Fenchurch General Insurance Company

Attending Physician Statement

Dear Doctor:

The individual identified in Section One is applying for tuition insurance benefits under their 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 successfully completing their studies.

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

Fax: 1.877.364-6666

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

Section One

(To be completed by Claimant)

Surname: Given Name:

Name of Institution:

AUTHORIZATION AND DECLARATION

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 their agents, 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 the applicable plan.

I AUTHORIZE FGIC or such designated agent or successor as may be appointed, 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.

I UNDERSTAND the purpose for which this information is collected and for which it may be used and disclosed is:

1. To adjudicate and manage my application for tuition insurance benefits;
2. In the context of litigation or legal claims assessment thereof.

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 **tuition insurance benefits** and to provide copies of any related reports to my attending physician.

I AGREE that any information provided to FGIC or their agents will be used by the insurer for the assessment of my application and for any other purpose related to the administration of my **tuition insurance** benefit claim. **Only information related to the decision will be disclosed to my academic institution and affiliated insurance group.**

I DECLARE that the information provided in this statement is true and complete.

_____ _____

Name (printed) and signature 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:**
Please indicate Severity of condition: Mild Moderate Severe Terminal	
Have you been treating this patient for a period of 60-days or greater. If yes, please indicate the date range:	**Frequency of visits: ❑ Weekly ❑ Monthly ❑ Other (describe):**

Was your patient hospitalized as a result of the reported disabling condition(s)? ❑ Yes ❑ 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:

Current Medical Status		
Please include any changes made in your patient's treatment plan and any complications.	❑ Improved ❑ Unchanged ❑ Worse	Comments:

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 Studies Planning
Please provide detailed information re: physical and/or cognitive limitations:
Is your patient able to return to their academic studies? ❑ Yes ❑ Yes – with limitations ❑ No **If No, what is the estimated time before he/she may return to school?**

Mailing and Faxing Information	
Mail: Fenchurch General Insurance Company 55 University Ave, Suite 1604 Toronto, ON M5J 2H7	**Fax:** **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.