Fenchurch General Insurance Company
Authorization for Release of Information

Authorization and Declaration	
Employee Name (Surname, Given Name, Initial(s):	
Date of Birth (mm/dd/yy):	**Claim/Reference No.**
Date of Loss:	

I AUTHORIZE any physician, health practitioner, clinic, hospital, government motor vehicle board or agency, insurance or reinsurance company, benefit plan administrator, union bargaining agent or service providers working with Fenchurch General Insurance Company (FGIC), Crawford & Company (Canada) Inc. and their authorized agents, including their legal representatives and other stakeholders, (collectively called the "Organizations") having relevant and material information available as to my claim for disability benefits arising from the Date of Loss set out above including but not limited to diagnosis, treatment and prognosis with regard to any physical or psychological condition and/or treatment or tests completed on me, and to provide FGIC, Crawford and Company Canada and their duly authorized agents any and all such information as is necessary to evaluate my application for benefits under either the short or long term disability plan.

I AUTHORIZE the Organizations to obtain, collect, receive, examine and disclose any necessary personal information or personal health information, including consultation reports from or to any physician (including my attending physician), other medical practitioner or health care provider, hospital, clinic, legal counsel, insurance company union bargaining agent, or investigative agency, as is relevant and material to my claim arising on the Date of Loss set out above and for the purposes set out below.

I UNDERSTAND the purpose for which this information is collected and for which it may be used and disclosed is:

- To adjudicate and manage my disability benefit claim;
- Facilitate rehabilitation and return to work planning;
- In the context of litigation or legal claims assessment thereof;
- Management of the employment relationship; and
- For the statistical requirements of all stakeholders.

I ACKNOWLEDGE that the information provided to the Organizations may be accessed by: adjudicators, case managers, and their support staff and management, and will be stored on the secure electronic server(s) of the Organizations, with access limited to solely to those individuals as necessary for such purposes.

All personal information will be protected in accordance with:

- *Personal Information Protection and Electronic Documents Act (Canada)*
- *Personal Information Protection Act (Alberta)*
- *Personal Information Protection Act (British Columbia)*
- *An Act Respecting the Protection of Personal Information in the Private Sector (Quebec)*
- *All other applicable laws.*

I ACKNOWLEDGE that such information may be transmitted to other entities across Inter-Provincial and/or International borders, and that such information will be held, used or communicated in accordance with the same restrictions as required in Canada and this Province, or any such higher restriction required by law.

Information on the Organizations' Privacy Policies, including, but not limited to, transmission interprovincially and/or outside of Canada, rights of access, and rectification, are available as follows:

Website: www.crawfordandcompany.ca (Electronic copy of policy) **OR** **Responsible Individual: Vice-président Administration, Privacy and Compliance, Crawford & Company (Canada) Inc., 539 Riverbend Dr., Kitchener, Ontario N2K 3S3**

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Website: www.fenchurchgeneral.com
(Electronic copy of policy)

OR

Privacy Officer
Fenchurch General Insurance Co.
2655 North Sheridan Way, Suite 115,
Mississauga, Ontario
Tel: 905-822-2282 x 225
Fax: 905-822-1282
PrivacyOfficer@Fenchurchgeneral.com

I ACKNOWLEDGE that the Organizations reserve the right to undertake, and, without limiting the generality of the foregoing, expressly consent to the disclosure for, independent medical evaluations and/or consultations of the information provided for the purpose of determining my initial eligibility and/or ongoing entitlement to disability benefits and to provide copies of any related reports to my attending physician.

I AGREE that any information provided to the Organizations will be used by the insurer for the assessment of my application and for any other purpose related to the administration and management of my disability benefit claim, including my return to work. Only information related to work restrictions or fitness will be released to my employer.

A photocopy or fax of this completed form is as valid as the original.

This signed authorization is valid for a period of 36 months from date of signing unless rescinded in writing.

Signed at _____ (City), _____ (Province/Territory) this _____ (Day) day of _____ (Month), _____ (Year)

_____ Employee Name (printed)

_____ Employee signature

_____ Witness Name (printed)

_____ Witness signature

Return to: **Fenchurch General Insurance Company**
400-90 Matheson Blvd., West
Mississauga, Ontario
L5R 3R3
Fax: 1-877-364-6666