OVERAGED INFIRM DEPENDANT FORM

PART A (TO BE COMPLETED BY THE INSURED)

Policy No.	Division	Certificate No.	Employer	Insured Name

Name of Dependant:_____Date of Birth:_____

1) Is he/she wholly dependant on you for support? Yes [ ] No [ ]
2) Do you or your spouse claim this dependant as a "Disabled Dependant" for tax purposes? Yes [ ] No [ ]

If Yes, please provide a copy of your most recent income tax form "Amounts for Infirm Dependants Age 18 and over."

I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution, or person, that has any records or knowledge on my dependant pertaining to his/her health, to give to The Empire Life Insurance Company or its reinsurer(s) any and all such information. A photographic copy of this authorization shall be as valid as the original.

Date_____Signature of Applicant_____

PART B (TO BE COMPLETED BY THE ATTENDING PHYSICIAN)

Onset Date of Disability	
Nature of Disability	
Physical Limitations	
Results of Intelligence Quotient Testing (if relevant)	

1) Is this dependant capable of working for remuneration or profit? Yes [ ] No [ ]
2) Is the condition permanent and stationary, or can improvement be anticipated?

_____
_____
_____

_____ _____ _____
Signature of Medical Doctor Date Telephone Number

_____ _____
Name of Medical Doctor (please print) Address of Medical Doctor