# Group Insurance Evidence of Insurability Form

RBC Insurance

*Please answer all applicable questions; all subsequent changes must be initialled by the Employee. On completion, the form must be signed and dated to be accepted.*

**IMPORTANT:**

The Employee must be a permanent resident of Canada with Canadian Citizenship or Permanent Resident status, and must be an eligible employee of the Policyholder in Active Employment as defined in the Group Insurance Policy on the date this Evidence of Insurability Form is signed.

## SECTION 1: EMPLOYER INFORMATION *(to be completed by authorized Plan Administrator)*

REASON FOR SUBMISSION OF EVIDENCE OF INSURABILITY BY EMPLOYEE:

☐ New Employee – Eligible for an amount exceeding Non-Evidence Maximum ☐ Optional Life ☐ Add Dependant

☐ Current Employee – Eligible for increase over Non-Evidence Maximum ☐ Late Application ☐ Other: _____

Name of Company: _____ Group Policy No: _____

Head Office Mailing Address: _____ City: _____ Prov: _____ Postal Code: _____

Company Phone No: _____ Authorized Personnel: _____

Billing Type: ☐ Insurer-Billed ☐ Self-Billed ☐ TPA – Name of TPA: _____

## SECTION 2: EMPLOYEE INFORMATION *(to be completed by Employee)*

Language Preference: ☐ English ☐ French

Full Legal Name: First: _____ Initial: _____ Last: _____

Date of Birth: _____ Gender: ☐ M ☐ F
(day/month/year)

Employee Home Address: _____ City: _____ Prov: _____ Postal Code: _____

Date of Hire: _____ Occupation: _____ Annual Earnings: $ _____
(day/month/year)

Name and Address of Personal Physician: Name: _____

Address: _____

Please provide the date, reason and results of your last consult with any physician:

**Eligible Dependent Spouse**

Full Legal Name: First: _____ Initial: _____ Last: _____

Date of Birth: _____ Gender: ☐ M ☐ F
(day/month/year)

Name and Address of Personal Physician (if different from Employee): Name: _____

Address: _____

**RBC Life Insurance Company**
6880 Financial Drive, Tower 1, Eighth Floor
Mississauga, Ontario L5N 7Y5

Please provide the date, reason and results of your last consult with any physician:

| |
|---|
| |

| **Eligible Dependent Child(ren)** | | |
|---|---|---|
| First Name (also indicate last name if different from Employee) | Gender | Date of Birth (day/month/year) |
| | | |
| | | |
| | | |

## SECTION 3: COVERAGE *(Check all that apply)*

**Employee**

☐ Basic Life:
Applying for: $ ____

☐ Optional Life:
Applying for: $ ____

☐ Extended Health Care

☐ Dental Care

☐ Short Term Disability:
Applying for: $ ____

☐ Long Term Disability:
Applying for: $ ____

**Dependant**

☐ Basic Dependent Life:
Applying for: Spouse: $ ____ Child: $ ____

☐ Optional Life:
Applying for: Spouse: $ ____ Child: $ ____

☐ Extended Health Care

☐ Dental Care

## SECTION 4: HEALTH AND LIFESTYLE QUESTIONS

The following questions must be answered by the applicable Employee and/or Spouse. **ALL QUESTIONS MUST BE ANSWERED.**
If the answer is "Yes" to any of the following questions, please circle the condition and provide full details in the space provided on page 4, including dates, duration, treatment, result and name of attending physician.

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.

| | | | **Employee** | **Spouse (if applicable)** |
|---|---|---|---|---|
| **1** | | Have you ever had any indication of, been told you have, or have you ever received treatment or advice for: | | |
| | **a** | Abnormal blood pressure, chest pain, heart attack, phlebitis, or any other disease or disorder of the heart or blood vessels?<br>If yes to abnormal blood pressure, please complete the following:<br>Date first advised of blood pressure: _____ Treatment: ☐ Diet ☐ Medicine ☐ Other<br>How long on treatment? _____ Still in treatment? ☐ Yes ☐ No<br>In the past two (2) years, have special tests been done? ☐ Yes ☐ No If yes, give type of tests, dates and results: _____<br>Do you have recent readings? ☐ Yes ☐ No If yes, give readings: _____ | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | | | Employee | Spouse (if applicable) |
|---|---|---|---|---|
| | **b** | Gastrointestinal disorder, ulcer, jaundice, chronic diarrhoea, gall bladder, hepatitis or liver disease/ disorder, or any other disease or disorder of the stomach, intestines or rectum? If yes, complete the following:<br>☐ Ulcer ☐ Other: _____ Date of first attack: _____ No. of attacks: _____<br>Treatment:<br>☐ Medicine – Give name: _____ ☐ Operation – Give date: _____<br>Do you now have symptoms? ☐ Yes ☐ No Are you under treatment? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **c** | Asthma, bronchitis, emphysema, tuberculosis or any other respiratory disease or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **d** | Abnormal urine, venereal disease, or any disease or disorder of the kidneys, bladder, prostate or reproductive organs? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **e** | Back or neck pain, whiplash, or any other disease or disorder, injury or deformity of the spine? If you answer yes to this question, please complete the "Back and Neck Disorder Questionnaire" on page **5**. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **f** | Arthritis, amputation, or any disease or disorder of the hip, knee, or other joints, bones or muscles, including fibrositis or fibromyalgia? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **g** | Epilepsy, paralysis, stroke, recurrent headaches, or any other disease or disorder of the brain or nervous system? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **h** | Nervous disorder, anxiety, depression or any stress related illness? If Yes, please complete the "Mental Health Questionnaire" on page **7**. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **i** | Diabetes, thyroid or other glandular disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **j** | Cancer, cyst, tumour or skin disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **k** | Anaemia, leukaemia, or any other disease or disorder of the blood or lymph nodes? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **l** | Any disease or disorder of the eyes, ears, nose or throat? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **2** | | Have you ever had any indication of, been told you have, or have you ever received treatment or advice for AIDS (acquired immune deficiency syndrome), ARC (aids related complex), or any immunological disorder; or had a positive blood test for antibodies to HIV (human immunodeficiency virus)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **3** | **a** | In the last five (5) years, have you been examined by or consulted a physician or other health care professional, received advice, treatment or medication, or been hospitalized for any disease or disorder not included in Question #1, on pages **2** and **3**? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **b** | Have you ever been advised to undergo investigation or have treatment, testing or consultation which has not yet been completed, or are you aware of any symptom, complaint or health-related disorder for which you have not yet sought treatment or consulted a health care professional? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **c** | In the last two (2) years, have you had any illness or injury which resulted in your absence from work for ten (10) consecutive days or more? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **d** | Are you currently receiving any medical advice, treatment or medication? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **4** | | Do you currently participate in any hazardous activities such as auto racing, hang gliding, rock climbing, aircraft flying or SCUBA diving below 50 feet? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **5** | | **Height and Weight:**<br>Employee's Current Height: _____ ☐ ft/in ☐ cm<br>Employee's Current Weight: _____ ☐ lb ☐ kg<br>If any change in weight of more than 15 lb/7 kg in the past 12 months, state amount and reason: _____<br>Spouse's Current Height: _____ ☐ ft/in ☐ cm<br>Spouse's Current Weight: _____ ☐ lb ☐ kg<br>If any change in weight of more than 15 lb/7 kg in the past 12 months, state amount and reason: | | |

| | | | Employee | Spouse (if applicable) |
|---|---|---|---|---|
| **6** | **a** | Have you ever had any application for life, disability, health or any other form of insurance (whether Individual or Group) declined, postponed, rated, cancelled or modified in any way? If yes, provide date(s), reason(s) and name(s) of insurance company(ies). | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **b** | Have you ever received benefits, compensation or pension because of an illness or injury? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **7** | | In the past 12 months have you used cigarettes, e-cigarettes, vaping products, more than one large cigar per month, water pipes, betel nuts more than once per month, smoking cessation products or nicotine or tobacco in any other form? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **8** | | 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 | ☐ Yes ☐ No |
| **9** | | Have you ever been advised to reduce your alcohol consumption or been treated for the excessive use of alcohol? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **10** | | Have you any family history of an inherited or familial disease or condition, including heart or kidney disease, stroke, diabetes, cancer, multiple sclerosis, Alzheimer disease, Huntington disease or motor neuron disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **11** | **a** | **This question is for a Female Employee or Female Spouse (if applicable):** Have you ever had a miscarriage, preeclampsia, toxaemia, caesarean section or other complication of pregnancy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | **b** | Are you currently pregnant? If yes, provide expected delivery date. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **12** | | **This question is for Employees applying for Dependant Coverage:**<br>Have any of your eligible Dependent Children been treated for or been given any indication of having any of the following: heart trouble, high blood pressure, cancer or tumours, kidney problems, disease or disorder of the stomach, back problems, a nervous or mental condition, respiratory problems, AIDS, alcoholism, drug dependency, or any other physical or mental disorder?<br>Name of child, condition, date and treatment: | (Employee to Respond)<br>☐ Yes ☐ No | |

**Details of "Yes" Answers**

| Question Number | Details | Date (dd/mm/yyyy) | Attending Physician's Name and Address |
|---|---|---|---|
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## Back and Neck Disorder Questionnaire

**If you answered Yes to question 1e, please complete this questionnaire.**

| | | | |
|---|---|---|---|
| **1** | | Have you ever had any type of back or neck pain or discomfort or any other neck or back related symptom or complaint or have you ever had any indication of or been treated for any disease or disorder of the back or neck?<br>**If yes, please answer all questions below.** | ☐ Yes ☐ No |
| **2** | | Specify area involved: ☐ Neck (cervical) ☐ Upper/middle (thoracic) ☐ Low (lumbar – waist and below)<br>**If more than one area is involved, please complete a separate questionnaire for each area affected.** | |
| **The following details relate to the ☐ Neck (cervical) ☐ Upper/middle (thoracic) ☐ Low (lumbar – waist & below)** | | | |
| **3** | **a** | How many episodes of back or neck pain or discomfort or related symptoms have you had? | |
| | **b** | Date of first episode: | |
| | **c** | Describe symptoms of the first episode: | |
| | **d** | How long did the symptoms of the first episode last? | |
| | **e** | What was the final diagnosis? | |
| | **f** | Date of the last episode: | |
| | **g** | Describe the symptoms of the last episode: | |
| | **h** | How long did the symptoms of the last episode last? | |
| | **i** | What was the final diagnosis for the last episode? | |
| | **j** | What was the longest duration of symptoms for all episodes? | |
| **4** | | Have you ever had any back or neck related numbness or tingling or radiation of pain to other parts of your body?<br>**If yes,** indicate date(s) and area(s) involved: | ☐ Yes ☐ No |
| **5** | **a** | Have any diagnostic tests been completed?<br>**If yes,** specify type(s), date(s), and results:<br>☐ X-ray studies<br>☐ CT scan<br>☐ MRI<br>☐ Bone scan<br>☐ Other (specify) | ☐ Yes ☐ No |
| | **b** | Have any tests or investigations been recommended?<br>**If yes,** specify nature of test(s) or investigation(s) and date(s) scheduled: | ☐ Yes ☐ No |
| **6** | **a** | Have you ever had epidural steroid injections or treatment at a pain clinic?<br>**If yes,** indicate date(s) and name(s) and address(es) of doctor(s) or medical facility(ies): | ☐ Yes ☐ No |
| | **b** | Have you ever had chiropractic manipulation or treatment?<br>**If yes,** provide details:<br>1. Date(s), frequency and duration of treatment: _____<br>2. Date of last chiropractic consultation: _____<br>3. Name and address of chiropractor(s): _____ | ☐ Yes ☐ No |
| | **c** | Have you ever had physical therapy or any other form of treatment for this condition?<br>**If yes,** indicate type(s), date(s) and duration of treatment, name(s) and address(es) of provider(s): | ☐ Yes ☐ No |

**(continued on following page)**

## Back and Neck Disorder Questionnaire, continued

| | | |
|---|---|---|
| **7** | Have you ever been prescribed medication for any back or neck condition or symptom?<br>**If yes,** provide details including name(s) of medication(s) and date(s) prescribed: | ☐ Yes ☐ No |
| **8** | Have you ever been hospitalized for any back or neck condition or symptom?<br>**If yes,** indicate date(s), duration, reason, name and address of hospital(s): | ☐ Yes ☐ No |
| **9** | Have you been told you may need surgery at some time in the future?<br>**If yes:**<br>a) Specify type of surgery: _____<br>b) Has surgery been scheduled? If so specify date: _____ | ☐ Yes ☐ No |
| **10** | Have you ever lost any time from work due to back or neck related symptoms?<br>**If yes,** provide details including dates and duration of time off work: | ☐ Yes ☐ No |
| **11** | Have your job duties or daily activities ever been restricted or modified in any way because of this condition?<br>**If yes,** describe restrictions, modifications or limitations: | ☐ Yes ☐ No |
| **12** | Do you have any ongoing symptoms?<br>**If yes,** describe symptoms:<br>**If no,** how long have you been completely free of any neck or back related symptoms? _____ | ☐ Yes ☐ No |
| **13** | Other than those already declared, please provide the full names and addresses of all doctors, health care professionals, hospitals or health care facilities consulted for this condition and the dates of consultations: | |

## Mental Health Questionnaire

**If you answered Yes to question 1h, please complete this questionnaire.**

**1** Please specify/describe all current and past symptoms, history or diagnosis of (tick off appropriate boxes):

| | | | |
|---|---|---|---|
| ☐ Stress | ☐ Fatigue, exhaustion | ☐ Marriage/family counselling | ☐ Bipolar disorder |
| ☐ Anxiety | ☐ Chronic fatigue | ☐ Attention deficit disorder | ☐ Suicidal thoughts or attempts |
| ☐ Depression | ☐ Major depression | ☐ Concentration problems | ☐ Psychosis/hallucinations |
| ☐ Burn out | ☐ Panic attack(s) | ☐ Memory problems | ☐ Anger management problems |
| ☐ Insomnia | ☐ Adjustment disorder | ☐ Agoraphobia | ☐ Seasonal affective disorder |
| ☐ Dysthymia | ☐ Bulimia | ☐ Post traumatic stress | ☐ Generalized anxiety disorder |
| ☐ Phobia(s) | ☐ Anorexia nervosa | | |

☐ Counselling for (specify): _____

☐ Other (describe):

**2** Have you experienced any symptoms within the last 12 months? ☐ Yes ☐ No

**If yes,** describe all symptoms:

**If no,** how long have you been completely symptom-free? _____

**3** a) Date of onset of your initial symptoms: _____

b) Cause(s) of symptoms

c) How many separate occurrences or episodes of symptoms have you had? _____

d) What was the duration of each occurrence or episode?

**4** Has your physician given you a diagnosis? ☐ Yes ☐ No

**If yes,** provide full details, including the date a diagnosis was given:

**5** Have you taken medication, prescribed or non-prescribed, or received treatment in the past 12 months? ☐ Yes ☐ No

**If yes,** provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment and the date treatment was first recommended:

**6** What other medication(s) or treatment has been prescribed in the past? Provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment, the date treatment was first recommended, and the date and reason medication(s) or treatment was discontinued:

**7** Have you been referred to a psychiatrist or psychologist for this condition? ☐ Yes ☐ No

**If yes,** provide full name(s) and address(es) of those consulted, date of first consultation, frequency of follow-up visits and date of the last consultation:

**8** Have you ever consulted an emergency room or been hospitalized for this condition? ☐ Yes ☐ No

**If yes,** provide date(s), reason(s) and name and address of hospital(s):

**(continued on following page)**

## Mental Health Questionnaire, continued

| | | |
|---|---|---|
| **9** | Have you ever had any suicidal thoughts or attempts?<br>**If yes,** provide dates and details: | ☐ Yes ☐ No |
| **10** | Have you ever lost any time from work due to this condition?<br>**If yes,** provide details including dates and duration of time off work: | ☐ Yes ☐ No |
| **11** | Have your job duties or daily activities ever been restricted or modified in any way because of this condition?<br>**If yes,** describe restrictions, modifications or limitations: | ☐ Yes ☐ No |
| **12** | Other than those already declared, please provide the names and addresses of all physicians, psychiatrists, psychologists, counsellors, mental health care providers, other health care practitioners, hospitals or facilities consulted for this condition and include details and duration of treatment: | |

## SECTION 5: DECLARATION

### EMPLOYEE STATEMENT

I hereby declare that the above answers and statements that I have given in this Evidence of Insurability Form are, to the best of my knowledge and belief, full, complete and true as of this date, and that any misstatements or failure to report information may be used as the basis for a rescission of my insurance. I understand and agree that they are material to the risk and form part of the Application and consideration for the insurance I am applying for. I further understand that if the insurance applied for becomes effective, it will be subject to the terms and conditions of the group policy.

**Signature of Employee:** _____ **Date:** _____

### SPOUSE STATEMENT (if applicable)

I hereby declare that the above answers and statements that I have given in this Evidence of Insurability Form are, to the best of my knowledge and belief, full, complete and true as of this date, and that any misstatements or failure to report information may be used as the basis for a rescission of my insurance. I understand and agree that they are material to the risk and form part of the Application and consideration for the insurance I am applying for. I further understand that if the insurance applied for becomes effective, it will be subject to the terms and conditions of the group policy.

**Signature of Employee's Spouse:** _____ **Date:** _____

## SECTION 6: AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand and authorize RBC Life Insurance Company and its reinsurers (hereinafter collectively referred to as "RBC Life") to gather personal information concerning me and to disclose, as necessary, to third parties the fact that I am seeking insurance coverage from RBC Life.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to RBC Life any information, records or other data regarding me and my medical history or treatment, or my past and present income or employment, which they have in their possession or control.

Persons to whom this Authorization applies: Any physician, nurse, counselor, psychologist, pharmacist, physiotherapist, chiropractor or other rehabilitation professional or other health care 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 company or other financial institution or insurance broker or administrator; and also my employer or former employers and any of their agents performing services relating to any employee benefits; and also any federal or provincial government department or organization, including the Workers' Compensation Board/Workplace Safety and Insurance Board and the federal or provincial income tax authorities; and also to any other organization, institution or person having information, records or data regarding me, my medical history or treatment or my past and present income and employment.

I understand that any information, records or data received by RBC Life pursuant to this authorization will be used for the purpose of determining eligibility for coverage under group insurance offered by my employer (underwriting), for the purpose of administering the group insurance policy(ies) arranged through my employer or for the evaluation of any claim for benefits.

To the extent reasonably necessary for this purpose, I authorize RBC Life to disclose any of the said information, records or data received to other insurance companies or any reinsurer; or to my employer and its insurance brokers or advisors or its benefit plan administrators; or to any other person or firm employed or engaged by RBC Life.

If this application is being made on behalf of my dependant(s), I am authorized to disclose information about them, for the purposes of underwriting, administration or adjudication of claims. I confirm that RBC Life is authorized to disclose information about this application to me, for the purposes of assessing this application and managing my group benefits plan.

A photocopy of this authorization, as executed by me, shall be as valid as the original and shall continue to have effect throughout the duration of my coverage under the group coverage offered by my employer.

**Signature of Employee:** _____ **Date:** _____

**Signature of Employee's Spouse** (if applying): _____ **Date:** _____

## SECTION 6: AUTHORIZATION FOR DISCLOSURE OF INFORMATION

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I authorize and direct the persons, institutions and organizations listed below to disclose and provide to RBC Life any information, records or other data regarding me and my medical history or treatment, or my past and present income or employment, which they have in their possession or control.

Persons to whom this Authorization applies: Any physician, nurse, counsellor, psychologist, pharmacist, physiotherapist, chiropractor or other rehabilitation professional or other health care 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 company or other financial institution or insurance broker or administrator; and also my employer or former employers and any of their agents performing services relating to any employee benefits; and also any federal or provincial government department or organization, including the Workers' Compensation Board/Workplace Safety and Insurance Board and the federal or provincial income tax authorities; and also to any other organization, institution or person having information, records or data regarding me, my medical history or treatment or my past and present income and employment.

I understand that any information, records or data received by RBC Life pursuant to this authorization will be used for the purpose of determining eligibility for coverage under group insurance offered by my employer (underwriting), for the purpose of administering the group insurance policy(ies) arranged through my employer or for the evaluation of any claim for benefits.

To the extent reasonably necessary for this purpose, I authorize RBC Life to disclose any of the said information, records or data received to other insurance companies or any reinsurer; or to my employer and its insurance brokers or advisors or its benefit plan administrators; or to any other person or firm employed or engaged by RBC Life.

If this application is being made on behalf of my dependant(s), I am authorized to disclose information about them, for the purposes of underwriting, administration or adjudication of claims. I confirm that RBC Life is authorized to disclose information about this application to me, for the purposes of assessing this application and managing my group benefits plan.

A photocopy of this authorization, as executed by me, shall be as valid as the original and shall continue to have effect throughout the duration of my coverage under the group coverage offered by my employer.

**Signature of Employee:** _____ **Date:** _____

**Signature of Employee's Spouse** (if applying): _____ **Date:** _____

Please send the completed form using one of the following options:

Email: MedicalUnderwritingSupport@rbc.com
Mail: Please place in an envelope marked "Private and Confidential" and retain a copy for your records.

RBC Life Insurance Company
Tower 1, 8th Floor, 6880 Financial Drive
Mississauga ON L5N 7Y5

## COLLECTION AND USE OF PERSONAL INFORMATION

### Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about the employer and the employees (collectively "clients") such as:

- information establishing identity (for example, name, address, phone number, date of birth, etc.) and personal background;
- information related to or arising from the relationship with and through us;
- information provided through the application and claim process for any insurance products and services; and
- information for the provision of products and services.

We may collect information from the employer or the employee, 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, Inc., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions and motor vehicle reports. Health information will not be shared with the employer without the consent of the employee.

### Using personal information

This information may be used from time to time for the following purposes:

- to verify the identity and investigate the background of the employer and employee;
- to issue and maintain insurance products and services that may be requested;
- to evaluate insurance risk and manage claims;
- to better understand the insurance situation of our clients;
- to determine eligibility for RBC insurance® products and services;
- to help us better understand the current and future needs of our clients;
- to communicate to our clients any benefit, feature and other information about RBC® products and services maintained with us;
- to help us better manage our business and the relationship with our clients; 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. If you are insured under a group insurance policy obtained through your employer, we may also share your information with your employer when necessary for the services we provide to you. Your health information will not be shared with your employer without your consent.

In the event our service provider is located outside of 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, Inc., 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 and (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.

**If we have a client's social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.**

### Right to access of personal information

Our clients may obtain access to the information we hold about them 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 or to ask questions about our privacy policies, the employee 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 asking for a copy of our "Financial fraud prevention and privacy protection" brochure, by calling us at the toll free number shown above or by visiting our web site at www.rbc.com/privacysecurity.