

WEEKLY INDEMNITY (SHORT TERM DISABILITY) CLAIM FORM EMPLOYER'S STATEMENT

1.	Name of employer		Group policy, division and certificate number	
	Name of employee (first, middle, last)			
	Name of supervisor		Phone number	Email address
2.	Weekly Income as of date last worked \$	Number of hours worked/week		Date employee was last paid (dd/mmm/yy)
	Has coverage for the employee been terminated? <input type="radio"/> yes <input type="radio"/> no — if yes, provide date and reason(s):			
	Date employee last worked (dd/mmm/yy)	Time	<input type="radio"/> am <input type="radio"/> pm	Was this a full shift? <input type="radio"/> yes <input type="radio"/> no Note additional details in section 3.
	Date employee returned to work (dd/mmm/yy)	Time	<input type="radio"/> am <input type="radio"/> pm	Was this a full shift? <input type="radio"/> yes <input type="radio"/> no Note additional details in section 3.
	Has modified work been offered to the employee? <input type="radio"/> yes <input type="radio"/> no (please provide details below)			
	Employee's job title			
	State exact duties and/or provide physical demands analysis/job description of the employee:			
Is the employee paid (partly or fully) on a commission basis? <input type="radio"/> yes <input type="radio"/> no If yes, please attach a copy of the employee's T4 and T4A slips for the most recent calendar year.				
3.	Additional Information - please provide any other information you think might help us in the consideration of this claim.			
4.	Declaration			
I certify that the above information is true and complete.				
Signature of Authorized Company Official X			Date (dd/mmm/yy)	
Name and title of Authorized Company Official				
Phone number		Fax number		Email address
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		