise indicated.

16. First or Company Name | Middle Name | Last Name | Prefix

S.I.N or Business Number | Relationship to Proposed Life Insured A and B (if any)

Contingent Owner

Must be completed if purchasing Child Rider.

If all Owners predecease the Life Insured(s), in the absence of a Contingent Owner, ownership passes to the estate of the last surviving Owner.

17. First Name | Middle Name | Last Name

Relationship to Proposed Life Insured A and B (if any)

Language of Policy

18. English French

COMPLETE ONLY IF APPLYING FOR A UNIVERSAL LIFE PLAN

Confirmation of Individual Applicant/Owner Identity

19. A minimum of one piece of identification is required, the original of which must be shown to the representative.

Driver's license Permanent Residence card Canadian Citizenship card Place of Issue _____

Birth Certificate Passport Document number _____ Country of Issue _____

Confirmation of Joint Applicant/Owner Identity if any

20. A minimum of one piece of identification is required, the original of which must be shown to the representative.

Driver's license Permanent Residence card Canadian Citizenship card Place of Issue _____

Birth Certificate Passport Document number _____ Country of Issue _____

Confirmation of Applicant/Owner Identity if Corporation or Entity

21. Please verify the identity of the Applicant/Owner using one of the documents below. For corporations only, ensure the document includes names of the directors or add this information in the attached Representative's Supplementary Report.

Certificate of corporate status Partnership agreement Trust document

Articles of association Other

A photocopy of the document must be submitted with this application.

22. Is any Applicant/Owner applying for this policy on behalf of a third party (i.e. will someone else be paying premiums)?
No Yes (If yes, complete Third Party Information)

Third Party Information

Name	Address	Principal Business or Occupation	Relationship to Proposed Life Insured

Insurance applied for - Proposed Life Insured A

23. Plan Single Life Joint Last-to-Die Joint First-to-Die Non-Smoker Smoker

Face Amount \$ _____ Insurance Riders/Benefits – include coverage amount _____

If applying for Payor Waiver Benefit, what is the Payor's relationship to the Applicant/Owner? _____
Complete the required sections or a separate application if this is a joint policy.

For Universal Life plans only Level Death Benefit with YRT Increasing Death Benefit with Increasing Death Benefit with
Cost of Insurance Level Cost of Insurance YRT Cost of Insurance

Are you applying for Long Term Care Benefit? Yes No If yes, please complete the Long Term Care Supplement.

Existing Insurance - Proposed Life Insured A

Insurance in force or pending? Yes No If yes, complete below. Complete Disclosure forms where necessary.

24. Year Issued	Company	Amount of Life Insurance including Term Riders			Other types of Insurance e.g. Accidental Death Benefit, CI, Disability	Is the insurance applied for intended to replace any insurance now in force with any company?	
		Personal	Business	Group		Yes	No

25. **Conversion:** Existing policy number _____ Full conversion? Partial conversion?

Balance of partial conversion Retain? (must meet plan minimum) Cancel?

Conversion details _____

Insurance applied for - Proposed Life Insured B

26. Plan Single Life Joint Last-to-Die Joint First-to-Die Non-Smoker Smoker

Face Amount \$ _____ Insurance Riders/Benefits – include coverage amount for each _____

If applying for Payor Waiver Benefit, what is the Payor's relationship to the Applicant/Owner? _____
Complete the required sections or a separate application if this is a joint policy.

Existing Insurance - Proposed Life Insured B

Insurance in force or pending? Yes No If yes, complete below. Complete Disclosure forms where necessary.

27. Year Issued	Company	Amount of Life Insurance including Term Riders			Other types of Insurance e.g. Accidental Death Benefit, CI, Disability	Is the insurance applied for intended to replace any insurance now in force with any company?	
		Personal	Business	Group		Yes	No

28. **Conversion:** Existing policy number _____ Full conversion? Partial conversion?

Balance of partial conversion Retain? (must meet plan minimum) Cancel?

Conversion details _____

Premium Payment

If applying for Universal Life, a signed illustration and a completed Investment Allocation form must be submitted with the application.

29. Initial Scheduled Premium Billing Frequency Annual Monthly PAC

\$ _____

PAC withdrawal date if different from policy date (1st – 28th) _____

Initial premium to be drawn by PAC? Yes No

Pre-Authorized Chequing (PAC) Agreement

30. Please attach a specimen cheque marked void.

The Payor named below agrees that:

- (a) RBC Life Insurance Company (RBC Insurance) is authorized to make monthly withdrawals to pay the premiums for this policy, including the initial premium if requested above, against the account at the financial institution indicated below in accordance with the rules of the Canadian Payments Association.
- (b) such withdrawals will be on dates and in amounts in accordance with the premium schedule as set out in the policy.
- (c) if the amount of withdrawal should vary, pre-notification by RBC Insurance is waived.
- (d) the financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Insurance to withdraw from the account indicated below.
- (e) unless otherwise requested above, 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(ies).
- (f) notification of any change to the information provided below, or to the amount to be withdrawn, shall be given to RBC Insurance by the Payor 5 days prior to the next scheduled withdrawal.
- (g) this Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Insurance or by the Payor.
- (h) the names of all persons whose signatures are required to authorize withdrawals from the account indicated below are included below and their signatures agreeing to these terms are included in the Declarations, Agreements and Consents section of this Application.
- (i) Add to existing PAC with policy number(s) _____

Bank Information

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

Address _____

City	Province	Postal Code
_____	_____	_____ _____ _____

Name of Payor (Account Holder)

Name of Second Payor (Account Holder) (if any)

Personal Information - Proposed Life Insured A and B

	A		B	
	Yes	No	Yes	No
1. Has the Proposed Life Insured:				
(a) had any application for any form of life or health insurance, any change or reinstatement declined, rated, cancelled or modified in any way? If yes, please give details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) applied for or received a pension, including CPP disability, income replacement benefits, compensation, workers compensation benefits of any type or Employment Insurance Disability Benefits? If yes, please give details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) in the last 3 years engaged in any activity or sport, including but not limited to racing, sky diving, ultra-light flying, hang gliding, scuba diving, mountaineering, heli-skiing, CAT or back-country skiing or have plans to do so? If yes, please provide details or complete the appropriate questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) flown an aircraft as pilot or student pilot or operated as a crew member in the last 3 years or have plans to do so? If yes, please complete the Aviation Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) within the last 2 years travelled outside Canada or the United States of America or have plans to do so in the future? If yes, please complete the Foreign Travel Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) been found guilty of a driving violation, had a driver's licence revoked or suspended in the last 10 years or are there any such charges pending? If yes, please give details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date _____ Type _____				
Date _____ Type _____				
Driver's Licence No. _____ Province of issue of licence _____				
(g) been found guilty of impaired driving or any other alcohol or drug related offence within the last 10 years or are there any such charges pending? If yes, please explain fully.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) been found guilty of a criminal offence within the last 10 years or are there any criminal charges pending? If yes, please explain fully.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) or the Applicant/Owner declared bankruptcy within the last 10 years? If yes, please explain fully, including dates of discharge if applicable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) ever had a licence to practise any occupation suspended, revoked or under review; been found guilty of any professional misconduct or had disciplinary measures recommended in connection with any licence to practise? If yes, please explain fully.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional details of "yes" answers.

Insured A or B	Question #	Details

Financial Information – Proposed Life Insured A

Complete for all applications

1. Main purpose of insurance
Personal Income Replacement Estate Conservation Investment Credit Facility
Other:
Business Buy/Sell Key Person Collateral
2. Source of planned premium _____
3. What is your annual earned income in Canadian dollars from:
Salary \$ _____
Commissions \$ _____
Bonuses \$ _____
Other \$ _____
4. What is your annual income in Canadian dollars from other sources:
Dividends \$ _____
Interest \$ _____
Other \$ _____ Source _____
5. If you are not currently working, what is the source of your income? _____

6. What is your estimated net worth in Canadian dollars? _____
7. What is the amount of mortgage outstanding on your personal residence? _____

Complete if applying for business insurance

1. Book value of business in Canadian dollars \$ _____
2. Fair market value of business in Canadian dollars \$ _____
3. Net annual before tax income of business in Canadian dollars \$ _____
4. Percentage of business owned _____ %
5. Are other partners, owners, executives insured for a similar amount? Yes No If no, please explain.

Complete if Proposed Life Insured is under age 16.

1. Amount of insurance on father \$ _____ If none, please explain.

2. Amount of insurance on mother \$ _____ If none, please explain.

3. Are all other children in the family insured? Yes No If no, please explain.

4. Amount of insurance on other siblings \$ _____
5. Source of premium. If not from parents, please provide details. _____

Financial Information – Proposed Life Insured B

Complete for all applications

1. Main purpose of insurance

Personal Income Replacement Estate Conservation Investment Credit Facility

Other:

Business Buy/Sell Key Person Collateral

2. Source of planned premium _____

3. What is your annual earned income in Canadian dollars from:

Salary \$ _____

Commissions \$ _____

Bonuses \$ _____

Other \$ _____

4. What is your annual income in Canadian dollars from other sources:

Dividends \$ _____

Interest \$ _____

Other \$ _____ Source _____

5. If you are not currently working, what is the source of your income? _____

6. What is your estimated net worth in Canadian dollars? _____

7. What is the amount of mortgage outstanding on your personal residence? _____

Complete if applying for business insurance

1. Book value of business in Canadian dollars \$ _____

2. Fair market value of business in Canadian dollars \$ _____

3. Net annual before tax income of business in Canadian dollars \$ _____

4. Percentage of business owned _____ %

5. Are other partners, owners, executives insured for a similar amount? Yes No If no, please explain.

Complete if Proposed Life Insured is under age 16.

1. Amount of insurance on father \$ _____ If none, please explain.

2. Amount of insurance on mother \$ _____ If none, please explain.

3. Are all other children in the family insured? Yes No If no, please explain.

4. Amount of insurance on other siblings \$ _____

5. Source of premium. If not from parents, please provide details. _____

Tobacco Usage

The information listed below is relied upon to establish the policy's premium rate and is material to the insurance risk. Failure to make proper disclosure will entitle RBC Insurance to render the policy null and void.

1. Has the Proposed Life Insured A ever used any of the following:	Yes	No	Quantity/Frequency	Date last used
(a) cigarettes	<input type="checkbox"/>	<input type="checkbox"/>		
(b) cigarillos	<input type="checkbox"/>	<input type="checkbox"/>		
(c) cigars	<input type="checkbox"/>	<input type="checkbox"/>		
(d) chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>		
(e) pipe	<input type="checkbox"/>	<input type="checkbox"/>		
(f) snuff	<input type="checkbox"/>	<input type="checkbox"/>		
(g) marijuana or hashish	<input type="checkbox"/>	<input type="checkbox"/>		
(h) smoking cessation products such as Zyban, patches or gum	<input type="checkbox"/>	<input type="checkbox"/>		
(i) tobacco substitutes such as betel nuts, betel leaves, supari, paan or gutka? Please specify.	<input type="checkbox"/>	<input type="checkbox"/>		

Additional details of "yes" answers.

2. Has the Proposed Life Insured B ever used any of the following:	Yes	No	Quantity/Frequency	Date last used
(a) cigarettes	<input type="checkbox"/>	<input type="checkbox"/>		
(b) cigarillos	<input type="checkbox"/>	<input type="checkbox"/>		
(c) cigars	<input type="checkbox"/>	<input type="checkbox"/>		
(d) chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>		
(e) pipe	<input type="checkbox"/>	<input type="checkbox"/>		
(f) snuff	<input type="checkbox"/>	<input type="checkbox"/>		
(g) marijuana or hashish	<input type="checkbox"/>	<input type="checkbox"/>		
(h) smoking cessation products such as Zyban, patches or gum	<input type="checkbox"/>	<input type="checkbox"/>		
(i) tobacco substitutes such as betel nuts, betel leaves, supari, paan or gutka? Please specify.	<input type="checkbox"/>	<input type="checkbox"/>		

Additional details of "yes" answers.

Child Term Rider

Must be natural or adopted child of Proposed Life Insured A or B. A Contingent Owner must be appointed. Any child over age 16 must sign the application.

(a) First Name Middle Name Last Name

Relationship to Applicant/Owner

Female Date of Birth (dd/mmm/yy) Age as of Nearest Birthday Height Weight
 Male | | | cm | ft/in | kg | lbs

(b) First Name Middle Name Last Name

Relationship to Applicant/Owner

Female Date of Birth (dd/mmm/yy) Age as of Nearest Birthday Height Weight
 Male | | | cm | ft/in | kg | lbs

(c) First Name Middle Name Last Name

Relationship to Applicant/Owner

Female Date of Birth (dd/mmm/yy) Age as of Nearest Birthday Height Weight
 Male | | | cm | ft/in | kg | lbs

(d) First Name Middle Name Last Name

Relationship to Applicant/Owner

Female Date of Birth (dd/mmm/yy) Age as of Nearest Birthday Height Weight
 Male | | | cm | ft/in | kg | lbs

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has any insurance application on any child been declined, postponed or modified in any way? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do any of the children have any physical or mental impairment or have they had any illness, impairment or injury that has required treatment or an operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are any of the children currently on medication or has any treatment or diagnostic test been advised that has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do all of the above children reside with either of the Proposed Life Insureds? If no, provide details about who the child lives with and how often the Proposed Life Insured sees the child. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. What was the reason for, the date of and the result of the child's last visit to the health care professional? Include health care professional's name, professional designation, address, postal code and phone number in the space below. | | |

Space for additional information to the above questions or names of additional children.

Child	Question	Details

Medical History Proposed Life Insured A

1. Height _____ cms ft/in Weight _____ kg lbs

2. Has your weight changed in the last year? Yes No Gained? Lost? _____ kg lbs
 If yes, state reason for change _____

3. (a) Name and address of your personal health care professional/clinic (If none, so state)

(b) How long have you been a patient there?

(c) Date and reason last consulted

(d) What was the diagnosis, treatment given or medication prescribed? (If none, so state)

4. (a) Other than the above, within the past year have you consulted any other health care professional? Yes No

(b) If yes, give the date, reason and any treatment given or medication prescribed.

5. Any family history of diabetes mellitus, cancer (specify type), high blood pressure, colon polyps, heart disease, polycystic kidney disease or other kidney disease, stroke, Huntington Disease, hepatitis or Parkinson Disease? Yes No

	Condition or Cause of Death	Age at Onset	Age if Living	Age at Death		Condition or Cause of Death	Age at Onset	Age if Living	Age at Death
Father					Brothers				
Mother					Sisters				

Additional details

Question #	Details

Medical History Proposed Life Insured B

1. Height _____ cms ft/in Weight _____ kg lbs

2. Has your weight changed in the last year? Yes No Gained? Lost? _____ kg lbs
If yes, state reason for change _____

3. (a) Name and address of your personal health care professional/clinic (If none, so state)

(b) How long have you been a patient there?

(c) Date and reason last consulted

(d) What was the diagnosis, treatment given or medication prescribed? (If none, so state)

4. (a) Other than the above, within the past year have you consulted any other health care professional? Yes No

(b) If yes, give the date, reason and any treatment given or medication prescribed.

5. Any family history of diabetes mellitus, cancer (specify type), high blood pressure, colon polyps, heart disease, polycystic kidney disease or other kidney disease, stroke, Huntington Disease, hepatitis or Parkinson Disease? Yes No

	Condition or Cause of Death	Age at Onset	Age if Living	Age at Death		Condition or Cause of Death	Age at Onset	Age if Living	Age at Death
Father					Brothers				
Mother					Sisters				

Additional details

Question #	Details

Medical History continued – Proposed Life Insured A and B

	A		B	
	Yes	No	Yes	No
6. Have you ever had, or been told you have or have you ever received treatment or advice for:				
(a) dizziness, fainting, convulsions, epilepsy, seizures, tremor, Parkinson disease, headache, migraine, speech problems, paralysis, stroke, transient ischemic attack (TIA), memory disorder, Alzheimer disease, numbness, neuropathy, multiple sclerosis or other neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) anxiety, depression, chronic fatigue, suicidal thoughts or any other psychiatric, emotional, behavioural, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) disorder of the eyes, ears, nose, mouth or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) shortness of breath, wheezing, chronic cough, chronic bronchitis, chronic obstructive lung disease, emphysema, asthma, blood spitting, hoarseness, pleurisy, pneumonia, tuberculosis, sleep apnea or other respiratory or lung disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) high blood pressure, elevated cholesterol, abnormal ECG (electrocardiogram), chest pain, angina, heart attack, myocardial infarction, coronary artery disease, coronary angiogram, angioplasty, coronary artery surgery, palpitation, irregular heart rhythm, heart failure, ankle swelling, heart murmur, rheumatic fever, heart valve abnormality, blood clot, thrombophlebitis, pulmonary embolus or other disorder of the heart, blood vessels or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) ulcer, stomach or intestinal bleeding, jaundice, hepatitis, hepatitis carrier state, colitis, Crohn disease, chronic diarrhea or other disorder of the stomach, intestines, liver, gallbladder or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) sugar, protein, blood or pus in the urine, kidney stone, kidney infection, kidney cysts, prostate disorder, abnormal PSA (Prostate Specific Antigen) test, ovarian, uterine or cervical disorder, sexually transmitted disease, complications of pregnancy or any other disorder of the bladder, kidneys or reproductive tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex) or a positive test for antibodies to HIV (Human Immunodeficiency Virus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) skin cancer, dysplastic nevi, rheumatism, arthritis, gout, lupus, SLE (Systemic Lupus Erythematosus), osteoporosis, amputation, fibromyalgia, chronic pain disorder or any other disorder of the skin, joints, muscles, bones, ligaments, soft tissues, discs, neck, back or spine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) any cancer, tumour, cyst, mass, lesion, lump, nodule or breast disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) anemia, bleeding disorder, clotting disorder, allergies, immune disorders, lymphoma, leukemia or any other disorder of the blood or lymph nodes or any serious or unexplained infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) diabetes mellitus, thyroid or other endocrine or hormonal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details of “Yes” answers. Include date, diagnoses, results of tests, duration and names and addresses of all attending health care professionals and medical facilities.

Insured A or B	Question #	Details

Medical History continued – Proposed Life Insured A and B

	A		B	
	Yes	No	Yes	No
7. (a) Do you currently take any medications, including herbal, naturopathic, homeopathic or other remedies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Within the past 12 months have you received chiropractic or acupuncture treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) In the past 5 years have you had any other tests not mentioned above (such as Coronary Calcium Score, CT scan, MRI, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Have you been advised to undergo investigations, have treatment, testing or consultation which has not yet been completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Are you aware of any other symptom or health-related disorder for which you have not yet consulted a health care professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Have you ever received or been advised to seek counselling or treatment regarding the use of alcohol, or ever attended Alcoholics Anonymous (AA) meetings or any other similar organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Do you currently use alcoholic beverages? If yes, state type, amount and frequency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Have you ever used sedatives, tranquilizers or hallucinogenic or narcotic drugs including cocaine and marijuana except as prescribed by a health care professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Females only: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please state your expected delivery date _____				

Details of "Yes" answers. Include date, diagnoses, results of tests, duration and names and addresses of all attending health care professionals and medical facilities.

Insured A or B	Question #	Details

Temporary Life Insurance Application

Only available when the amount of life insurance applied for is \$1,000,000 or less. If any of the following questions are answered 'Yes' or if any Proposed Life Insured is under 15 days or over 65 years old, do not proceed.

	A		B	
	Yes	No	Yes	No
Has any Proposed Life Insured				
1. ever been treated for or had any indication of heart or blood vessel disease, high blood pressure, chest pain, stroke, transient ischemic attacks (TIA), diabetes mellitus, chronic kidney, liver or lung disease, cancer or tumours, multiple sclerosis, paralysis, Alzheimer or Parkinson disease, AIDS or HIV infection, loss of speech, blindness or deafness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. within the last year, other than normal childbirth, been admitted to hospital or other medical facility or been advised to do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. been advised to have any tests, investigations or surgery not yet done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. in the last year had any application for life insurance, change or reinstatement declined, rated or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I declare that the above questions have been truthfully answered.

Dated at _____ this _____ day of _____ year _____

Signature of Applicant/Owner (if other than Proposed Life Insured)

Signature of Proposed Life Insured A

Signature of Joint Applicant/Owner (if any)

Signature of Proposed Life Insured B (if any)

Signature of any minor Proposed Life Insured age 16 and over or parent/guardian of minor Proposed Life Insured under age 16

Temporary Life Insurance Receipt

RBC Life Insurance Company (RBC Insurance) acknowledges receipt of \$_____ (at least the minimum premium at standard rates for the policy applied for under this Agreement or authorization was provided to RBC Insurance in this Application to withdraw this sum immediately by pre-authorized chequing) in payment for coverage under the Temporary Life Insurance Agreement on the life of _____

Temporary Life Insurance is subject to the conditions, limits of amount and duration as specified on the Temporary Life Insurance Agreement on the reverse of this receipt.

Dated at _____ this _____ day of _____ year _____

Signature of Representative

Temporary Life Insurance Agreement

If the terms, conditions and requirements are met, RBC Life Insurance Company (RBC Insurance) agrees to insure the Proposed Life Insured(s) specified in the Temporary Life Insurance Application subject to limits in the terms and conditions set out below.

Coverage

Temporary life insurance commences once the Life Insurance Application (Application) has been signed and the payment for coverage under this Temporary Life Insurance Agreement has been received.

In the event of the death of the specified Life Insured(s) (if more than one Life Insured, the first or last-to-die according to the contract) while this Agreement is in force and subject to a maximum aggregate liability of \$1,000,000 under this and all other Temporary Life Insurance Agreements issued by RBC Insurance, RBC Insurance will pay the LESSER OF:

- (a) the amount of life insurance applied for in the Application, OR
- (b) \$1,000,000.

Should payment for coverage under this Agreement not be honoured, this coverage will be considered null and void from the date of the Application.

Termination of Temporary Life Insurance

Insurance coverage provided by this Agreement will terminate on the earliest of:

- (a) 90 days from the date the Application is signed, OR
- (b) the date notice is given by RBC Insurance to the Applicant/Owner of termination of insurance under this Agreement (notice by mail shall be deemed to have been received two days following the date of mailing), OR
- (c) the date the policy applied for goes in force.

Except in the case of fraud, payment received by RBC Insurance will be refunded in the event of termination under (a) or (b).

Limitations

- (a) If there is material misrepresentation or non-disclosure in any part of the Life or Temporary Life Insurance Application, any application supplement or questionnaire, no Temporary Life Insurance will take effect and RBC Insurance shall, except in the case of fraud, refund the payment.
- (b) RBC Insurance shall have no liability if the specified Proposed Life Insured(s), while sane or insane, commits suicide.
- (c) No accidental death, disability/income replacement, critical illness or return/waiver of premium benefits are provided under this Agreement.
- (d) Post dated cheques are not acceptable.

Disclosure Statement for the Province of British Columbia

Pursuant to S.90 of the Financial Institutions Act of British Columbia, the financial product you are being offered is supplied by RBC Life Insurance Company, a company licensed to carry on business in British Columbia.

In relation to any application you may make for the acquisition of life insurance, annuities or other financial products:

- I am acting as a licensed insurance representative on behalf of this company;
- I will be entitled to receive commission from the company on successful completion of this transaction. This commission may take the form of an acquisition commission and/or an on-going service commission; and
- there is no condition associated with this transaction requiring that you must transact additional or other business with either myself or the company.

Dated at _____ this _____ day of _____ year _____

Signature of Representative

Dated at _____ this _____ day of _____ year _____

Signature of Representative

TO BE LEFT WITH THE PROPOSED LIFE INSURED

Notice regarding the Medical Information Bureau

Information regarding your insurability will be treated as confidential. RBC Life Insurance Company or its reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information Office is:

Medical Information Bureau, 330 University Avenue, Toronto, Ontario, CANADA M5G 1R7 Telephone: (416) 597 - 0590.

RBC Life Insurance Company or its reinsurers 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 a claim for benefits may be submitted.

Authorization

I authorize any health care professional, health or social service establishment, insurance company, the Medical Information Bureau, any financial institution, personal information agent or security agency, my employer or any former employer and any public body holding personal information concerning me, particularly medical information, to supply this information to RBC Life Insurance Company (RBC Insurance) and its reinsurers. Such information will be provided for the following purposes: (a) assessment of insurance risk for underwriting purposes; (b) investigations necessary to adjudicate any claim or assess the validity of the policy as issued.

I authorize RBC Insurance to share personal information with its reinsurers and other insurers as required. I also authorize RBC Insurance to release to my health care professional any medical information obtained for this insurance application including the results of any blood or urine tests or urine drug screening tests for purposes of revealing findings which might require further investigation or treatment or for purposes of explaining an underwriting decision.

I understand that if I refuse to provide this authorization, RBC Insurance will be unable to assess the insurance risk and therefore unable to issue a policy.

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 Insurance.

Dated at _____ this _____ day of _____ year _____

Signature of Witness

Signature of Proposed Life Insured A

Signature of Proposed Life Insured B

Signature of any minor Proposed Life Insured age 16 and over or parent/guardian of minor Proposed Life Insured under age 16

Authorization

I authorize any health care professional, health or social service establishment, insurance company, the Medical Information Bureau, any financial institution, personal information agent or security agency, my employer or any former employer and any public body holding personal information concerning me, particularly medical information, to supply this information to RBC Life Insurance Company (RBC Insurance) and its reinsurers. Such information will be provided for the following purposes: (a) assessment of insurance risk for underwriting purposes; (b) investigations necessary to adjudicate any claim or assess the validity of the policy as issued.

I authorize RBC Insurance to share personal information with its reinsurers and other insurers as required. I also authorize RBC Insurance to release to my health care professional any medical information obtained for this insurance application including the results of any blood or urine tests or urine drug screening tests for purposes of revealing findings which might require further investigation or treatment or for purposes of explaining an underwriting decision.

I understand that if I refuse to provide this authorization, RBC Insurance will be unable to assess the insurance risk and therefore unable to issue a policy.

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 Insurance.

Dated at _____ this _____ day of _____ year _____

Signature of Witness

Signature of Proposed Life Insured A

Signature of Proposed Life Insured B

Signature of any minor Proposed Life Insured age 16 and over or parent/guardian of minor Proposed Life Insured under age 16

Declarations, Agreements and Consents

The Applicant/Owner and any Proposed Life Insured, if other than the Applicant/Owner, declare to the best of their knowledge that all statements and answers in all parts of this application and in any supplement to this application are full, complete and true and agree that:

1. RBC Life Insurance Company (RBC Insurance) has 90 days to consider and act upon this application from the date the application was signed. If RBC Insurance has not given notice of approval or rejection within that time, this application shall be considered to have been declined,
2. insurance under the policy shall take effect only when (a) a policy tendered for delivery is accepted by the Applicant/Owner, (b) the full initial premium has been paid and (c) provided no change in insurability of any Proposed Life Insured has taken place between the time of application and delivery. If Medical History - Part 2, is submitted prior to completion of the application, the application shall be deemed to have been made as of the time such History was submitted,
3. RBC Insurance may be entitled to render this policy and any Temporary Life Insurance Agreement null and void if there is misrepresentation or non-disclosure in any part of the application for insurance, medical examination or any questionnaire completed in connection with this application that is material to the insurance risk,
4. the entire contract of insurance shall be the policy, any attached endorsements, exclusions, amendments, addendums or documents and all completed parts of this application, application supplement or questionnaire. Acceptance of the policy will constitute agreement to its terms and notification of any changes specified by RBC Insurance in the policy,
5. no statement made to and no information acquired by a representative of RBC Insurance or an examining physician shall be attributed to or binding upon RBC Insurance unless contained in the application or any related declaration of health-related evidence of insurability. No one other than an officer of RBC Insurance may (a) alter or modify the terms of this application or policy or (b) waive any of RBC Insurance's rights or requirements,
6. if the monthly mode of payment has been selected, I agree to the terms of the Pre-Authorized Chequing Agreement,
7. I have read the section entitled Your Privacy Matters to Us appearing in this application and understand and agree to its terms,
8. a copy of the "Notice regarding the Medical Information Bureau" has been received and read,
9. unless otherwise requested in the Language of Policy question in this application, the policy and all related documents have been expressly requested to be in the English language. À moins de stipulation contraire à la question relative à la langue du contrat de la présente proposition, il a été expressément demandé que le contrat et tous les documents qui s'y rapportent soient rédigés en anglais.

Dated at _____ this _____ day of _____ year _____

Signature of Witness

Signature of Proposed Life Insured A
(or Parent/Guardian if child under 16)

Signature of Proposed Life Insured B (if any)
(or Parent/Guardian if child under 16)

Signature of any minor Proposed Life Insured over age 16

Signature of Witness

Signature of Applicant/Owner if other than Proposed Life Insured
(if Corporate Owner, include Title of signing officer;
if Trustee Owner, sign as Trustee and identify the Trust)

Signature of Joint Applicant/Owner (if any)

I agree to the terms of the Pre-Authorized Chequing Agreement as outlined in this Application.

Signature of Pre-Authorized Chequing Payor if other than Applicant/Owner

Signature of Second Pre-Authorized Chequing Payor (if any)

Representative's Report

- 1. How long have you known the Proposed Life Insured A? _____ years Proposed Life Insured B? _____ years
- 2. Have you collected money? Yes No
If yes, indicate amount collected \$ _____ Date received _____
- 3. (a) Is the Proposed Life Insured fluent in the English language? Yes No
(b) If the Proposed Life Insured is not fluent in English, a Statement of Understanding in the Proposed Life Insured's language of choice must be completed and submitted before underwriting can proceed.
(c) If the language used to complete the application was not English, what was the language used and who explained the application? _____

- 4. (a) Were you present at the time of completion of the application? Yes No
(b) Who was present at the time of completion of the application? _____

Complete if Joint Lives

- 5. (a) Number of lives covered ____ (b) Names of other lives _____

Complete if Proposed Life Insured is a Child Under 16 Years

- 6. (a) With whom is the child living? (b) Are all other children in the family insured? Yes No
If not, why has this child been chosen? _____

- (c) Indicate the amount of insurance on:

	Father	Mother	Other Siblings
	\$	\$	\$

- (d) Is the Owner the child's parent? Yes No If no, please provide full details.

- 7. Back date to save age? Yes No Other special date _____
- 8. Evidence: The following requirements have been ordered

Medical <input type="checkbox"/>	Blood Profile <input type="checkbox"/>	Para-Medical <input type="checkbox"/>	
ECG/Ex.ECG <input type="checkbox"/>	Int. Medical <input type="checkbox"/>	Para-Medical company used _____	
Urine-HIV <input type="checkbox"/>	Inspection <input type="checkbox"/>	Other <input type="checkbox"/>	_____
Saliva-HIV <input type="checkbox"/>	MVR <input type="checkbox"/>		
- 9. I, the Representative, confirm that the Applicant/Owner has presented original documents to confirm their identity? Yes

10. Representative's Declaration

I declare that:

- I have clearly explained the provisions and limitations of the policy being applied for (and the Temporary Life Insurance Agreement, if applicable) to the Proposed Life Insured(s) (and the Applicant/Owner, if applicable),
- all of the questions in the application were clearly asked of, or read by, the Proposed Life Insured(s) (and the Applicant/Owner, if applicable),
- 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 Life Insured(s) that has not been disclosed on the application,
- if a policy is issued, I will deliver it to the Applicant/Owner 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 Life Insured(s),
- I understand that I cannot modify the application, the Temporary Life Insurance Agreement or the terms of the policy, if issued.

Date			
Representative's signature			

Representative's Name				
Representative's Company Name				
Marketing Office				
Share	%	Servicing Representative Code	%	Representative Code

Representative's Supplementary Report

Please use this space for any special instructions or additional information which would be helpful in the underwriting of this risk. e.g. occupation, aviation, avocation, purpose of insurance, amount, income, health problems, habits, finances, replacement, insurable interest.

Checklist

Use this Checklist BEFORE you submit the application.

Have you detached and given to the applicant:

Disclosure Statement for the Province of B.C. Medical Information Bureau's Pre-Notice TIA receipt (if applicable)

Have you attached to the application:

Supplementary questionnaires (if required) <input type="checkbox"/>	Disclosure form (if applicable) <input type="checkbox"/>
Payment for the first month <input type="checkbox"/>	A signed illustration for all Universal Life Plans <input type="checkbox"/>
A void cheque with legible banking codes (if using PAC) <input type="checkbox"/>	An Initial Investment Allocation Form for Universal Life Plans <input type="checkbox"/>

Application checked by:

Print Name _____

Code Number _____

Signature _____

Telephone _____

