CLAIMANT'S STATEMENT FOR DISABILITY BENEFITS

How to complete this form:

- Answer all questions in full to avoid delays in assessment of your claim.
- The physician who is treating your current injury or sickness must complete an Attending Physician's Statement (form G-0058). You are responsible for paying any fee your physician charges related to completing the form.
- If your Employer pays any portion of the premium for the disability benefit, we need to have your Social Insurance Number (SIN) so that we can issue tax slips.
- For questions or help completing this form please call our Customer Service Unit at 1 800 267-0215.

Throughout this form, "Empire Life" means The Empire Life Insurance Company.

Reset Form

1.

Group policy number	Group division number	Certificate number	
Name (first, middle, last)			
Address (street, number, apartment, etc.)	City	Province	Postal code
Date of birth (dd/mmm/yy)	SIN (if required)	Height (cm/in)	Weight (kg/lb)
Phone number	Email address		
Employer's name		Employer's phone number	
Employer's address	City	Province	Postal code
Your job title		Preferred language: ◯ English ◯ French	

2. **Claim Information** (complete all answers in full)

Is your claim the result of an injury or sickness? Select one: ◯ injury ◯ sickness

If your claim is due to an injury, please tell us when, where and how the injury happened:

What were your first symptoms?

When did you first notice these symptoms?

Is your medical condition preventing you from doing all activities of your current job? ◯ no ◯ yes	Date you were first treated by a physician (dd/mmm/yy):

Is your injury or sickness related to your occupation? ◯ no ◯ yes

I returned to work, or can return to work:

◯ Part-time from (dd/mmm/yy) _____ to (dd/mmm/yy) _____ ◯ regular or ◯ modified work

◯ Full-time from (dd/mmm/yy) _____ to (dd/mmm/yy) _____ ◯ regular or ◯ modified work

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3. Health Professionals

Please list all health professionals (e.g. doctors, physiotherapists, chiropractors, etc.) you have consulted for your current injury or sickness or for any other reason during the past two years:

Full name of health professional	Date consulted (dd/mmm/yyyy)	Telephone number
Address	Reason	
Full name of health professional	Date consulted (dd/mmm/yyyy)	Telephone number
Address	Reason	
Full name of health professional	Date consulted (dd/mmm/yyyy)	Telephone number
Address	Reason	
Full name of health professional	Date consulted (dd/mmm/yyyy)	Telephone number
Address	Reason	

4. Other Income

Do you receive of expect to receive any other income benefits as a result of your injury or sickness? ◯ no ◯ yes
If "Yes" please complete the information below:

	Amount/ frequency (weekly/monthly)	Date claim was filed (dd/mmm/yy)	Payment start date (dd/mmm/yy)	Payment end date (dd/mmm/yy)
◯ Canada or Quebec Pension Plan*	$			
◯ Retirement Pension Plan	$			
◯ Automobile insurance (including no fault)**	$			
◯ Workplace Safety & Insurance Act	$			
◯ Employment insurance	$			
◯ Short term disability	$			
◯ Salary continuance***	$			
◯ Social services	$			
◯ Association plan	$			
◯ Other (include individual or group benefits)	$			

* Attach copy of Notice of Entitlement or denial letter when received.
** List automobile insurance carrier, policy number and contact person.
*** Salary continuance is when an employer continues to pay the employee salary/wages when they are off due to an injury or sickness.

Have you been declined for any of the benefits listed in Section 7? ◯ no ◯ yes
If yes, please include the details and date of appeal, if applicable, below.

Benefit	Date of appeal (dd/mmm/yy)
Benefit	Date of appeal (dd/mmm/yy)
Benefit	Date of appeal (dd/mmm/yy)

5. Additional Comments

6. Declaration and authorization

Collection, Use and Access to My Personal Information

Collection:

I am making a claim for disability benefits to The Empire Life Insurance Company (Empire Life) and understand that Empire Life will need medical, financial, employment and other information about me in order to assess and administer my claim. I authorize Empire Life to collect my personal information that is relevant to my claim either directly or through third parties.

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 doctor and other health professionals and practitioners;
- hospitals, clinics, social service agencies and other similar agencies that have provided services to me;
- investigative and governmental agencies;
- other insurance companies with which I have or have had coverage;
- the MIB, LLC (a cooperative data exchange formed by the life and health insurance industry); and
- third parties who provide services related to my benefit plan (e.g. payroll, enrolment, fraud detection or claims handling services).

I also authorize Empire Life to collect personal information concerning me that is available publicly and/or online from third party sources, like publications and websites (including without limitation, news websites, social media, professional or business directories and public registries).

Use:

I authorize Empire Life to keep my personal information on file and to use it to:

- investigate, assess, administer and pay my claim, including verifying the accuracy of the information that I provided in support of my claim;
- implement risk management programs and procedures to detect and protect against overpayment of benefits, fraud, false information, errors, omissions, misrepresentations and/or contravention of laws;
- manage the terms of the group policy and meet legal, regulatory or contractual requirements;
- manage internal data for analytics purposes; and
- provide benefits and services to me (including rehabilitation assistance and other services designed to help me return to work). If disability benefits under my Plan are taxable, I consent to the use of my Social Insurance Number for tax reporting.

Access/Disclosure:

I understand that:

- my personal information will be kept on file by Empire Life;
- authorized Empire Life employees, representatives, and its reinsurers and third party service providers will have access to my file, for the purposes listed above;
- personal information may be exchanged with the persons and organizations listed above if required for the purposes listed above;
- from time-to-time Empire Life provides its auditors with access to my file so that they can assess Empire Life's claims practices;
- in all cases, Empire Life restricts its collection, use, disclosure and retention of my personal information to what is reasonably required for the purposes listed above;
- Empire Life may use third party service providers located inside or 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; and
- I can access Empire Life's most recent Privacy Policy at www.empire.ca..

Other:

I understand that:

- I must notify Empire Life promptly if the information I provided to Empire Life or if my circumstances change, including without limitation where: my medical condition improves, I start working (including self-employment), I start receiving benefits or income from third party sources
- Empire Life takes the submission of fraudulent claims seriously and Empire Life will verify the accuracy of the information provided in support of my claim. If Empire Life suspects fraud related to my claim and/or claim overpayment, it may exchange information about me pertaining to my claim without my knowledge to any appropriate organization to investigate, suppress and prevent fraud and/or claim overpayment. These organizations can include my employer, regulatory bodies, government organizations, other insurers and fraud-detection firms;
- if Empire Life reasonably determines that I submitted or allowed to be submitted a claim that includes any false, inaccurate, incomplete or misleading information material to the claim, Empire Life may, at its reasonable discretion and without prior notice, immediately terminate all my rights and benefits under the group policy; and
- If I am overpaid benefits, Empire Life may disclose my contact information and relevant financial information to a third party such as a collection agency to recover any overpayment. Empire Life reserves the right to undertake criminal prosecution and/or pursue civil action against me

6. Declaration and authorization (cont'd)

☐ **I certify that the information given in this form and other documents supporting my claim, and any future verbal or written statement provided by me, is true, full and complete to the best of my knowledge. I understand that my claim and my coverage may be denied or terminated as a result of my providing false, inaccurate, incomplete or misleading information.**

Signature of Employee **X**	Date (dd/mmm/yy)
Signed at (City and Province)	

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

Please return this completed form to:

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

Telephone: 1 800 267-0215
Fax: 1 855 430-9455
Email: grouplifeanddisability@empire.ca