EMPLOYEE AUTHORIZATION FORM – ADVICE TO PAY

Reset Form

Background:

- Your employer has a self-funded program of short-term disability benefits for employees (the "**Plan**").
- You have filed a claim with your employer for benefits under the Plan ("**Claim**") and your employer wants The Empire Life Insurance Company (**"Empire Life"**) to provide limited advisory services in relation to your Claim, including collecting and reviewing medical information in relation to your Claim.
- The Plan benefits are not insured by Empire Life and your employer has sole financial and legal responsibility for adjudicating your Claim and paying any benefits covered by the Plan.

1.

Name of employer			
Name of employee			
Address (street, number)	City	Province	Postal code
Phone number	Email address		
Employee's job title	Number of hours worked/week	Date employee was last paid (dd/mmm/yy)	
Name of Supervisor	Phone number	Email address	

2.

Name of Physician/facility first consulted			
Address (street, number)			
City	Province	Postal code	Phone number
Name of other treatment provider(s)			
Address (street, number)			
City	Province	Postal code	Phone number
Describe your current symptoms:			
List your current prescription medications:			

Empire Life

3. Additional Information – please provide any other information you think might help us in the consideration of this assessment.

4. Declaration and Authorization

Collection, Use and Access to My Personal Information

Collection:

- I am making a Claim for disability benefits with my employer and understand that my employer wants Empire Life to provide limited advisory services in relation to my Claim. I understand that Empire Life will need medical, employment and other personal information about me in order to provide its advisory services to my employer and review my Claim. I authorize Empire Life to collect my personal information that is relevant to my Claim. I authorize any person or organization that has information relevant to my Claim to disclose this information to Empire Life. The persons and organizations with information relevant to my Claim include:
- Individuals acting on my behalf, such as my guardian or legal representative;
- My current and former employers;
- My physician and other health professionals and practitioners; and
- Hospitals, clinics, social service agencies and other similar agencies that have provided services to me.

Use:

I authorize Empire Life to keep my personal information on file and use it to provide its advisory services to my employer, including the review of my Claim.

Access, Disclosure and Withdrawing Consent:

I understand that:

- my personal information will be kept on file by Empire Life;
- authorized Empire Life employees and medical consultants will have access to this file for the purposes listed above;
- my personal information may be exchanged with the persons and organizations listed above if required for the purposes listed above. However, specific details relating to medical conditions will not be disclosed to my employer unless required by applicable law. For greater clarity, Empire Life may disclose information about my medical restrictions, functional limitations, job task capabilities and necessary accommodations with my employer when relevant for the purpose of return-to-work planning;
- in all cases, Empire Life restricts its collection, use, disclosure and retention of personal information to what is reasonably required for the purposes listed above;
- Empire Life may use third party service providers located inside or outside 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 have the right to request access to my personal information in the file, as permitted or required by law, and where appropriate, to have any accurate information corrected;
- I can withdraw the authorizations provided above at any time by notifying Empire Life in writing; if I do, I acknowledge that (i) any action taken in reliance on my authorization prior to it being withdrawn will be valid; (ii) Empire Life may be unable to provide its advisory services to my employer which may affect my employer's Claim decision; and
- I can access Empire Life's most recent Privacy Policy at www.empire.ca

Other:

- I acknowledge and agree that my Plan is not insured by Empire Life and my employer has sole financial and legal responsibility for adjudicating my Claim and paying any benefits covered by the Plan.
- I hereby release and forever discharge Empire Life and its employees and agents from any and all actions, causes of action, complaints, claims, demands, debts and liabilities of any kind I have, have had or may have in respect of my Claim under the Plan.

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.

By signing below, I confirm that I have read, understood and agree to the statements in the Declaration and Authorization and consent to the use of my personal information as described. A photocopy of this Employee 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
Empire Life
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