Fenchurch General Insurance Company

Supplemental Claimant Statement- Appeal

To allow additional review of your claim appeal and determination of eligibility to benefits we ask that complete this questionnaire at the earliest opportunity and return the completed document by Fax or mail to:

Fax: 1.866-364-6666

Mail: Fenchurch General Insurance Company
Employee Protection Claims
90 Matheson Blvd., West 4th Floor
Mississauga, Ontario
L5R 3R3
claims@fenchurchgeneral.com

INCOMPLETE/ILLEGIBLE ENTRIES WILL DELAY ADJUDICATION OF YOUR APPEAL

Surname:	**Given Name:**	**Initial(s):**
Employer:		**Occupation:**
Policy No:	**Policy Class:**	**Claim No:**
Reason for appeal:		

Part 2 – General Information

Please describe your current medical status and provide comment on the progress you feel you have made since your disability commenced:

Other than the primary medical conditions accepted under your disability claim, do you feel there are any other medical conditions that contribute to your disability status? ❒ **Yes** ❒ **No**

If yes, please explain:

Part 3 – Medical Information

Please list the name and contact information for all physicians/health care providers you are currently seeing for treatment:

Name:	**Phone:**	**Specialty/Frequency of visits:**
Address:	**Fax:**	
Name:	**Phone:**	**Specialty/Frequency of visits:**
Address:	**Fax:**	
Name:	**Phone:**	**Specialty/Frequency of visits:**
Address:	**Fax:**	

Please list all medications and dosages currently prescribed/taken:

Please list all pending/follow up appointments with your physicians/other health care providers:

Part 4 – Functional Capacity

Please describe your typical daily activities at present:

Please describe any restrictions/limitations to your typical daily activities at present:

Part 5 – Rehabilitation and Retraining

Have you participated in any rehabilitation or retraining programs? ❒ **Yes** ❒ **No**

If yes, please provide details of the program, contact information, and dates attended:

Briefly describe the outcome/results of the rehabilitation/retraining program (if applicable):

Part 6 – Personal Care

What time do you typically wake up:	What time do you typically go to bed?

Do you have any trouble sleeping? ❒ Yes ❒ No

If yes, please describe your difficulty/sleeping pattern:

Has your sleeping pattern changed since your disability began? ❒ Yes ❒ No

If yes, please describe the change:

Do you require any assistance with your personal care and grooming needs? ❒ Yes ❒ No

If yes, please describe the assistance required:

Part 7 – Household Care

Have your eating habits changed since your disability began? ❒ Yes ❒ No

Please describe any changes:

Are you able to do any housework? ❒ Yes ❒ No

If no, please describe your limitations (activity, frequency, duration, etc.):

Are you able complete the following household tasks?

Laundry	❒ Yes ❒ No	**Dusting**	❒ Yes ❒ No	**Dishes**	❒ Yes ❒ No	**Mopping**	❒ Yes ❒ No
Lawn care	❒ Yes ❒ No	**Shoveling**	❒ Yes ❒ No	**Vacuum**	❒ Yes ❒ No	**Shopping**	❒ Yes ❒ No

What distance do you travel to do your shopping:

How do you get there? Walk ❒ Bike ❒ Bus ❒ Taxi ❒ Drive self ❒ Passenger ❒ Other ❒

If 'other', please describe:

Do you require assistance when shopping? ❒ Yes ❒ No

If yes, please explain:

Have there been any changes in your ability to care for your household since your disability began? ❒ Yes ❒ No **If yes, please describe these changes:**
Do you participate or attend social activities/meetings/gatherings regularly? ❒ Yes ❒ No **If yes, please describe the nature and frequency of the activity:**
Has there been any change to your regular social activities since your disability started? ❒ Yes ❒ No **If yes, please describe the changes:**

ASSIGNMENT, CERTIFICATION AND AUTHORIZATION

I CERTIFY that the information in this form is true and complete to the best of my knowledge.

I AUTHORIZE any employer, physician, practitioner, health care professional, hospital, medical organization or clinic, insurance company, Workers' Compensation Board, group plan administrator, legal counsel, investigative body or agency, to release and exchange with FGIC any medical or benefit payment information, or any other information or records that may be required by FGIC in the management of my claim.

I ACKNOWLEDGE that any person who knowingly files a statement of claim containing materially false, incomplete, or misleading information, or conceals any material facts with intent to defraud or deceive the insurer, may be guilty of a fraudulent act subject to civil or criminal penalties, and may be denied benefits related to their claim.

I ACKNOWLEDGE that Fenchurch General Insurance Company (FGIC) and its authorized agents and representatives may investigate this statement.

I AGREE that a reproduction of this document (photocopy or electronic) shall be as valid as the original.

_____ _____

Claimant's Name (Printed) and Signature Date

Contact number (day): _____

Contact number (evening): _____

Email: _____