CLAIMANT'S STATEMENT FOR DISABILITY

Incomplete forms may delay the assessment of the claim - please print clearly and fully answer all questions.
Original signatures must be submitted to Empire Life.
The Attending Physician's Statement (C-0022-ENG), should accompany the Claimant's Statement.
If the Claimant's condition was caused by an accident, attach a copy of the police or accident report.
The Claimant is responsible for any charges incurred for the completion of this form.

1.

Name (first, middle, last)			Policy/Contract Number(s)	
Address (number and street)	City		Province	Postal Code
Date of Birth (dd/mmm/yy)	Social Insurance Number	❍ Male ❍ Female	Home Telephone	

2.

Occupation	Employer's Name	Type of Business	
Occupational Duties		Earnings in the year immediately preceding disability $	
Business Address (number and street)	City	Province	Postal Code

3. Claim Information Complete areas A or B and C

A

Date of Injury (dd/mmm/yy)	Where and how did the injury occur?
What were your first symptoms?	

B

Date of Sickness (dd/mmm/yy)	What were your first symptoms?
When did you first notice these symptoms?	

C

Last day of work (dd/mmm/yy)	Date first treated by a medical advisor for this condition (dd/mmm/yy)	Have you ever had the same or similar condition? ❍ yes ❍ no If yes, when?

Before you stopped working, did your condition require you to change your job or the way you did your job? ❍ yes ❍ no
If yes, please explain:

Are your daily activities (home duties, personal needs, social activities) limited by your injury/sickness? ❍ yes ❍ no
If yes, please explain:

Is your condition related to your occupation? ❍ yes ❍ no	Have you filed, or do you intend to file, a workplace (e.g. WSIB/WCB) claim? ❍ yes ❍ no If yes, Claim Number:

Have you done any work for remuneration or on a volunteer basis since the date total disability commenced? ❍ yes ❍ no
If yes, provide details of when and type of work:

Have you returned to work? ❍ yes ❍ no If yes, please explain:	❍ Full-time ❍ Part-time ❍ Modified work	Hours per week:
	❍ Regular occupation ❍ Another occupation	

4. Treatment Information

List the name of all medical advisors consulted and hospitalizations for the present disability and any other condition during the past 5 years.

Name of Medical Advisor, Hospital or Institution	Address	Date (dd/mmm/yy)	Reason

5. Education and Training

What is your highest grade or level of education completed?	Type of Diploma/Certificate	University Degree/Major

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

List other jobs and previous work experience

Job Title	Company	Dates (mm/yy to mm/yy)	Duties

List any on the job training, education, apprenticeship programs, or training you have received.

Date completed (dd/mmm/yy)	Company	Type of Training

Driver's Licence Number	Class	Restrictions

Special Licence or Qualifications: (including professional licenses)

Type	Class	Restrictions

6. Other Income

Please indicate if you have applied for, are receiving or expect to receive other benefits because of your disability.

Benefit	Applied	Received	Company Name	Policy Number	Contact Person	Telephone Number
Salary Continuation/ Sick Pay						
Auto Insurance Income Payments (including no fault)						
Worker place Compensation (e.g.WSIB/WCB)						
Canada/Quebec Plan Disability						
Employment Insurance						
Retirement or Pension						
Other (including individual or group Benefits						

7. Additional Comments:

8. Declaration and Authorization

I authorize:

- any health care professional or practitioner as well as any public or private health or social services institution, any insurance company, the Medical Information Bureau, financial institutions, personal information agents, agencies which collect data on risk and losses, bodies having as their object the prevention, detection or repression of crime or statutory offences, market intermediaries, my current employer or my former employers, or any other person whom I have indicated as reference, and any other public or private organization that has information concerning me, including amongst others any medical information, to provide and exchange this information with The Empire Life Insurance Company (Empire Life), its reinsurers and their respective agents, for the purpose of appraising the risks or conducting any investigation relating to the study of any claim on a continuing basis, including providing rehabilitation assistance;

I understand that:

- to maintain the confidentiality of my personal information, Empire Life will establish a file to contain the information provided in the claim. The objective of this file is to enable Empire Life, its reinsurers and their agents to assess and appraise the claim. This file will be kept in the office of Empire Life and only Empire Life employees, agents or representatives will have access to it when performing their duties;
- Empire Life may use third party service providers located outside of Canada to process and store my personal information. To access a copy of the most recent Empire Life Privacy Policy, please visit the Empire Life Web site at www.empire.ca.
- Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

I certify that:

- the answers given and the information in other documents supporting this claim for benefits are true, full, and complete.

A photocopy of this authorization shall be valid as the original.

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