CRITICAL ILLNESS—CLAIMANT'S STATEMENT

Original signatures must be submitted to Empire Life.

Proof of Claim—Claimant's Statement

Reset Form

1. Personal Details

Name (first, middle, last)			Policy number
Address (number, street)			
City		Province	Postal code
◯ Male ◯ Female	Date of birth (dd/mmm/yy)	Home telephone	Work telephone

2. Claim Related Details

Please describe the nature and extent of your Critical Illness:

On what date did symptoms first commence? (dd/mmm/yy):

Please describe these symptoms:

On what date was your condition diagnosed? (dd/mmm/yy):

On what date did you first consult a medical practitioner in connection with your illness? (dd/mmm/yy):

Please indicate name of Physician seen:

Have you undergone any tests, investigations or surgery related to the diagnosis? ◯ yes ◯ no
If yes, please give details including dates:

Have you previously suffered from, or received treatment for, a similar or related illness? ◯ yes ◯ no
If yes, please give details including dates:

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3. Medical Consultations

Please provide the name and address of your personal physician

Please provide details of any other doctors or specialists who have been consulted in connection with your illness.

Name	Address	Date seen (dd/mmm/yy)

If you have been treated at a hospital or similar institution, please supply the following information.

Name of Hospital	City/Town	Date of Admission	Date of Discharge

What other treatment have you received and are you currently receiving in connection with your illness? (e.g. medications, therapy, etc.)

Type of Treatment	Institution/Prescribing Physician	Dates

4. General

Has any blood relative suffered from a similar or related illness? If yes, please indicate:

Relationship	Nature of illness	Age illness was first diagnosed	Date illness was diagnosed

Will you be claiming for benefits related to this illness from another company? ◯ yes ◯ no If yes, please indicate:

Name of Insurer	Type of Benefit	Amount of Benefit Insured	Has a claim been submitted?
			◯ yes ◯ no
			◯ yes ◯ no
			◯ yes ◯ no

Do you smoke or use any tobacco, marijuana or nicotine products, including but not limited to a nicotine patch or nicotine gum? ◯ yes ◯ no

If yes, how long have you been using tobacco?	Indicate type and amount per day

If no, did you previously use tobacco products? ◯ yes ◯ no

If yes, on what date did you stop using tobacco products (dd/mmm/yy)

5. Please provide any further information which you think might be helpful in support of your claim.

6. **Declaration and Consent**

I declare that the above statements are accurate and complete. I hereby authorize and direct any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, any insurance company, government agency, provincial health insurer, Medical information Bureau, Revenue Canada, institution, organization or person, that has any records or knowledge of me or of my health to release full particulars thereof including all prior medical history and present condition to The Empire Life Insurance Company (Empire Life), its reinsurers or its Associates for the purposes of administering my Critical Illness Claim.

I also authorize my insurer, or its reinsurers to exchange the personal information obtained during my application for this policy, or any claim under this policy with the insurer's Agents, affiliates, reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently hold respecting me, or which may be opened in the future by my insurer, for use in accordance with the object of such other files.

I understand that Empire Life may use third party service providers located outside of Canada to process and store my personal information. To access a copy of the most recent Empire Life Privacy Policy, please visit the Empire Life Web site at www.empire.ca.

A photostat of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim. I understand that by furnishing this form and investigating the claim or by accepting proofs of claim The Empire Life Insurance Company shall not be held to admit the validity of any claim not to have waived any of its rights in defence of any claim arising under the policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

A photocopy of this authorization shall be valid as the original.

Signature	Date (dd/mmm/yy)
X	

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