Application for Insurance
Part 2

Insurance

Name _____ _____ _____ Application/Policy No: _____
First Middle Last

Date of Birth _____
(DD/MM/YYYY)

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

If Yes, provide details.

Date Started	Date Ended	EI	Disability	WSIB	Other
		☐	☐	☐	☐ Describe
		☐	☐	☐	☐ Describe

2. Have You within the past 24 months been a student pilot, or piloted a plane, ultra-light or glider, or do You have any intention of doing so in the future? . . . . . Yes ☐ No ☐

If Yes, Provide details.

Total number of solo hours	Type(s) of aircraft (i.e. single/ multi-engine, home built etc.)	Type(s) of flying (i.e. crop dusting, water bombing, mapping etc.)	Next 12 months (hours)	Past 24 months (hours)

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

If Yes, provide details.

Dates	Countries/Cities	Length of Stay	Reason

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

If Yes, Provide details.

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

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 Have You ever had life, disability or critical illness insurance rated, modified, rejected, rescinded, or have You been denied renewal or reinstatement?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

If Yes, provide details.

Type of Insurance	Rated	Modified	Rejected	Rescinded	Denied Renewal or Reinstatement	Insurance Company	Reason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

6. Have You within the past 10 years been convicted of any criminal offence, or are there any such charges pending? . . . . . Yes ☐ No ☐

If Yes, provide details.

Date of Incident	Details Including Outcome

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

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

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

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.

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

Name of Medication	Dose Amount	Frequency Taken	Date Started

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

If Yes, please provide details:

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

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

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

13. Was any follow-up, further investigation or referral to another healthcare professional recommended? . . . . . Yes ☐ No ☐

If Yes, please provide details:

14. Current Height ☐ ☐cm ☐ft Current Weight ☐ ☐kg ☐lb
Have You lost 10 lb/5 kg or more within the past year? . . . . . Yes ☐ No ☐

If Yes:

Reason	Amount Lost
	☐ kg ☐ lb

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

Product Type (cigars, cigarettes, vaping, etc.)	Quantity and Frequency of Use	Date Last Used	Details of Smoke Cessation Therapy (type, date last used)

16. Have You used marijuana or hashish within the past 5 years? . . . . . Yes ☐ No ☐

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

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

If Yes, provide details.

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

Details must include conditions, symptoms, duration, results, treatment, medication, date of onset, name of healthcare provider, follow-up required, and date of recovery.

Have You:

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

Details

19. 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 ☐

Details

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

Details

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

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

Details

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

Details

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

Details

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

Details

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

Details

f. Any disease or disorder of the kidneys, urinary tract, bladder, prostate, or genital organs, or kidney stones, or albumin, blood, or sugar in the urine? . . . . . Yes ☐ No ☐

Details

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

Details

Details must include conditions, symptoms, duration, results, treatment, medication, date of onset, name of healthcare provider, follow-up required, and date of recovery.

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

Details

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

Details

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

Details

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

Details

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

Details

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

Details

n. Any arthritis, disease or disorder of the muscles, bone, hip, ankle, knee, wrist, elbow, shoulder, hands, feet or any other joint? . . . . . ☐ ☐

Details

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

Details

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

Details

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

Details

Details must include conditions, symptoms, duration, results, treatment, medication, date of onset, name of healthcare provider, follow-up required, and date of recovery.

Other than the information provided in questions 8-21, have You in the past 10 years:

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

Details

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

Details

c. Had an X-ray, ECG, CT scan, MRI, blood or urine test, abnormal PSA (Prostate Speci ic Antigen), or other diagnostic tests? . . . . . Yes ☐ No ☐

Details

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

Details

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

Details

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

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

Female Applicants Only

24. a. Have **You** ever had a miscarriage, or other complication of pregnancy? . . . . . Yes ☐ No ☐

b. Any complications with your most recent pregnancy? . . . . . Yes ☐ No ☐

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

If Yes, provide due date.

Details must include conditions, symptoms, duration, results, treatment, medication, date of onset, name of healthcare provider, follow-up required, and date of recovery.

As needed, provide additional details below to any Yes answer.

Question #	

I certify that to the best of my knowledge the answers given to the foregoing questions are full, complete and true, and agree that they shall form part of my insurance application to RBC Life Insurance Company.

Dated at _____ this _____ day of _____ , _____
City, Province Month Year

_____
Signature of Proposed Insured