



Fenchurch General Insurance Company

Attending Physician Statement

Dear Doctor:

The individual identified in Section One is applying for disability benefits under their employer's benefit plan with Fenchurch General Insurance Company (FGIC). As part of the adjudicative process, FGIC requires objective medical evidence (Section Two) to confirm that your patient has a medical condition severe enough to prevent them from performing the substantial portion of duties typically associated with their occupation.

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

Fax: 1.877.364-6666

Mail: Fenchurch General Insurance Company
400 - 90 Matheson Blvd. West
Mississauga, ON
L5R 3R3

Section One (To be completed by Claimant)	
Surname:	Given Name:
Name of Employer:	
AUTHORIZATION AND DECLARATION	
<p>I AUTHORIZE any physician, health practitioner, clinic, hospital, medical organization, any government motor vehicle board, insurance or reinsurance company, administrator or government benefits or service providers working with Fenchurch General Insurance Company (FGIC) or the Disability Management Institute (DMI) having relevant information available as to my diagnosis, treatment and prognosis with regard to any physical or psychological condition and/or treatment or tests completed on me, and to provide FGIC and its duly authorized agents or representative any and all such information to evaluate my application for benefits under either the short term or long term disability plan.</p> <p>I AUTHORIZE FGIC or such designated agent or successor as may be appointed, DMI and their respective authorized agents including their legal representatives and investors to collect, use and disclose any personal information or personal health information, including consultation reports from or to any physician (including my attending physician), and/or any other medical practitioner or health care provider, hospital, clinic, legal counsel, insurance company, or investigative agency who may be reasonably entitled to receive the information for the purposes described below.</p> <p>I UNDERSTAND the purpose for which this information is collected and for which it may be used and disclosed is:</p> <ol style="list-style-type: none"> 1. To adjudicate and manage my application for benefits; 2. Facilitate rehabilitation and return to work planning; 3. In the context of litigation or legal claims assessment thereof. <p>I ACKNOWLEDGE that FGIC reserves the right to undertake independent medical evaluations and/or consultations for the purpose of determining my eligibility for payment of disability benefits and to provide copies of any related reports to my attending physician.</p> <p>I AGREE that any information provided to FGIC and/or DMI will be used by the insurer for the assessment of my application and for any other purpose related to the administration of my disability benefit claim, including my re-entry into the workplace. Only information related to work restrictions or fitness will be released to my employer.</p> <p>I DECLARE that the information provided in this statement is true and complete.</p>	
<hr style="width: 30%; margin: 0 auto;"/> Name (printed) and signature	<hr style="width: 30%; margin: 0 auto;"/> Date

Section Two

(To be completed by Attending Physician)

Patient's Surname:	Patient's Given Name:	Date of Birth:
Primary Diagnosis (for psychiatric diagnosis include DSM-IV GAF):	Axis I – Axis II – Axis III – Axis IV – Axis V –	
Secondary Diagnosis:		
Objective Findings: (Mental or Cognitive diagnosis require a Mental Status Exam with validity measures and for physical / musculoskeletal disorders require functional, ROM and/or diagnostic testing results to be supplied)		
Subjective Findings:		
When did symptoms first appear?		
Date of first visit during current period of disability:	First date of disability due to condition:	
Date of last visit:	Frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (describe):	
Was your patient hospitalized as a result of the reported disabling condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give dates and a brief synopsis of treatment and results while in hospital:		

Has your patient undergone surgery Yes No
If yes, please give date, describe procedure and result:

Will your patient undergo surgery in future? Yes No
If yes, please give date and describe procedure to be performed:

What medication(s) is your patient currently taking or been prescribed?

Please indicate any other types and frequencies of treatments:

To your knowledge, is the patient following the recommended treatment program? Yes No

Does substance abuse (ETOH or drugs) contribute to your patients reported disability? Yes No
If yes, please describe the nature and severity of the substance abuse issue and treatment undertaken/proposed:

Does prescription drug misuse/abuse contribute to your patients reported disability? Yes No
If yes, please describe the nature and severity of the issue and treatment undertaken/proposed:

Current Medical Status	
Please include any changes made in your patient's treatment plan and any complications.	<input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Worse <div style="margin-top: 10px;">Comments:</div>
Diagnostic Procedures and Tests	
Please specify any tests that have been completed or are scheduled – provide copies of all reports and/or test results where applicable.	
Referrals	
Please provide copies of any specialist consultation and/or progress reports.	Referral to: _____ Specialty: _____ Referral to: _____ Specialty: _____ Referral to: _____ Specialty: _____
Functional Limitations and Return to Work Planning	
Please provide detailed information re: physical and/or cognitive limitations to working:	
Is your patient able to return to full work and regular hours at this time? <input type="checkbox"/> Yes <input type="checkbox"/> Yes – with limitations <input type="checkbox"/> No If No, what is the estimated time before he/she may return to work?	
Mailing and Faxing Information	
<u>Mail:</u> Fenchurch General Insurance Company 400 – 90 Matheson Blvd. West Mississauga, ON L5R 3R3	<u>Fax:</u> 1.877-364-6666

 Physicians Signature

 Date

Physicians Name/Specialty/License Number

Telephone Number

Fax Number

Please note that the costs associated with the completion of this form are the responsibility of the patient/claimant.