Dear Claimant,

Here is the Claimant's Statement and Attending Physician's Statement that need to be completed to submit a claim under your Empire Life Disability Credit Protect coverage. Please refer to your policy to understand the applicable elimination period and waiting period before completing these forms.

Here's what you need to do:

1. **Claimant's Statement - the claimant (Owner) and Life Insured complete this.**
   - Complete the Claimant's Statement for Empire Life Disability Credit Protect Monthly Benefit (pages 1-3), including signing the Declaration and Authorization on page 3
   - Answer each question clearly and fully. Incomplete information may require the Claimant's Statement to be returned for completion and cause a delay in assessing your claim.
   - If the Life Insured's condition was caused by an accident, attach a copy of the police or accident report.
2. **Attending Physician's Statement - the Life Insured's attending physician completes this.**
   - Have the Life Insured's attending physician complete the Attending Physician's Statement for Empire Life Disability Credit Protect Monthly Benefit (pages 4-7).
   - This form must be completed by the Life Insured's specialist or family physician who is treating the Life Insured for the injury or illness.
   - The Life Insured is responsible for any fees their specialist or family physician may charge to complete this form.

Please note that we may need additional information to complete our assessment. If we do, we will notify you of the additional information we require.

Return the documents to us in any of these ways:

By mail: Empire Life
Retail Claims
259 King St East
Kingston ON K7L 3A8

By fax: 1 800 419-4051

By email: Scan the documents and send to individualclaims@empire.ca

Once all information is received and reviewed, we will notify you of our decision.

If you require assistance with the forms or have questions, please contact Customer Service at 1 800 561-1268.

Retail Claims

Empire Life

CLAIMANT'S STATEMENT
FOR EMPIRE LIFE DISABILITY CREDIT PROTECT MONTHLY BENEFIT

Answer all questions in full to avoid delays in the assessment of your claim.

The physician who is treating the Life Insured's current injury or illness must complete an Attending Physician's Statement (pages 4-7).

If the Life Insured's condition was caused by an accident, attach a copy of the police or accident report.

Sections 1-7 to be completed by the Life Insured. Sections 8 and 9 to be completed by the claimant (Owner).

Reset Form

1.

Name (first, middle, last)		Date of birth (dd/mmm/yyyy)	Policy number	
Address (number and street)	City		Province	Postal code
Are you a Canadian resident or a permanent resident of Canada? ◯ yes ◯ no		Height ◯ cm ◯ in	Weight ◯ kg ◯ lbs	
Home phone number	Cell phone number	Are you currently incarcerated in a penitentiary or any government detention facility? ◯ yes ◯ no		
Email address (will only be used for the processing of this claim, you may withdraw your consent at any time by contacting us at individualclaims@empire.ca):				

2. Are you gainfully employed? ◯ yes ◯ no - You are considered gainfully employed if, for at least eight months during the past 12 months, you have been working for salary, wages or commissions on a continuing basis for a minimum of 20 hours per week.
If "yes", complete the remainder of this section 2. If "no", proceed to section 3.

Employer's name	Employer's phone number	Type of business	
Occupation		Job title	
Business address (number and street)	City	Province	Postal code

3. Claim Information - Complete sections A or B (as appropriate). All claimants to complete section C.

A

Date of injury (dd/mmm/yyyy)	Where and how did the injury occur?
Describe your injuries:	

B

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

C

Date first treated by a physician for this condition (dd/mmm/yyyy)	Have you ever had the same or similar condition? ◯ yes ◯ no If yes, when?	
Last day of work (dd/mmm/yyyy)	Number of hours worked _____ per day _____ per week	Months worked this year
Describe the regular duties you were performing at work immediately before your injury or illness:		
Before you stopped working, did your condition require you to change your job or way you did your job? ◯ yes ◯ no If yes, please explain:		
Is your condition work related? ◯ yes ◯ no	Have you filed, or do you intend to file, a workplace (e.g. WSIB/WCB/CNESST) claim? ◯ yes ◯ no If yes, claim number:	
Have you done any work for any form of pay or wages or on a volunteer basis since the date of the accident or the date when the illness commenced? ◯ yes ◯ no - if yes, provide details of when and type of work:		

3. Claim Information (cont'd)

c

Have you returned to work? ◯ yes ◯ no - if yes, please explain:

◯ Full-time ◯ Part-time ◯ Modified work	Hours per week	◯ Regular occupation ◯ Another occupation

If you are not gainfully employed, are you capable of working in any capacity despite your injury or illness? Refer to section 2 for definition of "gainfully employed". ◯ yes ◯ no - if no, indicate why:

4. Hospitalization

Were you hospitalized for this injury or illness? ◯ yes ◯ no

Please list all hospitalizations for your current injury or illness and any other condition during the past two years:

Full name and address of the hospital	Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)

5. Health Professionals

Please list all health professionals (e.g. doctors, physiotherapists, chiropractors, etc.) you have consulted for your current injury or illness or for any other reason during the past two years:

Full name of health professional, address and telephone number	Date consulted (dd/mmm/yyyy)	Reason (please use section 6 or attach another page if you need more room)

6. Additional Comments

7. Other Insurance or Benefits Covering Eligible Debts

("eligible debts" are described in Section 2 of the Proof of Eligible Debt form (INS-2944A))

Are any of the eligible debts covered by any other insurance? ◯ yes ◯ no - if yes, provide details below:

Name of insurance company	Policy number

Have you applied or been approved for disability benefits to cover any of the eligible debts? ◯ yes ◯ no
If yes, provide details:

Have you applied for or been approved for other disability benefits? ◯ yes ◯ no - if yes, provide details below:

Name of company or benefit provider

8. Direct Deposit - Receive your monthly benefit payment faster by direct deposit to your bank account.

Attach a void cheque or a pre-authorized transaction form (pre-printed) from your financial institution if this is (indicate which applies):

◯ a first request for direct deposit, or

◯ your banking information has changed

If approved for benefits, please deposit the monthly benefit payments to:

◯ the bank account indicated on the void cheque or pre-authorized transaction form provided, or

◯ the same account my policy premiums for the above policy are drawn from

9. Important Information

FRAUD NOTICE: Any person who knowingly files a claim containing any false or misleading information may be subject to criminal and civil penalties. In addition, an insurer may deny benefits if false or misleading information materially related to the claim or application for insurance were provided by the applicant or claimant.

LIMITATION PERIOD NOTICE: Every action or proceeding against an insurer for the recovery of insurance money payable under the insurance contract is absolutely barred unless commenced within the time set out in the Insurance Act (for British Columbia, Alberta and Manitoba), the Limitations Act, 2002 (for Ontario), or other applicable legislation (for all other provinces and territories).

PRIVACY NOTICE: To maintain the confidentiality of your personal information collected in this form, Empire Life will establish a file to contain the information provided in the claim. The purpose of this file is to enable Empire Life, its reinsurers and their agents to assess the claim. This file will be kept in our office and only Empire Life employees, agents, third party service providers or representatives will have access to it when performing their duties. Empire Life may use third party service providers located inside or outside of Canada to process and store the personal information. Personal information that is processed or stored in another jurisdiction may be subject to the laws of that jurisdiction, which may allow disclosure to courts, law enforcement or other government authorities of that jurisdiction under certain circumstances. A copy of the Empire Life privacy policy is available on the website at www.empire.ca

10. Declaration, Acknowledgement and Authorization

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

I acknowledge I have read and understand Section 9 - Important Information.

I acknowledge that Empire Life is not confirming the validity of any claim or waiving any of its rights in defence of any claim arising under the policy by furnishing this form, investigating the claim, or by accepting proofs of claim.

I authorize any health care professional or practitioner as well as any public or private health or social services institution, any insurance company, MIB Inc., 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, 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 Empire Life, its reinsurers and their respective agents, for the purpose of assessing your claim and conducting any investigation related to your claim on a continuing basis.

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

Signature of Claimant (Owner)

By signing below, I confirm that I have read, understood and agree to the statements in the Declaration, Acknowledgement and Authorization. If the claimant (Owner) is also the Life Insured and only signs this section, the claimant (Owner) is also signing as Life Insured.

Signature of claimant (Owner) X	Signed at (city and province)	Date (dd/mmm/yyyy)

Signature of Life Insured (if not the claimant (Owner))

By signing below, I confirm that I have read, understood and agree to the statements in the Declaration, Acknowledgement and Authorization.

Signature of Life Insured X	Signed at (city and province)	Date (dd/mmm/yyyy)

Empire Life®

ATTENDING PHYSICIAN'S STATEMENT
FOR EMPIRE LIFE DISABILITY CREDIT PROTECT MONTHLY BENEFIT

To be completed by the physician who is attending the patient to treat the injury or illness for which a claim for disability benefits is being made.

Original signatures must be submitted to The Empire Life Insurance Company (Empire Life).

The patient is responsible for any fees charged for the completion of this form.

1. To be completed by the Patient (Life Insured)

Patient's name (first, middle, last)		Policy number	
Address (number and street)	City	Province	Postal code
Phone number	Date of birth (dd/mmm/yyyy)		

- Authorization to disclose medical and health information: I hereby authorize my attending physician to disclose the medical and health information in my file to Empire Life and/or its authorized agents for the purpose of assessing a claim for disability benefits under my Empire Life Disability Credit Protect coverage. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records, but excludes any genetic test results.
- I understand that I can revoke this consent at any time but that without it a claim cannot be assessed.
- I understand that 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.

Signature of patient X	Signed at (city and province)	Date of consent (dd/mmm/yyyy)

Sections 2 to 13 are to be completed by the Attending Physician

2. Diagnosis

Height ◯ cm ◯ in	Weight ◯ kg ◯ lbs	Date of most recent visit (dd/mmm/yyyy)	Are you the family physician? ◯ yes ◯ no
How long have you been treating this patient?		On what date did you first start treating this patient for the current injury or illness? (dd/mmm/yyyy)	

Primary diagnosis

Secondary diagnosis and/or complications

Associated conditions which may prolong recovery

3. History

To the best of your knowledge, does the patient use any tobacco or nicotine products? ◯ yes ◯ no ◯ unknown
If yes, please indicate type and date last used:

Is the patient's condition due to an accident? ◯ yes ◯ no ◯ unknown

When did symptoms first appear or accident happen? (dd/mmm/yyyy)	Date of first visit for the present condition (dd/mmm/yyyy)	How often has patient been seen?
Date patient was unable to work due to present condition (dd/mmm/yyyy)	Is the patient's condition due to injury or illness arising out of patient's employment? ◯ yes ◯ no ◯ unknown	

Has the patient ever had the same or a similar condition? ◯ yes ◯ no- if yes, please describe and provide dates:

Has the patient's drivers licence or any other professional licence or certification been restricted or revoked as a result of his/her injury or illness? ◯ yes ◯ no

If yes, please specify the type of licence	Class of licence (if applicable)	Restriction date (dd/mmm/yyyy)

4. Symptoms

Subjective symptoms and severity

Objective clinical findings and significant results from investigation (x-ray, lab, etc.)

Is or was the patient: ◯ Bed confined ◯ House confined ◯ Hospital confined	If yes please provide dates
Is the condition due to pregnancy? ◯ yes ◯ no	If yes, what is the expected or actual delivery date? (dd/mmm/yyyy)

5. Treatment

Current treatment (include medications dose and frequency, physiotherapy and surgery)

Is the patient following recommended treatment? ◯ yes ◯ no - if no, please comment:

Has the patient been advised to have any surgery, tests or consultations not yet completed? ◯ yes ◯ no - if yes, provide details:

Has the patient refused any recommended treatment or investigation? ◯ yes ◯ no - if yes, please comment:

List other medical advisors the patient has seen or been referred to regarding the current injury or illness:

Name	Speciality	Address	Date (dd/mmm/yyyy)

6. Prognosis

Has the patient ◯ Recovered as of (dd/mmm/yyyy): _____ ◯ Improved ◯ Unchanged ◯ Deteriorated

What is your prognosis for recovery?

Has the patient achieved maximal medical improvement? ◯ yes ◯ no - if no, how soon do you expect fundamental changes in the patient's medical condition? ◯ 1-2 months ◯ 3-4 months ◯ 5-6 months ◯ Indefinite ◯ Never

Is the patient a suitable candidate for medical rehabilitation? ◯ yes ◯ no	Would vocational rehabilitation be recommended? ◯ yes ◯ no

What factors are likely to limit the effectiveness of the patient's rehabilitation?

7. Return to Work Plan

Complete this section if patient was employed at the onset of the illness or injury.

Have you discussed a return to work plan with the patient? ◯ yes ◯ no - if yes, on what basis?

◯ Part-time - hours per week _____ from (dd/mmm/yyyy) _____ to (dd/mmm/yyyy) _____

◯ Regular work ◯ Modified work

◯ Full-time modified work -from (dd/mmm/yyyy) _____ to (dd/mmm/yyyy) _____

◯ Full-time regular work - return date (dd/mmm/yyyy) _____

If a graduated return to work program is planned, provide details:

Please complete only those sections applicable to the patient's primary or associated condition.

8. Physical Impairment ◯ Not applicable

◯ Class 1 – No limitation of functional capacity, capable of heavy work. No restrictions. (0-10%)
◯ Class 2 – Slight limitation of functional capacity, capable of light to moderate manual activity. (15-30%)
◯ Class 3 – Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity. (35-55%)
◯ Class 4 – Marked limitation of functional capacity, capable of minimal (sedentary) activity. (60-70%)
◯ Class 5 – Severe limitation of functional capability, incapable of minimal (sedentary) activity. (75-100%)

What are the limitations? (bending, lifting, etc.)

For each of the following, indicate by marking the appropriate response(s).

The patient can lift up to: ◯ 10 pounds ◯ 20 pounds ◯ 50 pounds ◯ 100 pounds ◯ over 100 pounds ◯ none

The patient can frequently lift-carry: ◯ Up to 10 pounds ◯ Up to 25 pounds ◯ Up to 50 pounds ◯ over 50 pounds ◯ none

The patient can: ◯ Climb ◯ Kneel ◯ Stoop ◯ Reach ◯ Crawl ◯ Crouch ◯ Hear ◯ Grip ◯ Balance

9. Cardiac Impairment ◯ Not applicable

What was the patient's blood pressure at last visit?	Systolic	Diastolic

What is the functional capacity of the patient's heart? (based on the American Heart Association's definitions)
◯ Class 1 (no limitation) ◯ Class 2 (slight limitation) ◯ Class 3 (marked limitation) ◯ Class 4 (complete limitation)

10. Psychological/Psychiatric Impairment ◯ Not applicable

What are the symptoms that the Patient is displaying that indicate a mental impairment exists?

How does the Patient's psychological/psychiatric impairment affect his/her ability to work?

How does the Patient's home life situation contribute to his/her current condition? Please explain:

Is the patient's condition related to job dissatisfaction or difficulties in the workplace? If yes, please explain:

Has there been a psychiatric referral? If yes, please provide details:

What is the diagnosis(es) using the DSM V?

Do you believe the patient is competent to endorse cheques and direct the use of the proceeds? ◯ yes ◯ no	If no, then from what date? (dd/mmm/yyyy)

11. Visual Impairment ◯ Not applicable

What was the patient's vision at last testing?	O.D.	O.S.
With glasses		
Without glasses		

Can the patient's vision be restored in whole or in part by:

O.D.	◯ Lenses	◯ Treatment	◯ Operation	◯ Non-restorable
O.S.	◯ Lenses	◯ Treatment	◯ Operation	◯ Non-restorable

Indicate the nature of treatment, and date if an operation is scheduled:

12. Additional Comments

13. Attending Physician

The information in this statement will be kept on file with The Empire Life Insurance Company 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 the release to such persons of any information contained herein, without being edited.

Name of attending physician (please print)			Specialty
Address (number and street)			Telephone number
City	Province	Postal code	Fax number
Signature of attending physician **X**			Date (dd/mmm/yyyy)