# Fenchurch General Insurance Company

## Application for Disability Benefits
## Employer's Statement

Please complete this statement in full. Incomplete or illegible entries will delay processing of your employee's application. If you require any assistance in completing the document, you may contact Fenchurch General Insurance Company at 1.866.226.4817 or by email at claims@fenchurchgeneral.com.

*** INCOMPLETE OR ILLEGIBLE ENTRIES WILL DELAY PROCESSING OF YOUR EMPLOYEES APPLICATION ***

**Fax or mail your completed statement as soon as possible:**

Fax: 1.877.364.6666

Mail: Fenchurch General Insurance Company
100 Milverton Drive, Suite 300
Mississauga, ON
L5R 4H1

| | | | |
|---|---|---|---|
| **This application is for:** ❑ Short Term Disability ❑ Long Term Disability | | | |
| **Company Name:** | | | |
| **Policy No.:** | **Class:** | **Division/Site:** | **Union Affiliation:** |
| **Coverage effective date this policy (mm/dd/yy):** | | **Coverage effective date any policy (mm/dd/yy):** | |
| **Employee Name (Surname, Given Name, Initial):** | | | |
| **Date of Birth (mm/dd/yy):** | | **SIN:** | |
| **Hire Date (mm/dd/yy):** | **Employment terminated?** ❑ Y ❑ N | **If yes, reason:** | |

| **Primary Employer Contact** | **Alternate Employer Contact** |
|---|---|
| **Surname:** | **Surname:** |
| **Given name:** | **Given name:** |
| **Position/Title:** | **Position/Title** |
| **Phone** **Fax:** | **Phone:** **Fax:** |
| **Email:** | **Email:** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Basic (gross) Salary: $** | **Per:** ❑ Hour ❑ Week ❑ Month | | | **Date of last salary increase (mm/dd/yy):** | | | |
| **Typical hours worked/day** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Sun** |
| | | | | | | | |
| **Job Title/Typical Duties:** | | | | | | | |

**Please list sources and amounts of other benefits to which the employee is entitled and/or receiving:**

| Source of Income | Eligible | | Amount (wk/mth) | Date Claim Filed (mm/dd/yy) | Date of 1st Payment (mm/dd/yy) | Date Payment Ends (mm/dd/yy) |
|---|---|---|---|---|---|---|
| | Yes | No | | | | |
| Canada Pension Plan | | | | | | |
| Employment Insurance | | | | | | |
| Workers' Compensation | | | | | | |
| Motor Vehicle Insurance | | | | | | |
| Other group/private benefits | | | | | | |

| | | |
|---|---|---|
| **Last day worked (mm/dd/yy):** | | **First day absent (mm/dd/yy):** |
| **Is employee back at work?** ❑ Y ❑ N | **If yes, date (mm/dd/yy):** | |
| **Nature of Absence:** (check all that apply) | ❑ Accident ❑ Injury ❑ Motor Vehicle Accident ❑ Workplace Accident ❑ Eligible for WCB? ❑ Illness ❑ Hospitalization >24 hrs ❑ Pre-planned surgery? | |
| **Were there any changes to the employee's job responsibilities due to the reported disabling condition prior to the current workplace absence or after it was first reported? If yes, please explain including date change(s) was/were implemented for the reported condition:** | | |
| **Are there any labour management/employee relations issues that may be related to the employee's current workplace absence and reported disability? If so, please explain:** | | |

As an authorized representative of the employer, I the undersigned certify the information provided herein as being true and correct to the best of my knowledge

_____ _____ _____

Name (Print)/Signature Position/Title Date (mm/dd/yy)

Phone: _____

Fax: _____

Email: _____