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 by email at: claims@fenchurchgeneral.com

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

Fax or email to Fenchurch General Insurance Company as soon as possible (we do not require originals):

Fax: 1.877.364.6666 or Email: claims@fenchurchgeneral.com

Mail: Fenchurch General Insurance Company
55 University Ave. Suite 1604
Toronto, Ontario. M5J 2H7

Part 1 – Employer and Employee (Claimant) Information

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:**

Part 2 – Salary and Job Information

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:

Part 3 – Information About Other Benefits

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	☐	☐				

Part 4 – Absence Information

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: _____