



# 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 (email at [claims@fenchurchgeneral.com](mailto: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  
400 – 90 Matheson Blvd. West  
Mississauga, ON  
L5R 3R3

### Part 1 – Employer and Employee (Claimant) Information

This application is for: <input type="checkbox"/> Short Term Disability <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, reason:	
<u>Primary Employer Contact</u>		<u>Alternate Employer Contact</u>	
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: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> 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 1 <sup>st</sup> 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:  Accident  Injury  Motor Vehicle Accident  Workplace Accident  Eligible for WCB?  
(check all that apply)  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: \_\_\_\_\_