

# 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

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

  

2. <b>Claim Information</b> (complete all answers in full)	
Is your claim the result of an injury or sickness? Select one: <input type="radio"/> injury <input type="radio"/> 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?	
Your last day at work was (dd/mmm/yy):	Date you were first treated by a physician (dd/mmm/yy):
Have you ever had the same or a similar injury or sickness? <input type="radio"/> no <input type="radio"/> yes – explain when:	
Before you stopped working, did you have to change your job or the way you did your job because of this injury or sickness? <input type="radio"/> no <input type="radio"/> yes – please explain:	
Are your daily activities (home duties, personal needs, social activities) limited by your injury or sickness? <input type="radio"/> no <input type="radio"/> yes Please explain:	
Is your injury or sickness related to your occupation? <input type="radio"/> no <input type="radio"/> yes	
Have you filed, or do you intend to file, a Workplace (WSIB/WCB/CSST) claim? <input type="radio"/> no <input type="radio"/> yes	
Have you done any work for any form of pay or wages, or on a volunteer basis, since your injury or sickness started? <input type="radio"/> no <input type="radio"/> yes – specify when and type of work:	
I returned to work, or can return to work:	
<input type="radio"/> Part-time from (dd/mmm/yy) _____ to (dd/mmm/yy) _____ <input type="radio"/> regular or <input type="radio"/> modified work	<input type="radio"/> Full-time from (dd/mmm/yy) _____ to (dd/mmm/yy) _____ <input type="radio"/> regular or <input type="radio"/> modified work

### 3. Hospitalization

Were you hospitalized for this injury or sickness?  no  yes

Please list all hospitalizations for your current injury or sickness and any other condition during the past two years:

Full name and address of the hospital	Admission date (dd/mmm/yy)	Discharge date (dd/mmm/yy)

### 4. 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, address and telephone number	Date consulted (dd/mmm/yy)	Reason (please use section 8 or attach another page if you need more room)

### 5. Education and Training

What is the highest grade or level of education you have completed in:

Elementary school	High school	
Community college	Type of diploma/certificate/degree	
University	Degree	Major

What other formal education have you had? (e.g. night school, college courses, seminars, etc.)

What were the duties of the job you were performing immediately before your injury or sickness?

What other jobs have you had during your work experience? (please use section 8 or attach another page if you need more room)

1. Job title	Company	Dates (dd/mmm/yy)
Duties:		
2. Job title	Company	Dates (dd/mmm/yy)
Duties:		

**5. Education and Training (cont'd)**

What on-the-job training have you received?	Company	Dates (dd/mmm/yy)
List any education, apprenticeship programs, training, or work experience not included above:		Date completed (dd/mmm/yy)
Driver's licence: class	Restrictions	
Special licences or qualifications: (including professional licenses):		
Type	Class	Restrictions
Type	Class	Restrictions

**6. Legal Action**

Are you taking legal action against a third party as a result of your injury or sickness?  no  yes  
 If yes, please provide the following:

a) Name, address, and telephone number of your legal representative:

b) Name of the other party involved and the name of their insurance carrier and policy number:

c) Name, badge number and division number of investigating police officer:

Please attach a complete copy of the official police or incident report showing what charges were laid and against whom.

**7. Other Income**

Please check any other income benefits you have applied for, are receiving, or expect to receive as a result of your injury or sickness and complete the information requested.

	Amount/frequency (weekly/monthly)	Date claim was filed (dd/mmm/yy)	Payment start date (dd/mmm/yy)	Payment end date (dd/mmm/yy)
<input type="radio"/> Canada or Quebec Pension Plan*	\$			
<input type="radio"/> Retirement Pension Plan	\$			
<input type="radio"/> Automobile insurance (including no fault)**	\$			
<input type="radio"/> Workplace Safety & Insurance Act	\$			
<input type="radio"/> Employment insurance	\$			
<input type="radio"/> Short term disability	\$			
<input type="radio"/> Salary continuance***	\$			
<input type="radio"/> Social services	\$			
<input type="radio"/> Association plan	\$			
<input type="radio"/> 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)

## 8. Additional Comments

## 9. 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. 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;
- other insurance companies with which I have or have had coverage;
- the Medical Information Bureau (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 or claims handling services).

#### Use:

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

- investigate, assess, and pay my claim; 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 representatives and its reinsurers will have access to my file, 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; and
- I can access Empire Life's most recent Privacy Policy at [www.empire.ca](http://www.empire.ca).

#### Other:

I understand that:

- if Empire Life suspects fraud and/or Plan abuse related to my claim, it may collect, use and disclose information about me pertaining to my claim to any appropriate organization to investigate and prevent fraud and/or Plan abuse. These organizations can include my employer, regulatory bodies, government organizations, and other insurers;
- 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.

**I certify that the information given in this and other documents supporting my claim is true, full and complete.**

Signature of Employee

X

Signed at (City and Province)

Date (dd/mmm/yy)

**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

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