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

Reset Form

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? ❍ yes ❍ no — if yes, provide date and reason(s):

Date employee last worked (dd/mmm/yy)	Time ❍ am ❍ pm	Was this a full shift? ❍ yes ❍ no Note additional details in section 3.
Date employee returned to work (dd/mmm/yy)	Time ❍ am ❍ pm	Was this a full shift? ❍ yes ❍ no Note additional details in section 3.

Has modified work been offered to the employee? ❍ yes ❍ 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? ❍ yes ❍ 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

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