

The Fundamental Series® Disability Income Protection Injury Application



Insurance

This application is for Injury coverage only. If applying for Illness coverage, please also complete the Fundamental Series Illness Insurance Application form.

To be used for NEW policies ONLY.

Requests for changes to existing coverage:

- **Within 60 days of the coverage effective date – complete the Application for Reissue**
- **Over 60 days from the coverage effective date – complete the Application for Policy Change or Reinstatement**

FRANCHISE NUMBER (if applicable):

1. PROPOSED INSURED

Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other ☐ Specify Female ☐ Male ☐

First Name Middle Last

Date of Birth (dd/mm/yyyy)

Address: Apt # Number Street

City Province Postal Code

Home Telephone Number Cell Phone Number

Email Address

Do you understand English and/or French? Yes ☐ No ☐

If No, please complete and submit a Statement of Understanding in the language of your preference

Quebec Residents Only: Is the insurance you are applying for replacing or modifying any existing or pending individual disability insurance? Yes ☐ No ☐ If Yes, please complete and submit Disclosure forms.

1. a) Is this application part of the **Student Savings Program**? Yes ☐ No ☐

If Yes, the maximum monthly benefit is \$2,000.

1. b) If Yes to 1. a), are you registered with a certified college and/or regulatory body for your vocation? Yes ☐ No ☐

If Yes, Pre-Qualifying Question #2b may be answered No without impacting coverage availability.

If No, coverage under the Student Savings Program is not available.

1. c) Is this application part of an employer paid **Wage Loss Replacement Plan**? Yes ☐ No ☐

If Yes, submit a Wage Loss Replacement Plan Amendment A694 and complete the Ownership section of this application.

Please use the exact occupation wording as stated in the Rate Guide.

Do you work in any other occupation more than 15% of your time? Yes ☐ No ☐

If Yes, please also provide the secondary occupation.

Primary Occupation

Secondary Occupation

Describe the nature of the business

Describe the nature of the business

Describe your duties

Describe your duties

Percentage of office/clerical duties

Percentage of office/clerical duties

Percentage of manual duties

Percentage of manual duties

If you are a driver (primary or secondary occupation), please complete the following section.

What type of driver are you? What is your cargo?

What percentage of your occupation consists of manual duties? Less than 15% ☐ More than 15% ☐

If there is more than one occupation indicated above, please use the lower of the occupational ratings. (Class 1 is the highest.)

Occupational Rating¹: Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ Class 5 ☐ Class 6 ☐

Are you covered by any worker's compensation plan? Yes ☐ No ☐ If No, 24 hour coverage is mandatory.

If Yes, you may wish to consider non-occupational coverage only.

2. PRE-QUALIFYING QUESTIONS

a) Do you have any ongoing restrictions or limitations to your bodily movements or daily activities as a result of an injury or other condition? **If Yes, coverage is not available.** Yes ☐ No ☐

b) Are you currently working a minimum of 20 hours per week, 35 weeks per year? **If No, coverage is not available.** Yes ☐ No ☐

c) Are you a Canadian citizen or have you been granted Permanent Resident (landed immigrant) status by the Canadian government? **If No, coverage is not available.** Yes ☐ No ☐

¹ See the Feature Summary for more information on these terms.

3. LOSS OF INCOME CALCULATION (Complete only if applying for Loss of Income coverage. If applying for coverage under the Student Savings Program, completion of line (A) is not required.)

Employees Enter your annual Employment Income¹: (A) \$

Self-Employed Enter either your annual Business Income¹ plus your annual Employment Income¹ from the business or 50% of your annual Gross Revenue¹: (A) \$

Enter the Maximum Eligible Monthly Benefit from the Benefit Determination Chart based on the amount listed in (A):

(If applying as part of an employer paid Wage Loss Replacement Plan, use the Taxable Benefit Determination Chart.)

(If applying under the Student Savings Program, the maximum monthly benefit is \$2,000). (B) \$

Enter the monthly amount of any disability insurance that you are maintaining from all sources: (C) \$

Total maximum Monthly Benefit (B subtract C): (D) \$

4. BUSINESS OVERHEAD EXPENSE (BOE) CALCULATION (Complete only if applying for Business Overhead Expense coverage)

Monthly Amounts	
Lease Payments	\$
Property Rent	\$
Professional and Accounting Fees	\$
Insurance Premiums	\$
Utilities	\$
Other Fixed Expenses (Please list)	\$
	\$
	\$

Total Monthly BOE Expenses (E) \$

Enter the monthly amount of any business overhead disability insurance that you are maintaining from all sources:

(F) \$

Total maximum Monthly BOE Benefit (E subtract F): (G) \$

5. INJURY COVERAGE APPLIED FOR

Loss of Income – Injury Coverage

Coverage Type: 24 Hour ☐ Non-Occupational ☐

Benefit Period: 5 Years ☐ To Age 70 ☐

Elimination Period: 0 Days ☐ 30 Days ☐ 90 Days ☐ 120 Days ☐

Monthly Benefit Requested: (Cannot exceed the lesser of the class maximum issue limit or the amount in (D) above): \$

Coverage is available in \$100 increments with a minimum of \$500 per month required.

Accidental Death and Dismemberment (AD&D)

Benefit Requested: \$100,000 ☐ \$200,000 ☐ \$300,000 ☐ \$400,000 ☐ \$500,000 ☐

Coverage Type (for AD&D): With AMER² ☐ Without AMER ☐

Beneficiary of the Accidental Death and Dismemberment benefit (only required if applying for AD&D coverage). If no beneficiary designation is provided, benefits will be payable to the estate of the insured.

Beneficiary Name Relationship to Proposed Insured

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

Except in the Province of Quebec, if you have designated a beneficiary who is a minor (under the age of 18), a trustee should be named in order to avoid payment of the proceeds into court. In Quebec, benefits payable to minors are paid to the surviving parent(s) as tutor(s).

Name of Trustee Relationship to Proposed Insured

Business Overhead Expense – Injury Coverage

Monthly Benefit Requested: (Cannot exceed the lesser of the class maximum issue limit or the amount in (G) above, plus 25%): \$

Coverage is available in \$100 increments with a minimum of \$500 per month required.

The Benefit Period for injury BOE coverage is 12 months and the Elimination Period is 30 days.

¹ See the Feature Summary for more information on these terms.

² Accidental Medical Expense Reimbursement Benefit.

OWNERSHIP Complete if the owner is not the Proposed Insured. This must be completed if Wage Loss Replacement Plan is selected.

_____	Address _____
Print legal name of Proposed Owner	
_____	Address _____
Print legal name of Contingent Owner	
Email address (if owner is not the proposed insured) _____	
To Whom should correspondence be sent? _____	

6. PREMIUM PAYMENT – PRE-AUTHORIZED DEBIT (PAD)

Please select payment frequency: Monthly (PAD) ☐ or Annual (PAD) ☐

I/we hereby request and authorize RBC Life Insurance Company (RBC Insurance) to debit my/our account provided below to pay the premiums, pursuant to the Pre-Authorized Debit Agreement as outlined in the Feature Summary. I authorize RBC Insurance to withdraw the initial premium required to place the coverage into effect, immediately on the receipt of the application by RBC Insurance. Thereafter, RBC Insurance will withdraw the premiums on the date the premiums are due, or the date I/we have selected below. The names and signatures of all persons required to authorize withdrawals from the account are indicated below.

Special Withdrawal Date (Only applies to **Monthly (PAD)** payment frequency): Instead of withdrawing the monthly premiums on the date they are due, after the initial premium has been paid, please withdraw the premiums on the _____ of each month (limited to the 1st to 28th).

Bank Information (Please attach a cheque marked “VOID” – A line of credit account cannot be used.)

YOUR COMPANY NAME BY YOUR STREET YOUR CITY, PROVINCE A1B1C3		0001
DATE		D M Y Y Y Y
PAY to the order of		\$
YOUR FINANCIAL INSTITUTION 456 BANK STREET YOUR CITY, PROVINCE A1B1C3		DOLLARS
RE: _____		PER _____
⑈0001⑈ 123456789012345⑈		

Please use the banking information:

- ☐ From the attached void cheque, or
☐ From the information below

Transit Number Bank Number Account Number

_____	_____	_____	_____
Name of Bank or Financial Institution	Transit Number (5 digits)	Bank Number (3 digits)	Account Number
_____		_____	
Print Name of Payor (Account Holder)		Print Name of Second Payor (Account Holder) (if any)	
_____		_____	
Signature of Payor		Signature of Second Payor (if any)	

7. AGREEMENT

I declare that all statements and answers in all parts of this application are full, complete and true, and agree that:

- A) Insurance will take effect on the date of this application (the 1st of the following month in which the application was signed if the application was signed on the 29th, 30th or 31st of the month) provided that the first premium payment is honoured on presentation by RBC Life Insurance Company (RBC Insurance).
- B) I acknowledge having received and been advised to read the Feature Summary, which contains some of the key definitions, exclusions and limitations applicable to the coverage being applied for, as well as the “Collection and Use of Personal Information” privacy statement outlining the collection, use and disclosure of my personal information. I have also been advised to carefully review my policy contract when issued for a complete understanding of the terms, conditions, definitions, exclusions and limitations of the policy.
- C) If I have provided personal information about any other person, I confirm that I have obtained appropriate consents, in compliance with applicable privacy laws, to provide the information and for the information to be used for the necessary purposes.
- D) There are limits to the Monthly Benefit amounts that RBC Insurance will issue to any one person under the Fundamental Series (RBC Insurance refers to these limits as their “Issue Limits”). Monthly Benefits for Loss of Income are limited to \$6000 for classes 1 and 2 (\$8500 if a taxable Wage Loss Replacement Plan is selected), and to \$5000 for classes 3, 4, 5 and 6 (\$6500 if a taxable Wage Loss Replacement Plan is selected). Monthly Benefits for Business Overhead Expenses are also limited to \$6000 for classes 1 and 2, and to \$5000 for classes 3, 4, 5, and 6. If I already have a Fundamental Series policy and RBC Insurance issues another Fundamental Series policy to me and the combined insurance under the two Fundamental Series policies inadvertently exceeds the Issue Limits, the insurance issued in response to this application will be reduced so that the combined insurance does not exceed the Issue Limits. In this event, RBC Insurance will refund to me any premium paid for the excess insurance.
- E) There is also a limit to the amount of insurance that RBC Insurance will provide to any one person when combined with that person’s other disability insurance (other than the Fundamental Series). RBC Insurance refers to this limit as their “Participation Limit”. This Participation Limit is based on three things: it is based on the income that I declared in my application; it is based on any other disability coverage that I already have or that I have applied for; and it is based on the maximum amounts that RBC Insurance will provide in combination with that other disability coverage. I agree that RBC Insurance does not need to notify me if the amount that RBC Insurance issues is lower than the amount I have applied for. If I accept the policy with an amount of coverage that is lower than the amount I applied for, my acceptance will mean that I agree to the lower amount of coverage.
- F) RBC Insurance may be entitled to render my policy null and void if there is any misrepresentation or non-disclosure in any part of the application for insurance.

AGREEMENT (continued)

- G) No statement made to and no information acquired by a representative of RBC Insurance shall be attributed to or binding upon RBC Insurance unless contained in this application. No one other than an Officer of RBC Insurance may (a) alter or modify the terms of this application or any policy issued or (b) waive any rights or requirements of RBC Insurance.
- H) Quebec residents only: I acknowledge that I was offered the choice to enter into the agreements related to this insurance in English or in French and that I expressly requested to enter into a version of the agreements drawn up exclusively in English, after being provided the French version of these agreements. Therefore, I expressly agree that the agreements governing the Insurance and all of their related documents, including notices, be drawn up exclusively in English.
- Résidents du Québec seulement : Je reconnais qu'on m'a offert le choix de conclure les conventions liées à cette assurance en français ou en anglais et que j'ai expressément demandé à ce que ces conventions soient rédigées exclusivement en anglais, après avoir reçu leur version française. Par conséquent, je consens expressément à ce que les conventions régissant l'assurance et tous les documents qui s'y rattachent, y compris les avis, soient rédigés exclusivement en anglais.

Signed at this day of Year
(city/province) (day) (month)

Signature of Proposed Insured

Signature of Proposed Owner

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

ADVISOR'S REPORT

1. The Proposed Insured is an employee of RBC and qualifies for the Colleagues as Clients Discount. ☐

2. **Advisor's Declaration:**

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

Date		
Advisor's Signature		
Advisor's Name		
Advisor's Company Name		
Marketing Office/MGA		
Share	%	Servicing Advisor Code: % Advisor Code: