



1. Group No. Division Certificate No. Name of Employer
Insured's Name Date of Birth M D Y Social Insurance Number
Insured's Address (Number, street, city, province, postal code)
Has your employment terminated? No Yes If yes give date of termination M D Y
Are any medications/medical supplies required as a result of Workers' Compensation injury/sickness? No Yes
If treatment was required because of an accident, how did the accident happen? If yes, please submit them to Workers' Compensation Board.
Date of Accident M D Y Time AM PM Where did it happen? At work At home Elsewhere
Have you, your spouse or dependent children any other Insurance coverage under which the expenses being claimed are eligible? No Yes
If "Yes" give details: Name of Policyholder Policy No. Certificate No. Spouse's M D
Name and Address of other Insurance Company Birthday

SUMMARY OF EXPENSES CLAIMED Please attach ORIGINAL bills, receipts, statements, etc. If necessary continue on another claim form. Please submit drug claims when they total at least \$20.00 in excess of any deductible amount.

Table with 7 columns: PATIENT, Date of Purchase or Services Rendered, Name of Drug or Type of Service, Charge, Date of Purchase or Services Rendered, Name of Drug or Type of Service, Charge. Includes fields for Name, Date of Birth, Marital Status, Employee/Spouse/Child, and dependent status.

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Administrator: Please retain yellow copy and mail white copy to: J&D Benefits Administration Ltd. 8901 Woodbine Ave., Suite 228 Markham, ON L3R 9Y4

I certify the statements hereon and attached are complete and represent no duplication of charges previously submitted. I authorize: 1. physicians, hospitals and others to release full information to The Empire Life Insurance Company with respect to this claim, and 2. The Empire Life Insurance Company to release any statistical information regarding claims paid on behalf of me and my eligible dependents, other than specific details relating to a medical condition, to my employer. A photocopy of this authorization shall be as valid as the original.

Date Insured's Signature
Claims and all questions relating to claims should be submitted to your employer.

2. POLICYHOLDER/EMPLOYER - for completion. Was this Employee insured when the expenses were incurred? Yes No
If no, please give date of termination

Date Authorized Signature