



FIRST ALERT™ EMPLOYEE ABSENCE FORM

SECTION 1 Employee information

Employee name _____ Certificate No. _____

Address _____ Group Policy No. _____

Telephone No. (H) _____

Date last worked _____

Date of birth _____ Sex M F First date unable to work _____

Current occupation and title _____ Employee's salary _____

What part of your duties are you unable to perform? _____

Are you receiving benefits from WSIB/WCB/EI/salary continuance/other insurance benefits? _____

Amount _____ Start date _____ End date _____

What is your training; education; and experience? _____

When will you be returning to work? _____

Any part-time work done? _____

Medical information

Diagnosis _____ Accident/Sickness _____

Name of physician(s) _____ Address _____ Telephone _____

List all dates of consultation with your physician(s) _____

What treatment was discussed and/or medications prescribed? _____

SECTION 2 Employer information

Name of employer _____

Is this a WSIB/WCB claim? _____ Policy No. _____ Billing unit _____ Class _____

Can you accommodate modified work or part-time work? _____

Do you have any performance issues with your employee? _____

Additional information that will help in assessing the situation _____

Date (MM/DD/YYYY) _____ Name of Employer (Print) _____

Signature of Employer _____ Telephone No. _____

RBC Life Insurance Company, Life and Health Claims Department

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