DISABLED CHILD DEPENDANT FORM

This form should be used for a member's disabled child.

Reset Form

PART A – TO BE COMPLETED BY THE EMPLOYEE

Name of Employer	Group number	Division number	Certificate number

Name of Employee (first, middle, last)

Name of dependant (first, middle, last)	Date of birth (dd/mmm/yy)

Is the disabled child living with you and wholly dependant on you for support? ◯ yes ◯ no

Has a disability tax credit certificate been sent to and approved by the Canadian Revenue Agency (CRA) for income tax purposes?
◯ yes ◯ no — If yes, please send a copy of any approval documents from the CRA.

I confirm that I am legally authorized to act on behalf of my Dependant and to consent to this authorization on their behalf in relation to their personal information.

I authorize the release of medical and health information in my Dependant`s file to The Empire Life Insurance Company ("Empire Life") or its authorized agents for the purpose of assessing this request and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records.

I understand:

- I can revoke this consent at any time but that without it my request cannot be assessed.
- I am responsible for any fees related to the completion of this form.

I agree that a copy or electronic version of this authorization shall be as valid as the original.

Medical and health information excludes genetic test results.

Employee signature X	Date (dd/mmm/yy)

PART B – TO BE COMPLETED BY THE PHYSICIAN

Nature of the disability	Date the disability began

1. What is the clinical diagnosis, nature and degree of the mental/physical disability? Please provide details:

2. How does the mental/physical disability restrict the individual's ability to engage in normal activities?

3. Does the individual require assistance with activities of daily living, such as bathing, dressing, feeding, toileting, transferring, or continence? ◯ yes ◯ no – if yes, please provide details:

4. Is the individual capable of working for remuneration or profit? ◯ yes ◯ no – if yes, what type of work can the individual perform?

5. What is the prognosis?

6. Is the condition: ◯ permanent and stationary OR ◯ improvement is anticipated – expected date when the individual will be able to enter the workforce, or attend school: _____

Empire Life

PART B – TO BE COMPLETED BY THE PHYSICIAN (con'td)

7. Additional remarks/observations:

The information in this statement will be kept in a file with the group benefits provider and might be accessible by the patient or third parties to whom access has been granted, or those authorized by law.

By providing the information, I consent to such unedited release of any information contained herein.

I declare that the information provided above is full and true.

Name of Physician			
Address (number, street)	City	Province	Postal code
Phone number	Fax number	Email address	
Physician's signature X		Date (dd/mmm/yy)	