WEEKLY INDEMNITY (SHORT TERM DISABILITY) CLAIM FORM
EMPLOYEE'S STATEMENT

To ensure your confidentiality, submit this form with the **Attending Physician's Statement - Short Term Disability Claim** form GH-0054. The **Weekly Indemnity Claim form - Employer's Statement** form - GH-0052 can be submitted separately.

1.

Name of Employer			Group policy, division and certificate number
Name of Employee (first, middle, last)			
Address (street, number)	City	Province	Postal code
Phone number	SIN (required only if weekly indemnity benefit is taxable)		

2.

Date you last worked (dd/mmm/yy)	Date you first became ill or injured (dd/mmm/yy)	Date you returned or expect to return to work (dd/mmm/yy)

Did this claim result from an accident or injury? ◯ yes ◯ no — if yes, complete the sections below. If no, proceed to section 3.

Is a claim being made to another insurer (e.g. auto insurer, Provincial Workplace Safety Board)? ◯ yes ◯ no — if yes, provide:

Name of insurance carrier		
Adjuster name		Claim number
Phone number	Fax number	Email address

Was the accident or injury due to: ◯ auto* ◯ work ◯ other

Date of accident/injury (dd/mmm/yy)	Time of accident/injury

Where did the accident occur? Provide details of the accident:

If the injury is due to an auto accident, please provide a copy of the police Motor Vehicle Accident (MVA) Report.

3.

Name of Doctor/facility first consulted			Date first consulted (dd/mmm/yy)
Address (street, number)			
City	Province	Postal code	Phone number
Name of other treatment provider(s)			Date first consulted (dd/mmm/yy)
Address (street, number)			
City	Province	Postal code	Phone number

Describe your current symptoms:

Empire Life

4. Declaration and Authorization

I authorize:

- any health care professionals or practitioners as well as any public or private health or social services institutions, any insurance companies, 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 organizations that have information concerning me, including without limitation any medical information, to provide and exchange this information with The Empire Life Insurance Company (Empire Life), its reinsurers and their respective agents and representatives, for the purposes of (i) assessing and investigating my claim(s); (ii) administering coverage that I may have with Empire Life, including providing rehabilitation assistance; or (iii) complying with the requirements of an audit;
- Empire Life to exchange my contact information and relevant financial information with a third party (including, without limitation, a collection agency), and authorize that third party to use such information, for the purposes of recovering any overpayment of benefits that I received from Empire Life: and
- Empire Life to release to the Policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf, other than specific details relating to my medical condition.

I consent to:

- the use of my Social Insurance Number, where necessary, for tax reporting purposes.

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 respective agents and representatives to assess, appraise and administer 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; and
- Empire Life may use third party service providers located outside of Canada to process and store my personal information. I may access the most recent Privacy Policy of Empire Life on the Empire Life website at www.empire.ca.

I certify that:

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

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

Employee signature X	**Date** (dd/mmm/yy)

Please return this completed form to:

Life & Disability Claims
Group Solutions
The Empire Life Insurance Company
259 King Street East
Kingston ON K7L 3A8

Toll free phone # 1 800 267-0215
Toll free fax: 1 855 430-9455
Email: grouplifeanddisability@empire.ca

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