



# THE EMPIRE LIFE INSURANCE COMPANY

## DISABLED EMPLOYEE'S STATEMENT

1. Name of Employee: ..... Social Ins. No. ....
2. Address .....  
No. Street City Postal Code
3. Date you were last at work ..... Date you first became totally disabled .....
4. Date you have returned, or expect to return, to work .....
5. a) Did claim result from an accident?  No  Yes If yes, was accident  Auto  Work  Other  
 If "Yes" please give: Date of accident ..... Time of accident .....  
 Where did accident occur and give details?  
 .....
- b) Name of Auto Insurance Carrier if an auto accident ..... Policy No. ....  
 Address .....  
No. Street City Postal Code Telephone
6. Name and address of Doctor/ facility first consulted .....  
 Date first consulted for this disability .....  
 Date ..... Signature of Employee .....  
Day, Month, Year

## EMPLOYER'S STATEMENT

1. Group Policy No. .... Div No. .... Name of Employer .....
2. Certificate No. .... Name of Employee .....
3. Date employee became insured .....
4. Amount of benefit employee was insured for at time of disability \$ ..... per .....
5. Has coverage for employee been terminated?  No  Yes  
 If "Yes" please give date and reasons .....
6. Date employee last worked ..... time ..... a.m./p.m. Full Shift?  Yes  No Specify below
7. Date employee returned to work ..... time ..... a.m./p.m. Full Shift?  Yes  No Specify below
8. Number of work days missed (to nearest half day) .....
9. a) State exact duties of employee .....
- b) Was employee working full time  or, part time  or on workshare  at time of disability ..... No. of hours worked
10. Is claim being made for Worker's Compensation Benefits?  No  Yes
11. Please give any other information you think might help us in the consideration of this claim.  
 .....  
 .....
- Date ..... Signature of Authorized Official .....
- Telephone No. .... Fax No. .... Title .....

## Attending Physician's Statement - SD5

Instructions

1. Please print.

2. Part 1 to be completed by patient.

3. Part 2 to be completed by physician.

4. Any charge for completing this form is the patient's responsibility.

### Part 1: Patient Authorization

Policy no.

Date of Birth (day, month, year)

Name

I, the undersigned, authorize

(i) any health care professional or practitioner as well as any public or private health or social services institution, any insurance company, 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, including amongst others any medical information, to provide and exchange this information with THE EMPIRE LIFE INSURANCE COMPANY, its reinsurers and their respective agents, for the purpose of conducting any investigation relating to the study of any claim on a continuing basis, including providing rehabilitation assistance.

(ii) THE EMPIRE LIFE INSURANCE COMPANY to release any statistical information regarding claims paid on behalf of me, other than specific details relating to my medical condition. A photocopy of this Authorization will be as valid as the original.

Date: \_\_\_\_\_ ( ) - \_\_\_\_\_

Day, Month, Year

Employee's Signature

Telephone

### Part 2: Attending Physician's Statement

1. Diagnosis of present condition

a) Primary

b) Additional conditions or complications which might affect duration of absence from work

Height

Weight

2. To the best of your knowledge

a) indicate when symptoms first appeared or accident happened (day, month, year)

b) has patient had same or similar condition

No  Yes, please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment?

Yes  No Comments

4. If patient is/was pregnant indicate date or expected day of confinement (day, month, year)

5. a) If patient was referred to you, give name of referring physician

b) If you have referred patient to a specialist, give name(s) of physicians

6. a) Date of first visit for treatment during present period of absence from work (day, month, year)

b) Date of latest attendance for treatment (day, month, year)

c) Were you actively supervising this patient's care during the full period?

No, comment in remarks  Yes, state frequency of visits  Weekly  Monthly  Other (specify)

7. a) Date of hospital in-patient admission (day, month, year)

b) Date of discharge (day, month, year)

c) Name and Address of Hospital

8. Nature of treatment (e.g. medications; physio; date and type of surgery, etc.)

9. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition  
From (day, month, year) To (day, month, year) inclusive

b) If still unable to work, give approximate date patient should be able to return (day, month, year) or the estimated number of weeks before possible return

c) If unable to return to work fulltime, could patient return to work on a part-time basis?   
or to modified duties?   
From (day, month, year) To (day, month, year)

d) Is patient a suitable candidate for rehabilitation program?  
 Yes  No

10. Please advise how present condition affects patient's ability to work (for example restrictions, limitations, proposed surgery, etc.)

11. Remarks - Please provide comments and further details which you feel would be helpful

Name of attending physician (please print)

Specialty

Telephone No.

( ) -

Address (number, street, city, province, postal code)

Fax No.

( ) -

Signature

Date (day, month, year)