ONGOING PROOF OF TOTAL DISABILITY – CLAIMANT'S STATEMENT

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.
The Claimant is responsible for any charges incurred for the completion of this form

Reset Form

1.

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

2.

Employer's Name		Business Address (number and street)	
City	Province	Postal Code	Date Illness began or injury occurred (dd/mmm/yy)

Nature of illness or injury (if due to accident, state where and how it occurred)

Details of Occupation at time of Disability ❍ Full-time ❍ Part-time ❍ Unemployed

Since commencement of your disability have you been:
❍ house confined ❍ bed confined ❍ hospital confined - date (dd/mmm/yy):

Name and address of Hospital

Provide the dates during which you were wholly prevented from performing the following:	From (dd/mmm/yy)	To (dd/mmm/yy)
All duties of your occupation:		
Any work for remuneration or profit:		

Are you now totally disabled so that you are unable to do any work whatsoever? ❍ yes ❍ no	Date you expect to resume work (dd/mmm/yy)

3. List the name of all physicians and medical advisors consulted or attended during your disability.

Name of Physician / Medical Advisor or Hospital	Address	Dates (mm/yy to mm/yy)	Reason or treatment

4. List all medical attention you have received in the past 2 years.

Name of Physician / Medical Advisor or Hospital	Address	Dates (mm/yy to mm/yy)	Reason or treatment

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5. List all other accident or sickness benefits you are receiving due to your disability.

Company/Organization/Government	Duration of benefits	Amount of benefits
		$
		$
		$
		$

6. If the injury is due to motor vehicle accident, provide the amount of Lost Time Benefits received under your auto insurance
$

Name of auto insurance company

Are you making a claim under any compensation Act? (e.g. WSIB, WCB, CPP/QPP, EI, etc)? ❍ yes ❍ no

If yes, claim number	Benefit ❍ weekly ❍ monthly $

7. **Declaration and Authorization**

To maintain the confidentiality of your personal information, The Empire Life Insurance Company (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 our office and only Empire Life employees, agents or representatives will have access to it when performing their duties.

I understand that Empire Life may use third party service providers located inside or 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 the undersigned, authorize The Empire Life Insurance Company (Empire Life), its reinsurers and their respective agents to obtain and exchange any personal information concerning me or any of children under age 18 from and with any licenced physician, medical practitioner, hospital, clinic or any other medical or paramedical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has a file including any personal and health information concerning me or any of my children under age 18.

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

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

In furnishing this or other claim forms for the convenience of the Claimant, Empire Life does not admit any liability or waive its rights.