



# RBC Life Insurance Company Multi-Life Enrollment Form

Graduation Plan

GROUP NAME		DATE OF BIRTH		SOCIAL INS. #		SEX		LANGUAGE	
Canadian Federation of Medical Students		Mo ____ Day ____ Yr ____							
NAME OF PROPOSED INSURED			FIRST	MIDDLE	LAST		PROPOSED INSURED TELEPHONE NO.		
DR.									
CURRENT ADDRESS				CITY		PROVINCE		POSTAL CODE	
PERMANENT ADDRESS (example: parents)				CITY		PROVINCE		POSTAL CODE	
PROPOSED INSURED EMAIL ADDRESS (PERMANENT)				NAME OF BENEFICIARY FOR SURVIVOR BENEFIT			RELATIONSHIP TO INSURED		
PROGRAM MATCHED TO:			UNIVERSITY MATCHED TO:			RESIDENCY GRADUATION YEAR:			
QUESTIONNAIRE:									
1. For the period of time commencing 180 days prior to the date of this enrollment form, are you now or have you been unable to work continuously on a full-time basis in the usual and customary manner performing all of the duties of your occupation and/or have you been homebound and/or hospitalized due to an accident or sickness?								Yes	No
								<input type="checkbox"/>	<input type="checkbox"/>
2. Do you currently have the loss of: your power of speech, or your hearing in both ears, or sight in both eyes, or the use of both hands, or the use of both feet, or the use of one hand and one foot?								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>
3. Have you used tobacco products including any smoking cessation products within the past 12 months?								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>
4. Has an individual, group or association insurance company ever declined you disability coverage?								<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>
Details to "YES" answers:									
#									
#									
OTHER DISABILITY INSURANCE IN FORCE OR APPLIED FOR (INCLUDING INDIVIDUAL, GROUP OR ASSOCIATION) IF NONE, INDICATE NONE									
COMPANY	WAITING PERIOD	BENEFIT PERIOD	BENEFIT AMOUNT	TAXABLE?	TYPE -ID/GROUP/ASSOC.	REPLACING or MAKEOVER?	EFF. DATE OF LAPSE or M/O		
RBC INSURANCE APPLIED FOR									
PLAN NAME		WAITING PERIOD	BENEFIT PERIOD	BENEFIT AMOUNT	OPTIONAL BENEFITS		EFFECTIVE DATE OF COVERAGE REQUESTED		
The Professional Series Plan Level or Step - Circle One Group Offset Discount? Y or N - Circle One		90 days	To age 65	\$ _____	FIO \$ _____ COLA HCR OWN OCC? Y or N - Circle One		MONTH: _____ * PAC form and Void Cheque, along with first months premium must be submitted for processing		
It is understood and agreed as follows:									
1) I have read the foregoing statements and answers. They are true and complete. They are part of this application and any individual policy issued as a result.									
2) I will discontinue any policy(ies)/coverage shown to be discontinued or replaced. RBC Life Insurance Company ("RBC Insurance") will rely on such answers in determining the amount, if any, of insurance it will issue.									
3) No agent or broker has authority to waive the answer to any question, to determine insurability, to waive any rights or requirements or to make or alter any contract or policy.									
4) The insurance applied for will not become effective unless the issuance of the policy and payment of the first premium occur while the foregoing statements and answers remain the same.									
5) Any policy issued as a result of this form shall become effective (a) on the Date of Issue of the policy, if applicable; and (b) otherwise on the effective date of my group insurance.									
6) Acceptance of any policy issued as a result of this enrollment form will ratify my acceptance of any differences in the terms of coverage between the policy wording and as stated in this form.									
7) RBC Insurance shall not be liable for any claim on account of disability commencing prior to the effective date of insurance. Notwithstanding any interim premium payments, no temporary or conditional insurance is being provided to me.									
8) Any policy issued as a result of this application shall be subject to a group/association offset amendment and a pre-existing conditions amendment (which contains a coverage exclusion based on my pre-existing health), if applicable. Also, if individual coverage is part of a Wage Loss Replacement Plan, the policy is subject to a Wage Loss Replacement Amendment.									
9) I hereby authorize RBC Insurance to use my Social Insurance Number specifically for any tax reporting purposes.									
10) I acknowledge receipt of the Notice of Medical Information Bureau.									
11) I authorize RBC Insurance to release, to the appointed agent of record on this GSI offer, information limited to relevant details of my in force coverage for the purpose of determining the appropriate level of coverage available through this offer.									
12) I have read the section entitled Your Privacy Matters to Us and understand and agree to its terms.									
SIGNATURE:									
Proposed Insured: _____					Date _____				

For a personalized quotation and further information regarding this plan, contact our authorized consultants:

Daniel MacLellan  
MacLellan & Moffatt Financial  
(902) 431-2586 ph  
(902) 488-9995 cell  
(902) 892-6126 fax  
DMacLellan@mmfi.ca

## Pre-Authorized Payment Plan

Attach sample cheque or indicate add-to-policy number: \_\_\_\_\_

I (we) authorize RBC Life Insurance Company, and the financial institution, or any other financial institution that I (we) may later designate to withdraw funds from my named below account for the purposes of paying premiums.

A debit in paper, electronic or other form may be drawn on my (our) account beginning immediately. Subsequent premium payments are subject to the provisions of the policy(ies).

I (we) will notify RBC Life Insurance Company, in writing of any changes in the account information or termination of the authorization prior to the next withdrawal date of the pre-authorized payment.

I (we) also understand that should any withdrawal not clear my (our) account for reason of Insufficient Funds, RBC Life Insurance Company, will automatically attempt to withdraw these funds within 10 days of the returned item without prior notification.

I (we) acknowledge that delivery of this authorization to RBC Life Insurance Company, constitutes delivery by me (us) to the noted financial institution.

This agreement may be cancelled by either me (us) or RBC Life Insurance Company, in writing.

Name of Financial Institution: \_\_\_\_\_

Address of Branch: \_\_\_\_\_

Withdrawal Day: \_\_\_\_\_ 1st or 15th only

Signature of Account Holder(s): X \_\_\_\_\_  
(sign here)

X \_\_\_\_\_  
(sign here)

Date: \_\_\_\_\_

MacLellan & Moffatt Financial  
Call Toll Free 1-888-893-0508