WEEKLY INDEMNITY (SHORT TERM DISABILITY) CLAIM FORM
EMPLOYEE'S STATEMENT

To ensure your confidentiality, submit this form with the **Attending Physician's Statement - Short Term Disability Claim** form GH-0054. The **Weekly Indemnity Claim form - Employer's Statement** form - GH-0052 can be submitted separately.

Reset Form

1.

Name of Employer		Group policy, division and certificate number	
Name of Employee (first, middle, last)		Phone number	
Address (street, number)	City	Province	Postal code
Personal email address	SIN (required only if weekly indemnity benefit is taxable)		

2.

Date you last worked (dd/mmm/yy)	Date you first became ill or injured (dd/mmm/yy)	Date you returned or expect to return to work (dd/mmm/yy)

Did this claim result from an accident or injury? ◯ yes ◯ no — if yes, complete the sections below. If no, proceed to section 3.

Is a claim being made to another insurer (e.g. auto insurer, Provincial Workplace Safety Board)? ◯ yes ◯ no — if yes, provide:

Name of insurance carrier		
Adjuster name		Claim number
Phone number	Fax number	Email address

Was the accident or injury due to: ◯ auto* ◯ work ◯ other

Date of accident/injury (dd/mmm/yy)	Time of accident/injury

Where did the accident occur? Provide details of the accident:

If the injury is due to an auto accident, please provide a copy of the police Motor Vehicle Accident (MVA) Report.

3.

Name of Doctor/facility first consulted			Date first consulted (dd/mmm/yy)
Address (street, number)			
City	Province	Postal code	Phone number
Name of other treatment provider(s)			Date first consulted (dd/mmm/yy)
Address (street, number)			
City	Province	Postal code	Phone number

Describe your current symptoms:

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4. Declaration and Authorization

I authorize:

- any health care professionals or practitioners as well as any public or private health or social services institutions, any insurance companies, the Medical Information Bureau, financial institutions, personal information agents, agencies which collect data on risk and losses, bodies having as their object the prevention, detection or repression of crime or statutory offences, market intermediaries, my current employer or my former employers (or any other person whom I have indicated as reference), and any other public or private organizations that have information concerning me, including without limitation any medical information, to provide and exchange this information with The Empire Life Insurance Company (Empire Life), its reinsurers and their respective agents and representatives, for the purposes of (i) assessing and investigating my claim(s); (ii) administering coverage that I may have with Empire Life, including providing rehabilitation assistance; or (iii) complying with the requirements of an audit;
- Empire Life to exchange my contact information and relevant financial information with a third party (including, without limitation, a collection agency), and authorize that third party to use such information, for the purposes of recovering any overpayment of benefits that I received from Empire Life: and
- Empire Life to release to the Policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf, other than specific details relating to my medical condition.

I consent to:

- the use of my Social Insurance Number, where necessary, for tax reporting purposes.

I understand that:

- to maintain the confidentiality of my personal information, Empire Life will establish a file to contain the information provided in the claim. The objective of this file is to enable Empire Life, its reinsurers and their respective agents and representatives to assess, appraise and administer the claim. This file will be kept in the office of Empire Life and only Empire Life employees, agents or representatives will have access to it when performing their duties; and
- Empire Life may use third party service providers located outside of Canada to process and store my personal information. Personal information that is processed or stored outside Canada may be subject to the laws of the jurisdiction outside Canada where the information is processed or stored, which may allow disclosure to courts, law enforcement or other government authorities of that jurisdiction under certain circumstances.
- I may access the most recent Privacy Policy of Empire Life on the Empire Life website at www.empire.ca.

I certify that:

- the answers given in this document and the information in other documents supporting this claim for benefits are true, full and complete.

A photocopy of this Authorization will be as valid as the original.

Employee signature X	**Date** (dd/mmm/yy)

Please return this completed form to:

Life & Disability Claims
Group Solutions
The Empire Life Insurance Company
259 King Street East
Kingston ON K7L 3A8

Toll free phone # 1 800 267-0215
Toll free fax: 1 855 430-9455
Email: grouplifeanddisability@empire.ca

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ATTENDING PHYSICIAN'S STATEMENT - SHORT TERM DISABILITY CLAIM

Employee Information and Consent - TO BE COMPLETED BY THE PATIENT

Name of Employee (first, middle, last)					
Address (street, number)			City	Province	Postal code
◯ Male ◯ Female	Height	Weight	Date of birth (dd/mmm/yy)	Phone number	
Name of Employer			Group policy number	Division number	Certificate number

I hereby authorize the release of medical and health information in my file to The Empire Life Insurance Company and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records.

I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.

I understand that I am responsible for any fees related to the completion of this form.

I agree that a copy or electronic version of this authorization shall be as valid as the original.

Medical and health information excludes genetic test results.

Employee signature X	Date (dd/mmm/yy)

The patient is responsible for any fees related to the completion of this form.

Attending Physician's Statement - TO BE COMPLETED BY THE PHYSICIAN

- If your patient has returned or is expected to return to work within 4 weeks of the last date worked, complete **page 1 only** and sign the end of the form.
- For absences expected to be greater than 4 weeks, please complete **pages 1 and 2 in full**.

Primary diagnosis:

Secondary diagnosis and/or complications:

If childbirth - expected or actual delivery date (dd/mmm/yy)	Occupational illness/injury ◯ yes ◯ no If yes - date of illness/injury:	Auto accident ◯ yes ◯ no If yes - date of accident

Date of first visit to you pertaining to this condition (dd/mmm/yy)	First date of work absence due to this condition (dd/mmm/yy)

Has the patient ◯ been hospitalized or ◯ had day surgery for this condition?

Institution name	Date of admittance (dd/mmm/yy)	Date of discharge (dd/mmm/yy)

If surgery was performed, specify date (dd/mmm/yy) _____ and provide a description of the surgery:

Treatment (drug, dosage, physiotherapy, psychotherapy, etc.)

Prognosis - please provide the prognosis for recovery:

Expected return to work date (dd/mmm/yy):

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Continuation of Attending Physician's Statement - FOR ABSENCES THAT MAY BE GREATER THAN 4 WEEKS

Has the patient been treated for this same or a similar condition in the past? ◯ yes ◯ no — if yes, please state when and describe:

Please describe the patient's current symptoms including history, severity and frequency:

Frequency of visits ◯ weekly ◯ monthly ◯ other _____

Has the patient been advised to have any surgery, tests or consultations not yet completed? ◯ yes ◯ no - if yes, provide details below:

Please attach copies of all relevent consultation reports and test results/investigations, including physiotherapy reports.
If test results are not attached, we will interpret this as tests were not performed.

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:

Please list any complications/additional conditions impacting your patient's level of function or the typical recovery period:

Is the patient following the recommended treatment program? ◯ yes ◯ no

Do you have concerns about the patient's ability to manage his/her own affairs? ◯ yes ◯ no

Please provide comments and further details you feel would be helpful:

Notice to Physician:
The information in this statement will be kept in a life, health or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Name of Attending Physician (please print)		Certified specialty	Physician's stamp
Address (street, city, province, postal code)			
Telephone number	Fax number	Email address	
Attending Physician's signature **X**		Date (dd/mmm/yy)	

Please return this completed form to:

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Kingston ON K7L 3A8

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