



**FENCHURCH GENERAL INSURANCE COMPANY
THIRD PARTY ADMINISTRATOR (TPA)
DISABILITY NOTIFICATION FORM**



COMPLETED BY DMI	
DMI Case Manager/Coordinator:	_____
Third Party Administrator:	_____
Company/Employer:	_____
Name of Claimant:	_____
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Insurance Number:	_____
Policy Number:	_____ Class: _____
First Day of Absence:	_____
Type of Claim:	<input type="checkbox"/> STD <input type="checkbox"/> LTD
Reason for Absence:	<input type="checkbox"/> Injury <input type="checkbox"/> Illness
	<input type="checkbox"/> MVA <input type="checkbox"/> WCB <input type="checkbox"/> Hospitalization (24 hrs +)
STD Benefit Payment Period	_____ Weeks
	Taxable Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No
LTD Benefit Payment Period	_____ 1 year, 2 years, or to age 65
	Own Occupation Period _____ Years
	Taxable Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Submitted to TPA:	_____
COMPLETED BY TPA	
Employee is Eligible for Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No
STD Insured Benefit Amount	\$ _____ Per week
LTD Insured Benefit Amount	\$ _____ Per month
Coverage over the NEM for either benefits	<input type="checkbox"/> Yes (provide comment below) <input type="checkbox"/> No
Are premiums Paid To Date	<input type="checkbox"/> Yes <input type="checkbox"/> No (provide comment below)
Comment:	_____
Completed By:	_____
Date returned to DMI:	_____
FCC USE ONLY	
Date Received from DMI:	_____
FCC Case Manager/Coordinator:	_____
Waiting Period to Apply (days)	_____

COMPLETED FORM TO BE SUBMITTED TO FCC BY DMI WITH STD/LTD BENEFIT APPLICATION PACKAGE