Fenchurch General Insurance Company

Application for Temporary Disability Benefits

Claimant's Statement

Please complete this statement in full. Sign the Authorization and Declaration at the end of the application and complete Section One of the Attending Physicians Statement. It is your responsibility to provide medical information to support your application for benefits and to pay any costs incurred in obtaining this information. Where indicated (e.g., if your injury/illness is attributed to a motor vehicle accident, workplace injury, etc.), you may be instructed to provide additional information as part of the application process.

*** INCOMPLETE OR ILLEGIBLE ENTRIES WILL DELAY PROCESSING OF YOUR 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
Attention: Disability Department
55 University Ave. Suite 1604
Toronto, ON
M5J 2H7

Part 1 – Claimant and Employment Information

This application is for: ❑ Short Term Disability ❑ Long Term Disability

Employer:	**Job Title:**
Union affiliation (if applicable):	
Name (Surname, Given Name, Initial(s):	

Date of Birth (mm/dd/yyyy):	**Sex:** ❑ M ❑ F ❑ Other	**Ht:**	**Wt:**	**Dominant Hand:** ❑ R ❑ L

Mailing Address: **Street:** **City:** **Province:** **Postal Code:**	**Home Phone:** **Cell Phone:** **Email:**
Please describe the work typically associated with your occupation:	

Part 2 – Information About the Disability

Are you unable to work for medical reasons? ❑ Y ❑ N	**Last day worked (mm/dd/yyyy):**	**Number of hrs. worked:**
Has your employment been terminated? ❑ Yes ❑ No	**If yes, state reason:**	

Have you returned to work? ❑ Y ❑ N ❑ Full time ❑ Part time Date (mm/dd/yyyy):	If you have not returned to work, do you expect to return: ❑ Y ❑ N ❑ Full time ❑ Part time Date (mm/dd/yyyy):
Are you self-employed or working for another employer? ❑ Y ❑ N If yes, please provide details:	

Are you attending school or a similar training institute at this time? ❑ **Yes** ❑ **No**

If yes, please provide all particulars including institution, program/course description, hrs/days per week, etc.:

Are you a commercial truck owner/operator? ❑ **Y** ❑ **N**

(If yes, please complete and attach an Owner/Operator Declaration)

Is your current disability attributable to a motor vehicle accident? ❑ **Y** ❑ **N**

(If yes, please complete and attach a Subrogation Agreement and Claimant's Accident Statement)

Is your current disability attributable to a work place accident or illness? ❑ **Y** ❑ **N**

If yes, have you applied for Workers' Compensation benefits? ❑ **Y** ❑ **N**

Workers' Compensation claim number:

Part 3 – Information About the Condition Causing Your Disability

For an *INJURY*, please answer the following:

Date the injury occurred (mm/dd/yyyy):	**Date you were first treated by a physician (mm/dd/yyyy):**

Describe the circumstances leading to the injury (where and how did the injury occur):

For *an ILLNESS*, please answer the following:

Date symptoms first appeared (mm/dd/yyyy):	**Date you were first treated by a physician (mm/dd/yyyy):**

Describe your first symptoms and those currently experienced:

For INJURY or ILLNESS, please state why you are currently unable to work (i.e., how does the reported condition affect your ability to work)?:

Have you ever had the same or similar condition(s) in the past?: ❑ Y ❑ N

If yes, please state particulars (dates, nature of symptoms, description of medical care received, name of physician's seen, etc.)

Part 4 – Information About Physicians, Care Providers and Hospitals

Medical attention for current disability first received **from: Doctor's name:** **Specialty** **:** **Address:**	**Phone:** **Fax:**	**Date 1st seen:** **Date last** **seen:** **Frequency of visits:**
List all other physician's, therapists and hospitals: **Name:** **Address:** **Name:** **Address:** **Name:** **Address:**	**Phone:** **Fax:** **Phone:** **Fax:** **Phone:** **Fax:**	**Specialty:** **Specialty:** **Specialty:**
If admitted to hospital, name of Hospital: **Admission date (mm/dd/yy)**	**Discharge date (mm/dd/yy):**	

Part 5 – Information About Other Benefits

Please list sources and amounts of other benefits to which you are entitled and/or receiving:

Source of Income	Applied/Eligible		Amount (wk/mth)	Date Claim Filed (mm/dd/yyyy)	Date of 1st Payment (mm/dd/yyyy)	Date Payment Ends (mm/dd/yyyy)
	Yes	No				
Canada Pension Plan						
Employment Insurance						
Workers' Compensation						
Motor Vehicle Insurance						

Other group/private benefits						

Part 6 – Other Information
Were there any changes to your 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 your current workplace absence and reported disability? If so, please explain:

AUTHORIZATION AND DECLARATION

I, the undersigned, hereby make claim for temporary disability benefits under my employer's benefit plan with Fenchurch General Insurance Company (FGIC). I understand that any information provided to FGIC or their respective authorized agents, will be used in the initial adjudication and determination of my eligibility for benefits, claim and care coordination provisions under the terms of the Master Policy Agreement, and potential entitlement to any extension of benefits under this claim.

I DECLARE that the statements provided by me in this authorization and declaration are true and complete, and given of my own free will.

I UNDERSTAND that while in receipt of disability benefits from FGIC, I am required to report all income from other sources to which I am in receipt or may be entitled including retirement or pension plan payments (including CPP/QPP), severance pay, Workers Compensation, Employment, or other third party insurance. Such other income or benefits may be deemed to be a direct offset against my claim with Fenchurch General Insurance.

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 AGREE that a reproduction of this authorization is as valid as the original.

Applicants Name (Printed) and Signature Date

Contact number (day):

Contact number (evening):

Email:

IMPORTANT: IF YOU ELECT TO APPOINT A REPRESENTATIVE TO ACT ON YOUR BEHALF WITH FGIC WITH RESPECT TO YOUR DISABILITY BENEFIT CLAIM, A COMPLETED "DESIGNATION OF REPRESENTIVE" FORM (FORM F600A) IS REQUIRED. NO INFORMATION WILL BE RELEASED TO ANY PARTY CLAIMING TO REPRESENT YOU WITHOUT THIS AUTHORIZATION.