## ATTENDING PHYSICIAN'S STATEMENT - SHORT TERM DISABILITY CLAIM

| Employee Information and Consent - TO BE COMPLETED BY THE PATIENT   |         |        |                 |   |         |                   |                       |  |  |
|---|---------|--------|-----------------|---|---------|-------------------|-----------------------|--|--|
| Name of Employee (first, middle, last)  |         |        |                 |   |         |                   |                       |  |  |
| Address (street, number)  |         |        | City            |   | Prov    | vince             | Postal code           |  |  |
| <ul><li>○ Male</li><li>○ Female</li></ul>   | Height  | Weight | Date of birth ( | dd/mmm/yy)  | Pho     | Phone number      |                       |  |  |
| Name of Er  | nployer |        | I               | Group policy numb   | er Divi | sion number       | Certificate number    |  |  |
| I hereby authorize the release of medical and health information in my file to The Empire Life Insurance Company and/or its authorized agents for the purpose of assessing my disability claim 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.<br>I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.<br>I understand that I am responsible for any fees related to the completion of this form.<br>I agree that a copy or electronic version of this authorization shall be as valid as the original.<br>Medical and health information excludes genetic test results. |         |        |                 |   |         |                   |                       |  |  |
| Employee signature  |         |        |                 |   |         | Date (dd/mmm/yy)  |                       |  |  |
| The patient is responsible for any fees related to the completion of this form.   |         |        |                 |   |         |                   |                       |  |  |
| <ul> <li>Attending Physician's Statement - TO BE COMPLETED BY THE PHYSICIAN</li> <li>If your patient has returned or is expected to return to work within 4 weeks of the last date worked, complete page 1 only and sign the end of the form.</li> <li>For absences expected to be greater than 4 weeks, please complete pages 1 and 2 in full.</li> </ul>  |         |        |                 |   |         |                   |                       |  |  |
| Primary diagnosis:  |         |        |                 |   |         |                   |                       |  |  |
| Secondary diagnosis and/or complications:   |         |        |                 |   |         |                   |                       |  |  |
| If childbirth - expected or actual delivery<br>date (dd/mmm/yy) Occupational illness/injury<br>If yes - date of illness/injury:   |         |        | ⊖ yes ⊖ no      | Auto accident $\bigcirc$ yes $\bigcirc$ no<br>If yes - date of accident |         |                   |                       |  |  |
| Date of first visit to you pertaining to this condition (dd/mmm/yy) First date of work absence due to this condition (dd/mmm/yy)  |         |        |                 |   |         | ition (dd/mmm/yy) |                       |  |  |
| Has the patient $\bigcirc$ been hospitalized or $\bigcirc$ had day surgery for this condition?  |         |        |                 |   |         |                   |                       |  |  |
| Institution name  |         |        | E               | Date of admittance (dd/mmm/yy   |         | /yy) Date of      | discharge (dd/mmm/yy) |  |  |
| If surgery was performed, specify date (dd/mmm/yy) and provide a description of the surgery:  |         |        |                 |   |         |                   |                       |  |  |
| <b>Treatment</b> (drug, dosage, physiotherapy, psychotherapy, etc.)   |         |        |                 |   |         |                   |                       |  |  |
| <b>Prognosis</b> - please provide the prognosis for recovery:   |         |        |                 |   |         |                   |                       |  |  |
| Expected return to work date (dd/mmm/yy):   |         |        |                 |   |         |                   |                       |  |  |



| Continuation of Attending Physician's Statement - FOR ABSENCES THAT MAY BE GREATER THAN 4 WEEKS  |                                      |                            |                   |  |  |  |  |  |
|--|--------------------------------------|----------------------------|-------------------|--|--|--|--|--|
| Has the patient been treated for this same or a similar condition in the past? $\bigcirc$ yes $\bigcirc$ no $-$ if yes, please state when and describe:  |                                      |                            |                   |  |  |  |  |  |
| Please describe the patient's current symptoms including history, severity and frequency:  |                                      |                            |                   |  |  |  |  |  |
| Frequency of visits 🔿 weekly 🔿 monthly 🔿 other   |                                      |                            |                   |  |  |  |  |  |
| Has the patient been advised to have any surgery, tests or consultations not yet completed? $\bigcirc$ yes $\bigcirc$ no - if yes, provide details below:  |                                      |                            |                   |  |  |  |  |  |
| Please attach copies of all relevent consultation reports and test results/investigations, including physiotherapy reports.<br>If test results are not attached, we will interpret this as tests were not performed.   |                                      |                            |                   |  |  |  |  |  |
| Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:  |                                      |                            |                   |  |  |  |  |  |
| Please list any complications/additional conditions impacting your patient's level of function or the typical recovery period:   |                                      |                            |                   |  |  |  |  |  |
| Is the patient following the recor   | nmended treatment program? (         | ) yes () no                |                   |  |  |  |  |  |
| Do you have concerns about the   | e patient's ability to manage his/he | er own affairs? 🔵 yes 🔵 no |                   |  |  |  |  |  |
| Please provide comments and further details you feel would be helpful:   |                                      |                            |                   |  |  |  |  |  |
| Notice to Physician:<br>The information in this statement will be kept in a life, health or disability benefits file with the insurer or plan administrator and might<br>be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information<br>you consent to such unedited release of any information contained herein. |                                      |                            |                   |  |  |  |  |  |
| Name of Attending Physician (ple   | ease print)                          | Certified specialty        | Physician's stamp |  |  |  |  |  |
| Address (street, city, province, postal code)  |                                      |                            |                   |  |  |  |  |  |
| Telephone number   | Fax number                           | Email address              |                   |  |  |  |  |  |
| Attending Physician's signature X  |                                      | Date (dd/mmm/yy)           | -                 |  |  |  |  |  |
| Please return this completed form to:  |                                      |                            |                   |  |  |  |  |  |
| Life & Disability ClaimsGroup SolutionsToll free phone # 1 800 267-0215The Empire Life Insurance CompanyToll free fax: 1 855 430-9455259 King Street EastEmail: grouplifeanddisability@empire.caKingston ON K7L 3A8Email: grouplifeanddisability@empire.ca   |                                      |                            |                   |  |  |  |  |  |

