Fenchurch General Insurance Company

Tuition Insurance 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. Where indicated (e.g., if your injury/illness is attributed to a motor vehicle accident), 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 mail your completed statement to as soon as possible to:

Fax: 1-877-364-6666

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

Part 1 – Claimant and Education Information

School Name:		**Program of study:**		
Year of study:				
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 studies:				

Part 2 – Information About the Disability

Are you unable to attend school for medical reasons? ❑ **Y** ❑ **N**	**Last day class attended (mm/dd/yyyy):**	
Have you returned to school? ❑ **Y** ❑ **N** ❑ **Full time** ❑ **Part time** **Date (mm/dd/yyyy):**	**If you have not returned to school, when do you expect to return:** ❑ **Y** ❑ **N** ❑ **Full time** ❑ **Part time** **Date (mm/dd/yyyy):**	

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.:

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 continue with your academic studies (i.e., how does the reported condition affect your ability to study/attend school)?:

Applications due to Death, please answer the following:

Date Student Past Away: (mm/dd/yyyy):

For Applications due to death, please ensure the death certificate is submitted.

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 <u>first</u> 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 6 – Other Information

Were there any accommodation requests due to the reported disabling condition prior to the current academic absence? If yes, please explain including date change(s) was/were implemented for the reported condition:

Are there any academic relations (ie. Academic probation, misconduct decisions etc.) issues that may be related to your current absence and reported disability? If so, please explain:

AUTHORIZATION AND DECLARATION

I, the undersigned, hereby make claim for tuition insurance benefits under my 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 under the provisions using the terms of the Master Policy Agreement.

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 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.